LEGAL EAGLE EYE NEWSLETTER

November 2005 *For the Nursing Profession* Volume 13 Number 11

Code Status Not Clarified: Court Upholds Penalty Imposed On Skilled Nursing Facility.

The US Circuit Court of Appeals for the Sixth Circuit has ruled that clarification of each patient's code status is part of the process of ongoing assessment and care-planning required by Federal regulations for patients in nursing facilities.

The court upheld a civil monetary penalty, dollar amount not specified, imposed on a skilled nursing facility by a contract inspector working for the US Centers for Medicare and Medicaid Services (CMS).

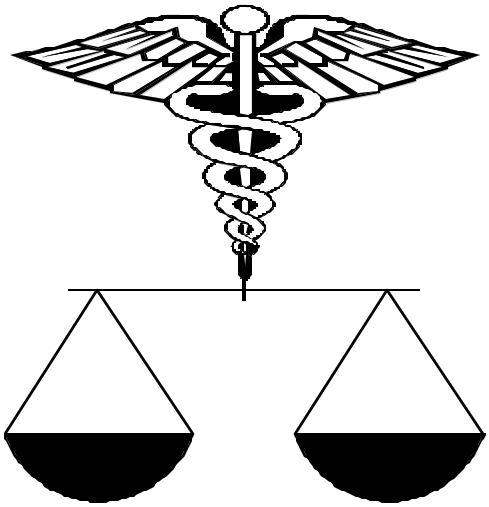
In these legal proceedings, patients are identified only by aliases in compliance with patient-confidentiality rules.

Patient CL1

The admission assessment indicated the patient had no durable power of attorney or other paperwork regarding a health care directive.

The patient had to be taken to the emergency room and was admitted to the hospital as a full-code patient, but then was described as a no-code patient in her hospital discharge papers.

Back at the nursing facility she became pale and unresponsive, stopped breathing and had no pulse. Based on the no-code designation in the hospital papers the nurse did not call paramedics, but instead called the physician to clarify the patient's code status.



Federal regulations call for comprehensive care-planning in nursing facilities.

These regulations, which are written in very general terms, can be interpreted in very specific terms to require clarification of each patient's code status before an event which requires staff to know whether or not to resuscitate.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
October 11, 2005

The court agreed with the CMS inspectors that the nurse's phone call to the physician fifteen minutes after the patient became unresponsive showed that the patient's code status had not been properly clarified.

Proper Clarification Defined

A patient's code status is properly clarified, according to the court, when the physician writes a Full Code or a Do Not Resuscitate order, after having considered the patient's advance directive, or lack thereof, discussions with the patient, family and friends, the patient's religious beliefs, etc.

Patient R27

The patient's chart contained a hospital transfer form indicating she was no-code. The physician's admission notes went over the fact the family wanted the patient classified as no-code due her terminal illness.

However, there was no physician's DNR order. When asked about the patient's code status, the nurses could not find a DNR order in the physician's-order section of the chart and told the CMS inspectors the patient was, therefore, a Full-Code patient. The court saw that as substandard care planning in violation of Federal regulations. **Omni Manor Nursing Home v. Thompson, 2005 WL 2508547 (6th Cir., October 11, 2005).**

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Employee Misconduct: Elevated Glucose Not Reported To Charge Nurse.

An aide working as a psychiatric technician was terminated after she tested a patient's blood glucose, obtained an elevated level and then failed to follow the hospital's policy that she was to verbally inform a registered nurse immediately in order that proper and timely medical follow-up could be initiated.

It was not until a nurse overheard the aide talking about the elevated blood glucose that the nurse was able to take appropriate measures.

The court record did not indicate how high the glucose level was, how long was the delay or whether the patient was actually harmed.

An employee's failure to comply with the employer's policies and procedures can amount to misconduct justifying termination, especially in cases where the employee is a healthcare professional whose failure to adhere to prescribed safety procedures could jeopardize the welfare of a patient.

NEW YORK SUPREME COURT
APPELLATE DIVISION
September 15, 2005

The New York Supreme Court, Appellate Division, ruled that the aide was guilty of misconduct serious enough to warrant termination for cause, which is the general rule when a healthcare worker's neglect did or could have harmed a patient. **Claim of Powell, 800 N.Y.S.2d 790 (N.Y. Sup., September 15, 2005).**

Employee Misconduct: Aide Refuse To Participate In Corrective Interview.

An aide working in a nursing home was reprimanded in writing for improper phone usage, failure to record her patients' weights and for a disrespectful response to a supervisor's instructions to manager her time better.

The aide was asked to meet with the human relations director and director of nursing to discuss their concerns over these incidents and with the aide's overall attitude and behavior.

The aide attended the meeting but refused to address their concerns. She used the meeting instead as a forum to sound off about working conditions at the facility.

Employee misconduct justifying termination is intentional, negligent or indifferent conduct that is a serious violation of the standards the employer has a right to expect or which shows a substantial lack of concern for the job.

COURT OF APPEALS OF MINNESOTA
September 13, 2005

The Court of Appeals of Minnesota upheld the nursing home's right to terminate the aide for misconduct.

Refusal to participate in a meaningful way in a corrective interview is, in and of itself, misconduct justifying termination.

The seriousness of the employee's underlying deficiencies is not the relevant issue when an employee balks outright at corrective action. **Carter v. Lyngblomsten Care Center, Inc., 2005 WL 2208051 (Minn. App., September 13, 2005).**

Employee Misconduct: Discrimination Suit Dismissed.

An aide was terminated for four incidents of misconduct on the job. He responded to his termination by filing an employment-discrimination case against his former employer.

The aide was accused of failing to respond or even to acknowledge a page from a nurse, improperly copying confidential patient records containing the names of the patients, refusing to assist another aide in repositioning a patient in serious respiratory distress, after several requests, and violating special procedures for isolation of patients with antibiotic-resistant staph infections. The patient with whose repositioning the aide refused to assist was transferred to the ICU the same day and died the next day, although it was not directly alleged the aide in question was to blame for the patient's death.

An employer can respond to charges of employment discrimination by showing one or more legitimate, nondiscriminatory reasons for the action taken against the employee.

UNITED STATES DISTRICT COURT
WASHINGTON
October 4, 2005

The US District Court for the Western District of Washington noted the aide could not identify a non-minority with an equivalent record of patient-care deficits who had been treated more favorably by the employer.

More convincing, however, were the serious errors and omissions committed by the aide, which, in the court's judgment, amounted to legitimate, nondiscriminatory reasons for the action his superiors had taken against him. **Howell v. Swedish Medical Center, 2005 WL 2455020 (W.D. Wash., October 4, 2005).**

Aspiration Of Intestinal Contents: Nurses Cleared Of Negligence, Relied Upon Physicians' Orders.

After reviewing the facts in detail the Court of Appeal of California upheld the lower court's dismissal of the family's wrongful death/malpractice lawsuit against the hospital. The court could not find fault with the nurses who took care of the patient and could not assign any degree of responsibility to them for his unfortunate death.

The patient entered the hospital for colostomy-reversal surgery. During the procedure a nasogastric tube was put in which stayed in place while he was in the post-anesthesia recovery unit.

The next day, however, when he was on an acute care unit, the patient himself pulled out the nasogastric tube, according to the court, because it was bothering him.

The patient's nurses promptly called the surgeon. The surgeon told them to leave the tube out. The surgeon came to the unit, examined the patient and continued his order to leave the tube out.

Nursing assessments performed and documented that day indicated the patient denied pain. He was still being medicated for post-surgical pain, was ambulated in the hallway and spent time out of bed in the chair in his room.

The evidence in this case is conclusive. The nurses are not at fault.

The surgeon who had just done the colostomy reversal ordered the nasogastric tube <u>not</u> to be reinserted when the nurses called him right after the patient pulled it out himself.

The surgeon came and saw the patient and reiterated his order <u>not</u> to reinsert the nasogastric tube.

The next day the patient's primary-care physician came and saw him and concurred with the plan to leave the tube out.

When the patient vomited a little that evening, the surgeon was notified.

The next morning he vomited a large amount. The nurses called the house physician and had the patient transferred to the ICU.

He was intubated through a tracheostomy and died three months later.

CALIFORNIA COURT OF APPEAL
September 28, 2005

The next day the patient declined his pain meds, but complained of nausea and got medication for that. Nursing assessments indicated his abdomen was soft and his vital signs were stable. He was ambulated again in the hallway. He was still npo, but the surgeon did allow it and the nurses gave him sips of water sparingly.

His primary-care physician also came in, examined him and concurred that the nasogastric tube should stay out.

Late that evening he complained of nausea and vomited about 50 cc. The nurses gave him Compazine and promptly notified the surgeon.

Early the next morning he vomited a large amount of coffee-ground liquid. The nurses reported it to the house physician. When he started showing signs of respiratory distress the nurses sent him to the ICU where he was intubated through a tracheostomy. He died three months later from Candida septicemia, renal failure and pulmonary vascular compromise.

Family's Nursing Expert's Opinion Is Rejected – Nurses Not At Fault

The court expressly rejected the family's nursing expert's opinion that the nurses deviated from the standard of care by not taking steps to advocate for the nasogastric tube being reinserted after the patient vomited the coffee-ground emesis.

Three times his physicians expressly rejected reinserting the tube. It would only be speculation to say the nurses could have obtained an order for the tube and only speculation to say the tube would have made any difference. **<u>Arguelles v. Seton Medical Center</u>, 2005 WL 2375628 (Cal. App., September 28, 2005).**

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Sleeping On The Job: Nurse's Disability Discrimination Case Rejected.

After twenty-three years at the hospital a nurse was terminated for substandard performance.

Other hospital personnel in the neonatal intensive care unit reported the nurse for sleeping on the job and for being unable to respond quickly to calls for assistance with patients.

The nurse's supervisor twice met with her and offered to transfer her to a different shift to help combat her problem. She refused to change shifts, continued her substandard performance, was fired and then sued for disability discrimination.

Chronic fatigue syndrome may or may not be a disability. That is not the point. The point is, whether or not it is a disability, was there a legitimate, nondiscriminatory reason behind this nurse's employer's decision to terminate her?

COURT OF APPEALS OF OHIO
September 23, 2005

The Court of Appeals of Ohio declined to set a definitive legal precedent whether or not chronic fatigue syndrome should be recognized as a legal disability.

Even if it is a disability, the hospital employer made a sufficient effort to work with this employee to accommodate her condition and had a legitimate, nondiscriminatory reason to terminate her after the accommodation was refused and problems continued which compromised patient-safety standards, the court said. **Cox v. Kettering Medical Center, 2005 WL 2327124 (Ohio App., September 23, 20005).**

Fall During Transfer: Court Faults Nurse.

The patient came to the outpatient clinic for a lithotripsy procedure to dissolve her kidney stones.

The nurse had her change into a hospital gown and lie on a stretcher. The nurse started an IV line in her left hand.

After speaking with the anesthesiologist the patient rejected anesthesia but still wanted to go ahead.

When she was wheeled into the treatment room they tried to lift her bodily off the side of the stretcher but with her kidney stones and with no anesthesia that was too painful. She would have to try to transfer herself. The nurse had her scoot toward the foot of the stretcher, but the nurse did not stand by at the foot of the stretcher when she tried to stand. The patient fell and broke her wrist.

Testimony from an expert witness is proper when the average jury member would not be familiar with the situation and it would assist the average jury member to decide the disputed factual issues in the case.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
October 14, 2005

The Superior Court of New Jersey, Appellate Division, ruled the patient did have the right to sue for the nurse's negligence in not standing by to assist her.

The Appellate Division ruled that the jury's verdict not in the patient's favor in the lower court was in error because the judge refused to allow the patient's nursing expert witness to testify, the judge believing that lay persons are fully competent to judge a nurse's actions in this situation without having to hear expert testimony on the standard of care. **Martin v. Lithotripsy Treatment Group, 2005 WL 2585487 (N.J. Super., October 14, 2005).**

Labor Law: Court Says Hospital Must Fire Non-Union Nurses.

The US District Court for the Eastern District of Missouri noted there was no dispute over the basic facts:

The union was certified by the National Labor Relations Board to represent all 1,400+ nurses at the hospital; 73 nurses refused to pay union dues; the collective bargaining unit as written called for the hospital to discharge any bargaining-unit employee who refused to pay union dues after ninety days on the job; the hospital was the region's only burn center and provided the region's only critical care, obstetrics and neonatal intensive care.

The hospital has not carried the day with its argument that confirming the arbitrator's ruling abruptly dismissing 73 nurses would violate public policy.

UNITED STATES DISTRICT COURT
MISSOURI
September 22, 2005

The hospital argued that its nurse-staffing obligations under state and Federal laws and patient-care quality would be jeopardized and these were valid public-policy reasons to void the arbitrator's decision it had to dismiss 73 nurses abruptly.

The court agreed nurse staffing and patient-care quality are valid concerns, but ruled that the hospital needed to do more that raise those issues in a general way.

The hospital did not come up with convincing evidence as to the actual impact the dismissals would have on patient care delivery or prove why it could not just hire more union nurses. **United Food and Commercial Workers v. St. John's Mercy Health System, 2005 WL 2333922 (E.D. Mo., September 22, 2005).**

Long-Term Care: New CMS Regulations Now Require Influenza, Pneumococcal Immunizations.

SUMMARY: The goal of this final rule is to increase immunization rates in Medicare and Medicaid participating long term care (LTC) facilities by requiring LTC facilities to offer each resident immunization against influenza annually, as well as lifetime immunization against pneumococcal disease.

LTC facilities will be required to ensure that before offering the immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of immunization.

The facilities will be required to offer immunization against influenza annually and immunization against pneumococcal disease once, unless medically contraindicated or the resident or the resident's legal representative refuses immunization. Increasing the use of Medicare-funded preventive services is a goal of both CMS and the Centers for Disease Control and Prevention (CDC).

Effective Date: These regulations are effective on October 7, 2005.

Sec. 483.25 Quality of care.

* * * * *

(n) Influenza and pneumococcal immunizations--

(1) Influenza. The facility must develop policies and procedures that ensure that--

(i) Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures that ensure that--

(i) Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

(v) Exception. As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

FEDERAL REGISTER October 7, 2005
Pages 58833-58852

On October 7, 2005 the US Centers for Medicare and Medicaid Services (CMS) announced new regulations that will take effect immediately requiring that influenza and pneumococcal immunizations be offered in long-term care facilities.

These regulations have been formally adopted in final, mandatory form and take effect October 7, 2005.

In our September, 2005 newsletter we published a proposed version of the new regulations which CMS published August 15, 2005.

Please take note that the wording of the final regulations dated October 7 is different from the August 15 proposed version.

Our readers are advised to discard the August, 2005 version of these regulations and to refer only to the final version of the regulations we are publishing here. These materials are not copyrighted and may be copied and redistributed.

The CMS October 7, 2005 Federal Register announcement is on our website at http://www.nursinglaw.com/LTCvaccines.pdf. The new regulations are at the very end of the announcement.

FEDERAL REGISTER October 7, 2005
Pages 58833-58852

Male And Female Bathed In Same Room: Nursing Home Aide Cleared Of Abuse Charges.

An aide working with dementia patients in a nursing home brought a seventy-six year-old male and an eighty-two year-old female resident into the same bathroom at the same time, one for a tub bath, the other for a shower, and they saw each other naked.

The aide was convicted of the criminal offenses of mistreatment of a confined person and disorderly conduct by a caregiver. The Court of Appeals of Minnesota, however, threw out the convictions, finding that the aide had no intention to abuse her patients.

Time Pressure To Complete Personal Care Assignments

According to the court, the aide had only forty five minutes to bathe and dress the two residents before dinner. They were both elderly and suffered from dementia. The woman usually resisted being bathed and took extra time.

The aide brought the woman into the bathroom, undressed her and put her in the tub. Then she went and got the male resident, undressed him where the woman in the tub could not see him, put him in the shower and pulled the privacy curtain around him.

It was when both were being dried, at this point with the help of a second aide, that they briefly saw each other.

No Intent To Abuse

The court said the aide had no illicit purpose in mind when she brought the two residents together as she did. Her motivation was only to get both of them ready for dinner in a compressed time frame.

The female resident was upset after the incident, but the court pointed out she was usually a difficult patient to bathe and would often become upset under normal circumstances over having to bathe.

Intent to commit abuse is necessary to convict a caregiver of criminal charges and that intent did not exist in this case, the court ruled. **State v. Gondrez, 2005 WL 2429812 (Minn. App., October 4, 2005).**

The nursing director of the facility testified that bathing a male and female patient together is a violation of accepted standards for personal care in a nursing home. It is a violation of the right to personal privacy which is guaranteed to nursing-home residents by state law.

However, a violation of personal privacy is not a criminal offense unless there is intent to inflict some element of embarrassment, humiliation or mental cruelty upon the vulnerable person.

Abuse of a vulnerable person can include offensive, obscene or abusive language or conduct, knowing or having reasonable grounds to know that it will or will tend to anger, alarm or disturb the vulnerable person.

Abuse is a criminal offense only when it is intentional. Intentional means that the perpetrator either has a purpose to do the thing or to cause the result or believes that the act performed will cause the result.

COURT OF APPEALS OF MINNESOTA
October 4, 2005

Ice Packs Post-Knee Surgery: Nurses Found Negligent, But No Link To Complications.

The physician crossed out the portion of the hospital's standard post-op order form referring to "cold therapy" as his way of communicating the nurses that he did not want ice packs used on his patient's knee following knee replacement surgery.

The nurses, however, went ahead covered the bandaged knee with towels and applied ice packs.

When the surgeon was sued for malpractice over complications in the healing of the surgical wound, his lawyers alleged the complications were caused by the nurses' negligence in ignoring or misinterpreting the doctor's orders.

A physician is not liable for the negligence of nurses over whom the physician has no control.

However, there still must be proof of a cause-and-effect link between the nurses' negligence and harm to the patient.

COURT OF APPEALS OF GEORGIA
October 4, 2005

The Court of Appeals of Georgia agreed it is negligence for nurses not to follow the physician's orders. However, the physician himself testified he made no mention of the ice packs in the chart because he saw no real potential for complications. Negligent or not, there was no direct link between the nurse's actions and delayed healing, in the court's opinion. **Moss v. Weiss, __ S.E. 2d __, 2005 WL 2432566 (Ga. App., October 4, 2005).**

Student Nurse: Errors And Omissions Are Professional Malpractice.

According to the record in the Court of Appeals of Michigan, a student nurse administered nystatin to a patient through an intravenous line rather than giving it orally and the patient soon died as a direct result.

The family sued the hospital where it happened and the board of regents of the university where the student nurse was enrolled. The circuit court dismissed the family's lawsuit on the grounds the family's attorneys did not file an expert witness report as required by state law.

Failure of a student nurse to read, understand and implement a physician's order is professional malpractice, not ordinary negligence.

The reasons why a nystatin suspension must be given orally and not intravenously are not within the common understanding of lay persons.

COURT OF APPEALS OF MICHIGAN
September 29, 2005

The Court of Appeals of Michigan agreed and upheld the dismissal.

A student nurse is required to exercise professional nursing judgment when administering medications. A student nurse is expected to understand the importance of correctly reading and following physicians orders and must also understand and follow safety considerations when administering medications to patients.

Expert testimony is required to sue for a student nurse's errors and omissions, the court ruled. **Dennis v. Specialty Select Hosp.-Flint, 2005 WL 2402454 (Mich. App., September 29, 2005).**

Nurse Midwife: Court Finds Substandard Practice, Upholds Suspension Of ARNP License.

Maternal care, including prenatal care and labor and delivery can be practiced safely in an out-of-hospital setting.

While there may be two schools of thought, one for independent and one for hospital-based midwives, there is only one legal standard of care for midwives.

Regardless of whether the birth was a hospital birth or a home birth, certain standards exist for patient safety. Midwives must make decisions which result in healthy outcomes for the families they serve.

The law does not support the argument that a midwife from one school of though, an independent midwife, cannot be judged by the standards reflected in the expert testimony of a midwife from the other school of thought, that is, hospital-based midwifery.

The Nursing Care Quality Assurance Commission sets state standards for nursing advanced practice and passes judgment on alleged violations of those standards. The courts give great deference to the Commission's findings.

COURT OF APPEALS OF WASHINGTON
September 26, 2005

The Court of Appeals of Washington upheld the state's Nursing Quality Assurance Commission's suspension of a Certified Nurse Midwife's license for substandard care of two patients.

Two Schools of Thought?

The court expressly rejected the argument that an independent nurse midwife practices under a different legal standard of care than a hospital-based nurse midwife, finding there is only one legal standard of care for patient safety defined by the state Commission's regulations.

Patient A

The patient came to the midwife's office to report a possible fluid leak the day before. The leak was confirmed with a chemical test as possible evidence of premature rupture of her membranes. Two days later the midwife went to the patient's home because she called her to report a temp of 100.8º and a fetal heart rate of 170. The midwife phoned a physician who recommended hospital transfer, prophylactic antibiotics and blood work. The next morning the patient, still at home, was fully dilated and meconium was present but her labor was not progressing. The patient was not transported to the hospital until later that afternoon.

Patient B

The midwife began following this patient at twenty-seven weeks. The patient indicated a preference for a water delivery.

The patient was having intermittent high blood pressure, but no medical follow-up was suggested to her. After her due date and revised due date had passed, the midwife recommended she not consider induction of labor. At more than forty-two weeks the midwife did an ultrasound which showed the fetus had died.

The court upheld the Commission's findings of fault based on delay in physician consultation in both cases where the signs pointed to complications beyond a midwife's expertise. **O'Conner v. Dept. of Health, 2005 WL 2338685 (Wash. App., September 26, 2005).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Narcotics, Respiratory Depression, Hypoxia, Brain Injury: Court Applies A Different Standard Of Care In Emergencies.

The patient was treated in a hospital emergency room following a motor vehicle accident in which she lost consciousness.

Treatment involved administration of morphine, Phenergan and Ativan. The patient apparently suffered respiratory depression which resulted in hypoxia, which in turn led to neurological brain injuries.

The patient's malpractice lawsuit alleged negligence on the part of the physician and nurses who treated her in the emergency room. The lawsuit specifically faulted the manner in which medications which can cause respiratory depression were administered.

The patient's medical expert's opinion only reiterated the generic standard of care:

A baseline of vital signs must be established, i.e., blood pressure, pulse, respiratory rate and mental status, prior to administration of the medication.

After administration of the first dose, and before and after each subsequent dose, the same vital signs must be periodically reassessed for evidence of respiratory depression.

Any departure from this standard of care is negligence. If it can be proven to have harmed the patient, the patient can sue for damages, according to the patient's expert.

The Court of Appeals of Texas, however, ruled that the patient's physician/expert was not an expert on the standard of care for doctors and nurses treating emergency cases. The Court of Appeals dismissed the lawsuit on the grounds that competent expert testimony was lacking.

In emergency situations, caregivers are not necessarily able to assess and reassess the patient's vital signs, mental status and respiratory function at their leisure, and other factors such as a cranial injury, which sometimes cannot be readily and quickly assessed, may come into play while the patient needs medication for pain and anxiety so that necessary care can be given. **Cox v. Vanguard Health Systems, Inc., 2005 WL 2367582 (Tex. App., September 28, 2005).**

Pressure Sores: Court Upholds Sanctions Imposed On Nursing Facility By CMS Inspectors.

Federal regulations require long term care facilities to ensure that a resident who enters the facility without a pressure sore does not develop a pressure sore unless the resident's clinical condition demonstrates that it was unavoidable.

The US Circuit Court of Appeals for the Sixth Circuit pointed out that the administrative law judge required the nursing facility to prove the patient's pressure sores were unavoidable, rather than requiring the CMS inspectors to prove they were avoidable.

The court said that may contradict the US Administrative Procedures Act which in general places the burden of proof on the government. However, the court declined to make this case a definitive precedent on that issue.

A nursing facility can appeal a violation of Federal standards.

The state inspector's ruling can be appealed to a Federal administrative law judge, then to the Department Appeals Board within the Department of Health and Human Services, then to the US Court of Appeals.

The court, however, gives great deference to the inspector's judgment.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
October 7, 2005

The court found specific deficits in the patient's care which justified the $2,800 fine imposed on the facility:

The patient had to be placed on a psychoactive medication. The medication tended to decrease his mobility, but his plan of care was not amended for almost two months to take into consideration his new increased susceptibility to breakdown of skin integrity.

The new care plan called for daily skin assessments, but the physician wrote orders only for weekly assessments and only that was done.

Only sporadic repositioning could be found in the nursing records as the patient was starting his psych med and was most vulnerable to skin breakdown. **Sanctuary at Whispering Meadows v. Thompson, 2005 WL 2470997 (6th Cir., October 7, 2005).**