Patient vs. Patient Assault In Long Term Care: Court Finds Violation Of Federal Regs.

An elderly gentleman was admitted to a long term care facility with a diagnosis of organic brain syndrome.

For almost three years at the facility he had numerous incidents of aggression toward staff and other residents. Some of the episodes involved physical assaults on other residents, others were merely verbal.

He was seen numerous times by psychiatric professionals. Recommendations were made that he needed a structured behavior program, something the facility in question did not offer. With organic brain syndrome he was not a candidate for treatment in a psychiatric hospital.

At times his acting out would subside, and once did subside for almost a year with close medical monitoring of his psychiatric medications. At other times he did act out in ways that were quite alarming to facility staff.

The administrator began the process of involuntarily transferring him to a facility with a structured behavior program for patients like him, but the state long term care ombudsman told the administrator she would block any attempt to move him.

He then attacked a vulnerable female resident who had a walker, pushing her against the wall. The resident died from her injuries. The episode prompted a state investigation.

Federal Regulations

The department found a violation of Federal regulations which require long-term care facilities to attend to their residents' psychosocial needs.

The regulations dealing with abuse and neglect by facility staff were not violated.

The Court of Appeals of Indiana ruled expressly that the administrator should have known that the ombudsman had no legal authority to block an involuntary transfer and should not have aborted the process on that basis. **Board of Health Facility Administrators v. Werner, __ N.E. 2d __, 2006 WL 306385 (Ind. App., February 10, 2006).**

The facility violated Federal regulations for long-term care, specifically 42 CFR 483.25(f):

(f) Mental and Psychosocial functioning.

Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

The regulations at 42 CFR 483.13(c) dealing with abuse and neglect by staff were not violated.

The overall quality of care at the facility was actually quite good. The administrator should have been censured, not suspended.

COURT OF APPEALS OF INDIANA
February 10, 2006