Skilled Nursing, Medicare Standards (Continued.)

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An inspector observed an aide wiping stool from a resident's perineal area forward toward the area of her urinary tract without turning the cloth to a clean side or getting another clean cloth.

The resident did not then have or later develop a urinary tract infection. Only on one occasion did the inspector see her receive incontinence care.

However, actual harm to a resident is not necessary for a violation of Medicare standards to occur. The court sided with the inspectors on this issue. All that is necessary for a violation is inappropriate care that creates a risk of more-than-minimal harm to a resident.

Range of Motion
No Knee Splints

42 CFR § 438.25 (e)(1) says that a facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

One resident, who entered with no range-of-motion deficits in his lower extremities, developed limitations in both knees despite orders from his physician for knee splints on an alternating four-hours-on, four-hours-off cycle. The physician's orders were implemented nine days late, after the inspection.

The facility argued that he was bedridden and was not going anywhere. Furthermore, he was easily agitated and often refused to take his pills. The court pointed out, however, that Medicare standards contain no "difficult to work with" exemption. A physician's orders must be followed or at least there must be competent documentation why not, the court said.

Janitor's Closet Not Locked
Created Accident Hazard

42 CFR § 438.25 (h)(1) requires a facility to ensure that the residents' environment remains as free of accident hazards as is possible.

The court accepted the state inspectors' observation that the janitor's closet was not locked and validated their judgment that an unlocked janitor's closet poses an unacceptable risk of harm due to the presence of dangerous substances that dementia patients could get into.

The court rejected the facility's argument that it could not be penalized with no actual harm happening to a resident. The court reiterated again that the potential for more than minimal harm to a resident is all that is required to impose a civil monetary penalty on a nursing facility.

Two Persons To Assist In Transfer
Only One Aide Involved – Fall

42 CFR § 438.25 (h)(2) requires a facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

One resident's nursing and occupational-therapy assessments pointed to the need and her care plan stated that she was to have two staff members for bed mobility, toileting, transfers and bathing.

In reading her chart the state inspectors found a past incident where she slid out of her geri chair, fell to the floor and injured her forehead and nose, while in the bathroom with only one aide.

When the surveyors questioned the aide about the incident the aide said she had put a gait belt on the resident's waist, then stood in front of her and tried to raise her to a standing position.

If another staff member had been present, per the resident's care plan, the other person could have grasped the gait belt correctly from behind the patient and prevented her fall, the court concluded.

The court was not swayed by an occupational-therapy assessment two weeks later to the effect the resident was mentally alert and physically strong enough for one-person assists in transfer. It was not relevant to the time frame in question; at that time she was still a two-person-assist patient. **Harmony Court v. Leavitt, 2006 WL 2188705 (6th Cir., August 1, 2006).**

Postpartum Bleeding: Jury Rules Nurses Not At Fault.

Six hours after an induced delivery the patient had to have a dilation and curettage under saddle-block anesthesia because she had been expelling large blood clots. Fifteen minutes after the D & C she coded and died. The cause of death could not be established in the autopsy.

The family's lawsuit, among other things, alleged faulty monitoring by the postpartum nurses before the D & C.

The nurses reported to her obstetrician that she had stable vital signs but was expelling large blood clots, some estimated at 500 cc, and had lost a lot of blood while voiding urine. The nurses did not flush the toilet, so that the physician could see what was there when he came to see the patient. The nurses also re-started a specified dose of pitocin and performed uterine fundal massage as ordered.

The Superior Court of New Jersey, Appellate Division, approved the jury's verdict exonerating the physicians, nurses and hospital.

The jury rejected the family's nursing expert's opinion that the nurses should have counted and calculated a total net fluid weight for all the pads she had used. **Hein v. Community Medical Center, 2006 WL 2265100 (N.J. App., August 9, 2006).**

Nursing Home Arbitration Thrown Out.

The District Court of Appeal of Florida ruled that an alternative-dispute-resolution clause in nursing-home admission papers is invalid if it tries to limit the resident's rights set out by state nursing-home statutes. The resident can file suit in court to enforce his or her rights. **SA-PG-Ocala, LLC v. Stokes, __ So. 2d __, 2006 WL 2347369 (Fla. App., August 11, 2006).**