LEGAL EAGLE EYE NEWSLETTER

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Understaffing: Court Blames DON For Death, Aide Did Not Have Time To Read Care Plan.

The resident's care plan called for two people to work with her any time she was transferred from her wheelchair to her bed.

She was considered a dependent transfer. Any time a dependent transfer was carried out the facility's rules called for a transfer belt to be used.

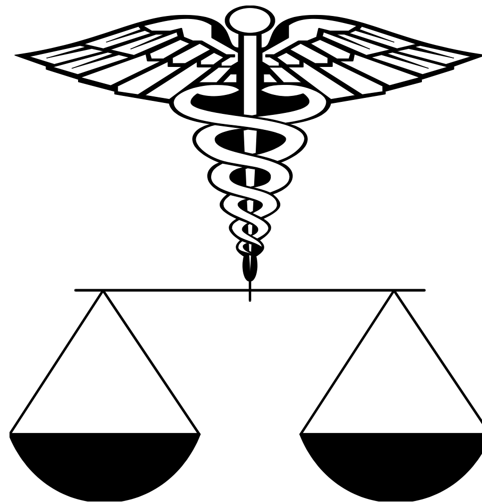
One certified nurses aide tried to transfer the resident from her wheelchair to her bed. She fell to the floor. She died the next day. The medical examiner ruled trauma from the fall was the cause of death. The family sued the nursing facility, the administrator and the director of nursing.

The jury awarded $856,000 to the family, finding the administrator and the director of nursing negligent.

The Court of Appeals of Texas, in a memorandum opinion, agreed with the jury that the administrator and director of nursing were negligent, but overturned the jury's verdict on evidentiary grounds and ordered a new trial.

Understaffing
Aide Did Not Have Time
To Read The Care Plan

The aide testified she did not read the care plan because she did not have time. Had she read the care plan she would have known this resident was a two-person transfer.



The aide did not read the care plan that called for a two-person transfer.

The jury was entitled to conclude the aide did not read the care plan because the aide did not have time because the facility was understaffed.

The administrator and the DON deliberately allowed the facility to go understaffed.

COURT OF APPEALS OF TEXAS
MEMORANDUM OPINION
June 23, 2004

Had she read the care plan, this tragic incident would not have occurred, according to the court.

Medicare guidelines required the facility to provide sufficient staffing so that 191 minutes of certified aide time would go to this resident in any 24 hour period. However, general staffing levels at the facility would allow only 105 minutes for this resident, in clear violation of Medicare standards.

On the day in question the situation was worse because two aides called in sick. The administrator and director of nursing knew the facility was critically understaffed but did not call in off-duty personnel, did not phone the facility's four sister facilities in the area to locate available staff or go to a nursing agency to get help, the court said.

The court laid the blame squarely on the administrator and director of nursing for the resident's death.

Evidence of Other Falls

The judge allowed the family's lawyers to present evidence there were more than 800 other falls at the facility. Without proof they all happened under similar circumstances the judge was in error to allow that evidence in the case, and a new trial was ruled appropriate.

Penalver v. Living Centers of Texas, Inc., 2004 WL 1392268 (Tex. App., June 23, 2004).

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