NURSING HOME ABUSE AND NEGLECT CLAIMS

By

Melvin B. Wright
Colling Gilbert Wright & Carter
2301 Maitland Center Parkway
Maitland, Florida 32751
(407) 712-7300
www.TheFloridaFirm.com
MWright@TheFloridaFirm.com

WHAT IS NURSING HOME ABUSE?

I. FEDERAL LAW

a. UNITED STATES CODE

42 U.S.C. 1395i-3(c)

A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free from restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--
(I) to ensure the physical safety of the resident or other residents, and
(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency

circumstances specified by the Secretary until such an order could reasonably be obtained).

(iii) Privacy

The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

(iv) Confidentiality

The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

(v) Accommodation of needs

The right--
(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and
(II) to receive notice before the room or roommate of the resident in the facility is changed.

(vi) Grievances

The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(vii) Participation in resident and family groups

The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(viii) Participation in other activities

The right of the resident to participate in social, religious, and community activities that do not interfere

with the rights of other residents in the facility.

(ix) Examination of survey results

The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

(x) Refusal of certain transfers

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this subchapter) to a portion of the facility that is not such a skilled nursing facility.

(xi) Other rights

Any other right established by the Secretary.

b. CODE OF FEDERAL REGULATIONS

42 C.F.R. § 483.13

(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must--
(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
(ii) Not employ individuals who have been--
(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

42 C.F.R. § 488.301

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

42 C.F.R. § 483.25 Quality of care.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to--
(i) Bathe, dress, and groom;
(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and
(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident--

(1) In making appointments, and
(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that--

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and
(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) 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; and
(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent

further decrease in range of motion.

(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.

(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and
(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents. The facility must ensure that--

(1) The resident environment remains as free of accident hazards as is possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;
(3) Colostomy, ureterostomy, or ileostomy care;
(4) Tracheostomy care;
(5) Tracheal suctioning;
(6) Respiratory care;
(7) Foot care; and
(8) Prostheses.

(l) Unnecessary drugs--(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
(i) In excessive dose (including duplicate drug therapy); or
(ii) For excessive duration; or
(iii) Without adequate monitoring; or
(iv) Without adequate indications for its use; or
(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--
(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors. The facility must ensure that--

(1) It is free of medication error rates of five percent or greater; and
(2) Residents are free of any significant medication errors.

c. 42 C.F.R. §483.15 Quality of life.

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

d. INTERPRETIVE GUIDELINES TO SURVEYORS OF LONG TERM CARE FACILITIES

"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

Properly trained staff should be able to respond appropriately to resident behavior. The CMS does not consider striking a combative resident an appropriate response in any situation. Retaliation by staff is abuse and should be cited as such. [added 10-14-05]

This also includes deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, pain or mental anguish.

"Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability.

Examples of verbal abuse include, but are not limited to: threats of harm: saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

"Sexual abuse" includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.

"Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

"Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

II. STATE LAW

a. RESIDENT'S RIGHTS ACTS (CHAPTER 400, *FLA. STAT.)*

400.022 Residents' rights.--

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights….

(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents...

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's

spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

....

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral

explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

400.023 Civil enforcement.--

(1) Any resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death. If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action, and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.023-400.0238 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022. This section does not preclude theories of recovery not arising out of negligence or s. 400.022 which are available to a resident or to the agency. The provisions

of chapter 766 do not apply to any cause of action brought under ss. 400.023-400.0238.

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 400.022 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(4) In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(5) A licensee shall not be liable for the medical negligence of any physician rendering care or treatment to the resident except for the administrative services of a medical director as required in this part. Nothing in this subsection shall be construed to protect a licensee, person, or entity from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(6) The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights

specified in this part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

(7) An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

b. FLORIDA ADMINISTRATIVE CODE

FLORIDA ADMINISTRATIVE CODE § 59A-4.1288

- Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 C.F.R. 483.
- In other words, OBRA is the standard of care in Florida nursing homes that accept Medicare/Medicaid reimbursement.

c. FLORIDA ADULT PROTECTIVE SERVICES ACT

§415.102(1), Florida Statutes

- "Abuse" means the nonaccidental infliction of physical or psychological injury or sexual abuse upon a disabled adult or an elderly person by a relative, caregivers, or household member, or an action by any of those persons which could reasonably be expected to result in physical or psychological injury, or sexual abuse of a disabled adult or an elderly person by any person.

- "Abuse" also means the active encouragement of any person by a relative, caregivers, or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological injury to a disabled adult or an elderly person.

d. § 415.102(20), Florida Statutes

- "Neglect: means the failure or omission on the part of the caregiver of a disabled adult or elderly person to provide the care, supervision, and services necessary to maintain the physical and mental health of the disabled adult or elderly person, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well being of a disable adult or an elderly person.

- The term "neglect" also means that failure of a caregiver to make a reasonable effort to protect a disabled adult or an elderly person from abuse, neglect, or exploitation by others. "Neglect" is repeated conducted or a single incident of carelessness which produces or could reaonably be expected to result in serious physical or psychological injury or a substantial risk of death.

e. FLORIDA STAFFING REQUIREMENTS

FLORIDA ADMINISTRATIVE CODE

- (4) The nursing home facility shall have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

- The facility will staff, at a minimum, an average of 1.7 hours of certified nursing assistant and .6 hours of licensed nursing staff time for each resident during a 24 hour period.

- (6) No nursing services staff person shall be scheduled for more than 16 hours within a 24 hour period, for three consecutive days, except in an emergency. Emergencies shall be documented and shall be for a limited, specified period of time.

§ 400.23 AND § 400.141, FLORIDA STATUTES

- Pursuant to Section 400.23, CNA staffing at nursing homes must be increased to 2.3 hours of direct care per patient per day beginning January 1, 2002, 2.6 hours by January 1, 2003 and ultimately increasing to 2.9 hours beginning January 1, 2004.

- This section also requires nursing homes to have not less than one CNA for every 20 residents beginning January 1, 2002.

- It also requires a minimum of one hour of licensed nursing care per resident per day.

- Additionally, Section 400.141 requires that every nursing home must submit to AHCA twice a year information on staff to resident ratios, staff turnover, and staff stability.

- This section also requires nursing homes to report compliance with nurse staffing standards and to post daily the names of staff on duty.

III. TYPES OF ABUSE

- *Sexual and Physical Abuse*

  Sexual and/or physical assault and battery by other residents or staff members occur far too often in long term care facilities, often due to understaffing and resulting lack of supervision providing the undiscovered predator the opportunity to abuse defenseless physically and mentally impaired residents. Unlike a negligent security case against an apartment complex or commercial establishment, negligent hiring or retention of a sexual or physically abusive predator or notice of the propensity to sexually or physically abuse others is not necessarily a predicate to liability of the long term care facility for the abuse. Long term care facilities owe a non-delegable duty to residents to assure their safety, privacy, and to keep them free from such abuse.

  The failure to perform background checks of employees who turn out to be sexual predators or physically abusive, the failure to observe suspect behavior in employees hired with "clean" criminal records, and the failure to have adequate policies and procedures in place to protect against abuse by eliminating the opportunity for sexual or physical abuse by either employees or other residents, may all provide a basis for liability of a long term care facility for sexual abuse of its residents.

- *Verbal and Mental Abuse*

  Caring for physically and mentally impaired residents of long term care facilities is a demanding job, both emotionally and physically. This is particularly true for the rank and file floor nurses and aides who provide most of the hands-on care. When those nurses and aides are not provided the tools, i.e. adequate number of staff, adequate training, proper instruction, and established policies and constant reminders, it is only human for some staff members to lose their focus and allow their attention to quality of care to suffer as a result. Unfortunately, in their frustration, some staff will attempt shortcuts to finishing their daily chores and such shortcuts can include engaging in verbal and/or mental abuse to exert control over physically and mentally impaired patients in a misguided effort to save time and get the job done during their shift.

  Staff members have been known to use threats and intimidation toward patients in order to exert control and induce quick compliance with simple requests. Others have been known to engage in name-calling, racial or ethnic slurs, and other forms of verbal abuse. Forced "solitary confinement" or withholding of desired activities, treasured mementos, or other forms of mental abuse are all too common.

These types of abuse are strictly forbidden, and like sexual and physical abuse, can be virtually eliminated with proper hiring, training, instruction and supervision. "Rogue" employees will always exist, but such behavior is contagious if not checked and can become the rule rather than the exception if left unchecked by management. This can only be accomplished with aggressive, continuous implementation of strict policies and procedures to discourage and eliminate such abuse.

- *Physical and Chemical Restraints*

The OBRA regulations enacted in 1987 prohibit the use of restraints, either mechanical or pharmaceutical, absent a physician's order in almost all cases. Such restraints may only be used in narrow circumstances to protect the resident or others from harm. Presumably, all facilities have policies and procedures tracking the requirements of federal regulations, as well as any additional state laws or regulations, with regard to the use of restraint devices. Additionally, the use of sedatives, behavioral modification drugs, and antipsychotic medications are strictly regulated and virtually all facilities have policies tracking those regulatory requirements, consistent with the guidance and orders of attending physicians and consultants. Narcotic medications, particularly, require maintenance of detailed records of dispensation and strict storage rules.

IV. TYPES OF NEGLECT

- *Pressure sores*

Pressure sores or "bedsores" are caused by unrelieved pressure, typically on the bony areas of the body, e.g. tailbone, heels, elbows, etc. in bedridden patients. While bedsores are sometimes unavoidable in patients with severely compromised immune systems and other disease processes, most bedsores are preventable with diligent skin care and recognized preventative care according to the wealth of medical literature and professional and federal guidelines.

The initial admission assessment and periodic reassessments of the resident by the interdisciplinary care team at the long term care facility should identify whether a particular resident is at risk. If so, the extent of risk is assessed and interventions proposed to avoid development of pressure sores or worsening of existing pressure sores. Prevention measures include turning and repositioning schedules, pressure relief mattresses or pads, regular skin care and assessment, proper hygiene, proper toileting, adequate nutrition, and wound care. Failure of the care planners to properly assess and plan for prevention or treatment of bedsores, as well as failure of staff to provide the care and services required by the care plan, make it very difficult for a long term care facility to defend a bedsore case on the grounds that it was unavoidable.

- *Malnutrition and Dehydration*

Of course, proper nutrition is essential to good health in any human being, and are even more critical for residents of long term care facilities who, by definition, have pre-existing conditions and aging processes leaving them at increased risk for declining health and the development of health problems. Assuring that residents who require assistance at mealtime are receiving adequate nutrition and fluids is time-consuming and requires adequate staffing. Widespread malnutrition and dehydration at a facility is an indicator of chronic understaffing. Meal and fluid intake forms must be analyzed to determine whether the staff provided the necessary services to maintain adequate nutrition and hydration. Likewise, urine output and toileting records, weight charts, and specific laboratory data are important pieces to the puzzle in determining whether a particular resident's malnutrition or dehydration was unavoidable due to disease or aging process or due to abuse or neglect.

Dieticians, speech therapists, and restorative nurses should also be used to address particular conditions leaving certain patients at higher risk of weight loss or dehydration. Stroke victims, for example, will often have neurological damage causing swallowing difficulties, and patients with dementia, dentures or gastrointestinal conditions may also be at increased risk of malnutrition. Proper assessment of their dietary needs may call for specialized diets, such as mechanically softened meals, pureed food, and food supplements. It is the duty of the long term care facility to ensure that the interdisciplinary care team meets its responsibilities in ensuring nutritional needs are met, even in "problem" patients with these risk factors for malnutrition or dehydration.

The use of feeding tubes are last resorts that must be discussed with family members and/or health care surrogates responsible for making decisions for residents based upon the particular medical conditions and the residents' previously documented desires in living wills or other advance care directives.

- *Medication Errors*

  One of the most common types of negligence in any health care setting, nursing homes included, is medication error. Errors can be the result of transcription error on physician's orders, MAR's (medication administration errors), nurses' notes or physician's progress notes. Medication errors can also simply result from human error. Rarely are medication errors considered outright abuse or neglect, and most often, they are single incidents of negligence.

- *Falls, Elopements, Wandering*

  Upon admission to a long term care facility, residents are assessed for many risks, and among these, are the risk of falling, wandering, or elopement from the facility. Almost all facilities have assessment forms used in this process, and when residents are assessed at risk, standard interventions are made a part of the care plan to prevent such incidents. Prevention measures include frequent

monitoring, toileting schedules, use of lowered beds, removable restraints (lap belts, lap "buddies", etc.), electronic body and bed alarms, and even specialized equipment such as electronic tethering devices that sound an alarm when a resident leaves a certain areas of the building or when passing through exits from building.

- *Choking/Asphyxiation*

  Residents with special diets or neurological damage from strokes or other medical conditions are often at increased risk of choking, particularly at mealtime. Proper nutritional assessments should include an assessment of the risk of such injuries which are most often fatal if a patient aspirates food, chokes, or asphyxiates while unsupervised at mealtime. In addition to specialized diets, the need for restorative dietary aides to assist at mealtime must be addressed and each particular resident's needs met in order to avoid tragic consequences.

- *Burns/Scalds*

  Burn injuries are more common than one might expect in long term care facilities. Often, burns involve residents who are smokers and accidentally ignite themselves or burns from uncontrolled water temperatures in showers or whirlpool therapy.

  Obviously, residents who smoke should be required to follow smoking policies of the particular facility. Almost all facilities have strict smoking policies with designated smoking areas and procedures for staff to follow when supervising resident smokers. If they do not have such a policy, each facility should also have a policy requiring smoking paraphernalia to be kept in secure locations to prevent impaired residents from smoking at improper times, places or manners. Since many residents are mentally or emotionally impaired, the staff is obliged to keep a close watch on their smoking habits, both for the security of the resident smoker and resident non-smokers. Supervision of smoking is the primary key to safety.

  Water temperature must be strictly controlled and any applicable state regulations or internal facility policies followed. Again, supervision is the primary key to safety as many residents have impaired senses that may result in serious burn injuries before the resident realizes the excessive temperature.

  Serious thermal injuries can also occur from overexposure when frail residents with poor skin turgor are left outdoors for excessive periods.

PROVING ABUSE AND NEGLECT

I. Law Enforcement Investigation

If your case involves a reported case of abuse or neglect, law enforcement authorities will often be called upon to investigate. After a full investigation, a an investigative report will result and can serve as a road map for litigation in many cases and, at worst, a valuable investigative tool for the civil litigation.
Law enforcement authorities investigate a wide variety of cases including sexual or physical abuse, neglect or exploitation, unexplained or suspicious deaths, and elopement/missing persons cases.

II. Department of Children and Families

Like law enforcement authorities, the State of Florida Department of Children and Families is called upon to investigate reported cases of abuse or neglect. They also issue investigative reports that can be valuable sources of investigative information for litigants and their attorneys. Always ask your client if they have reported a case of suspected abuse or neglect to the "abuse hotline" of the Department of Children and Families. If they haven't, it is often wise to do so, and to await the investigative results and request the investigative report.

III. Agency for Health Care Administration

The State of Florida Agency for Health Care Administration also performs investigations of incidents of abuse and neglect to determine if the facility has violated laws and regulations setting the standard of care and operations of long term care facilities. Always ask clients if they have reported suspected abuse or neglect to AHCA. If they have not, it is advisable that they do so. The investigative survey reports arising from these investigations can likewise prove to be valuable sources of information for the litigants and their attorneys.

AHCA also performs surveys of all long term care facilities at regular intervals to assure compliance with OBRA regulations, the Florida Administrative Code and federal and state statutes. AHCA issues citations regarding any deficiencies that are discovered during these investigations. Surveys are extremely valuable tools for establishing deficiencies in overall facility operations during certain time frames that will overlap with a particular residents stay. AHCA surveys can help prove a pattern of inadequate care in all categories of patient care, from facility-wide staffing and hiring practices to specific areas of resident care, such as pressure sore prevention and treatment, nutrition, hydration, infection control, etc.

While surveys do not identify residents or staff members by name, one can often determine if a particular resident is the subject of any survey findings by reference to certain rooms, halls or wings of a facility, together with the medical diagnoses and condition of the resident. More often than you would expect, a particular abused or neglected resident is the subject of surveyors' findings and citations. In addition, although surveys do not always result in "confirmed" instances of abuse or neglect, the factual observations of the surveyors and citations issued can be valuable elements of

proof that corroborate litigants' independent investigation findings and discovery in litigation.

IV. Patient Records

All patient records should be requested and reviewed by both counsel and a qualified expert in nursing home care. In the typical nursing home case, a nurse with experience in long term facility nursing standards, such as a former director of nursing, is a must. In addition, records should be reviewed by a qualified geriatric medical specialist, such as an internal medicine physician with experience in geriatric care. Preferably, a former long term care facility medical director is the medical expert of choice.

Patient records include not only the nursing home chart, but also the hospital records prior to and after the nursing home stay, as well as any interval hospital visits during the nursing home admission. All of these records will be compared and contrasted by the nursing and medical consultants with litigation experience. Often, inconsistencies in the records will be evident, perhaps indicating potential areas of inaccurate assessment or care at the long term care facility causing or leading to neglect or abuse.

A careful analysis of the records will often times reveal misleading, inaccurate, and fraudulent charting relating to the nursing home's care of your client. False charting or late entries, for example, are often indicators of abuse or neglect and attempts to cover up poor care or specific instances of abuse of neglect. The trained eye can often easily spot false or misleading record entries. Comparing different parts of the same chart will sometimes suggest falsification or inaccurate record keeping. For example, medication administration records, flowsheets, and even progress notes have been found to contain entries during known hospitalizations and even after death of a resident, calling into question the historic accuracy of the entire chart. Given poor outcome, records of excellent care are unconvincing in context with suspect record entries.

Evaluation of a nursing home claim is based, at least initially during screening, on the records prepared by the nursing home staff and management. Detailed analysis of the records will often uncover misleading, inaccurate, and even fraudulent charting of the care of your client. Look for the following examples of fraudulent charting:

1. *False charting*: Scrutinize the Activities of Daily living (ADL) or care flow sheets and compare them to Physical Therapy notes, Nurses Notes, Physician's Progress Notes, Consultation reports, and other records in the chart. Often the nursing staff charts for care that was never provided. Comparing these records to employee time records sometimes reveal care was provided when the recording employee was not on duty.

2. *Late Entries*: A "late entry" in the resident's chart should always invite close scrutiny. After the occurrence of an incident of abuse or neglect, the staff will often attempt to sanitize the record of what exactly occurred to cover up abuse, neglect or negligence.

3. *Charting by Exception*: Most nurses will tell you "if it wasn't charted, it wasn't done". Staff in long term care facilities often testify that they do not chart everything they do for a resident because it is unnecessary to document all of the specific care provided to a resident. Most will also admit, however, that assuring continuity of care requires accurate records of the care provided to a resident in order to achieve care plan goals. Multi-disciplinary care plan teams rely almost strictly on the records of care provided and the outcome of that care in order to determine whether goals are being met or whether the care plan requires modification to assure the resident's condition does not decline. For example, if a care plan requires a resident to be turned and repositioned every 2 hours to avoid pressure sores and the resident develops pressure sores when the records showing this care was provided are absent, the long term care facility will have a difficult time explaining to the jury that, while the services not recorded, the staff still turned and repositioned the resident every 2 hours. The outcome belies the assertion that the care was provided. Moreover, authoritative literature on many specific care issues, such as pressure sore prevention, mandate recording services provided and the outcome of the care plan requiring that those services, in order to attain and maintain the resident's condition.

V. OPERATIONAL RECORDS

Each facility maintains records of their operations that are helpful in proving that the facility was understaffed with qualified caregivers during a particular timeframe. It is critical to each case to obtain these records to corroborate a claim of abuse or neglect cause in part by improper management or operation of the long term care facility.

1. *Resident Census*: The long term care facility's census records the population of the facility during a given time frame. These records are important for forensic accounting analyses of whether there was compliance with staff to patient ratios required by federal or state law or regulations.
2. *Employee Time Cards and Payroll Records*: These records are likely the most accurate recordation of the number of staff on duty during a specific timeframe and the hours worked during that timeframe. By comparison of these records to census, posted staff schedules, staff sign-in sheets, and your client's chart, a complex and detailed staffing analysis can he helpful in proving whether and to what extent a facility was understaffed.
3. *Policy and Procedure Manuals*: Bountiful information on the self-imposed standards of each long term care facility are found in their own policy and procedure manuals. Specific policies and are typically outlined and standard operating procedures defined on issues such as:

    - Prevention and reporting of physical or sexual abuse;
    - Prevention and reporting of Verbal abuse;
    - Wandering and injury prevention;
    - Prevention of elopement and handling "missing persons";
    - Proper and improper use of restraints;

- Use of Antipsychotic medications, depressants, etc.
- Pressure sore prevention, assessment, staging and treatment;
- Assuring proper hydration and nutrition;
- Safe tube feeding;
- Fall prevention;
- Medication errors;
- Physical therapy and prevention of contractures;
- Urinary incontinence and catheter maintenance;
- Proper bowel and bladder maintenance;
- Etc.

VI. FORMER EMPLOYEE TESTIMONY

A common and often overlooked method of proving what kind of care a long term care facility provided during a particular time frame and under certain management is presentation of testimony of former employees of the facility. Often, the most accurate and truthful testimony of an instance of abuse or a pattern of neglectful care comes from one-time employees who left their job because they couldn't tolerate the neglect or abuse or who was terminated from their job for speaking out against the neglect or abuse.

Former employees can be located through formal discovery via interrogatories and document production, as well as through worker's compensation claims records and other sources of public information. Locating such employees can be expensive but well worth the expense and effort since most nursing home residents are incapable of testifying about their own observations and since most family members will have limited knowledge and be viewed as having a financial motive for their testimony. Good private investigators experienced in investigating cases of institutional abuse and neglect are expensive but, when successful, can find the single most important witness in a case of abuse or neglect.

VII. TESTIMONY OF FAMILY AND FRIENDS

Testimony of family and friends about their own observations are obviously the most freely available source of information about abuse and neglect of residents. Family members who regularly visited their loved one can and will testify about their personal experiences at the long term care facility. Friends, particularly clergy, church members, and other close friends often provide the most compelling testimony in cases of abuse or neglect.

VIII. PHOTOGRAPHS

Early in the investigation of a case, the attorney should have a professional photographer available on short notice to take photographs of injuries sustained by the resident or medical conditions that developed or worsened during the nursing home stay. These photographs not only provide compelling evidence to any jury or judge,

but they also can be useful to medical professionals and experts in diagnosing the cause of the injury or condition. For example, photographs of pressure sores can prove critical in accurately staging the sore and are often in conflict with the records of the long term care facility.

Photographs taken by the long term care facility, hospitals, wound care centers, or physicians are likewise probative, compelling and critical pieces of evidence that must be obtained. These health care providers will often fail to produce these photographs in response to routine record requests, so it is extremely important to never assume that such photographs do not exist. Separate specific written requests for such photographs should be made. In addition, before assuming the photographs do not exist, it is often advisable to take the deposition of the designated records custodian of those health care offices.

IX. INSPECTION OF LONG TERM CARE FACILITY

Particularly in cases involving sexual or physical abuse, falls, wandering, and elopement, it is advisable to request entry and inspection of the premises for purposes of photographing the facility, it's layout, the site of the injury, safety equipment and devices, nursing stations, exits and entrances, common areas, break rooms, smoking areas, etc. Most long term care facilities also have floor plans, if for nothing else for fire safety purposes, which may be very helpful in setting the stage for discovery by giving counsel and all witnesses a frame of reference for testimony about specific occurrences, events, routine practices, procedures, and factual reference points for where and how services were provided or events occurred regarding a particular resident.