

Legal Issues



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Preventing Resident-on-Resident Abuse

Because of varying temperaments and cognition levels, resident-on-resident abuse is a constant concern in nursing facilities. F-tag 223 provides that a “resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion,” so facilities must protect vulnerable residents from abuse from all sources, including fellow residents.

In April 2009, the Health and Human Services’ Departmental Appeals Board (DAB) upheld the decision of an administrative law judge enforcing civil money exceeding \$300,000 for failing to protect a female nursing home resident from potential abuse until after a state survey revealed an incident that showed she was at risk.

The incident involved a mentally competent and alert man with significant visual impairment but who was capable of moving around his room without assistance. The female resident had dementia, poor decision-making skills, and a tendency to wander.

The male resident had occasionally asked female staff members for dates, “patted” them on their buttocks, and asked them for kisses. The female resident was known for being flirtatious and affectionate.

One day, the female resident was walking down a hallway when a nurse assistant overheard the male resident tell the female resident to come into his room. Shortly thereafter, two nurse assistants entered the room, and the residents were in the bathroom with their pants in positions suggesting that they may have been engaging in sexual intercourse. The judge found the evidence “inconclusive” as to whether sexual contact had actually occurred but ruled that the facility had nevertheless failed to take appropriate steps to protect the female resident from potential abuse.

The judge ruled—and the DAB upheld—that the woman had been in “immediate jeopardy” of abuse until 99 days after the incident occurred, when it submitted its plan of correction following the state survey. (The fine was determined by multiplying the daily penalty of \$3,050 times 99.)

Approximately 6 months prior to the bathroom episode, the male resident had reported that the woman had entered his room and hit him in the nose. The judge noted that abuse within a facility is not limited to sexual abuse and that the facility should have been alerted to the potential for physical abuse between these two residents. Furthermore, the judge ruled that the facility should have known

that the female resident was particularly vulnerable because of her cognitive impairment, poor decision-making skills, and inability to communicate effectively. She was thus incapable of consenting to sexual intercourse. The DAB also held that the facility failed to take adequate steps to protect the female resident and other residents from potential abuse, both sexual and otherwise, after the bathroom incident.

At that time, the facility implemented one-on-one supervision for the female resident, but it allowed her to wander the facility alone after only 1 week. There was no interdisciplinary note or care plan entry explaining or justifying why the one-on-one monitoring was suspended.

The DAB rejected the facility’s argument that full-time one-on-one monitoring was not realistic because neither Medicare nor Medicaid pays for it. The appeals board held that if that amount of attention was the only way to fulfill the resident’s assessed need, the facility would have to provide it by law. Even if a less costly intervention may have been adequate, the facility failed to implement any after the one-on-one monitoring ended, the board found.

The DAB also agreed with the judge that other cognitively impaired and wandering female residents in the facility were vulnerable to abuse. However, the facility could not present any evidence that staff were instructed to keep those vulnerable residents away from the male resident’s room. Although the facility’s administrator and social worker claimed that the staff received such instructions after the bathroom incident, there was no documentation of when such in-services occurred, who attended, or what topics were discussed.

Finally, the DAB found that the facility failed to adequately monitor the male resident after the incident or that his plan of care was modified to prevent a recurrence of his inappropriate behavior. Again, the facility claimed that the resident was counseled about his behavior and that the interdisciplinary team met to discuss it—but the facility could produce no documentation.

The DAB rejected the facility’s argument that its residents couldn’t be in immediate jeopardy for so long since there had not been any additional documented incidents of abusive behavior.

In addition to reminding facilities that they must protect their residents from abuse by other residents, this DAB decision emphasizes the importance of documenting the interventions implemented and the all-staff training done

following any resident-on-resident incident.

The facility in this case argued that it had in fact performed in-services and acted to prevent the male resident from engaging in future abusive behavior. But it could not provide documentation of such in-services. Had the facility maintained proper documentation, the judge and the DAB may very well have found that the facility had removed the immediate jeopardy.

When addressing an incident of potentially abusive behavior, a facility must take prompt and direct steps, such as to:

- ▶ Review policies and procedures to ensure compliance with F-tags 223-226 on abuse, neglect, and misappropriation.
- ▶ Understand the definitions within F-223 and compare them with the state’s definitions for the same actions. State and federal definitions may require different reports.
- ▶ Immediately protect residents when an allegation of abuse, neglect, or misappropriation occurs, including removing the alleged perpetrator from the building until the investigation is completed.
- ▶ Conduct ongoing education for staff members on the disease processes that may place residents at risk of abuse.
- ▶ Review and modify action plans and care plans for residents at risk of abuse

following any type of incident.

- ▶ Review and modify action plans and care plans for alleged or potential resident abusers.
- ▶ Promptly comply with state and federal requirements to report to law enforcement authorities any possible “crime.”
- ▶ Conduct and document training of staff in the requirements for prevention, investigation, and follow-up regarding abuse, neglect, and misappropriation.
- ▶ Meticulously follow the facility’s screening policies and procedures for employees regarding criminal background checks. States have various requirements in this area.
- ▶ Collaborate with experts, such as the medical director, psychologist, or psychiatrist, to understand techniques for dealing with residents who may be potential abusers or objects of abuse. 

This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.

Medical Expert Perspective

This case is of significant concern to long-term care providers on multiple levels. The recommendations at the end of the article are well taken. Facilities certainly should have a low threshold for self-reporting any event in which even a slim suspicion of “possible” abuse exists.

The notion that constant one-on-one supervision must be provided by a facility if it is “necessary” for the safety or protection of a resident is a worrisome trend. Historically, provision of a “sitter” has been considered a responsibility of the facility, and if widely adopted, this interpretation could prove to be financially disastrous. Certainly, there are many cases in every facility where such services would at least be helpful, if not absolutely necessary (to, for example, prevent falls or elopement). But such services have generally been something that patients’ families have covered when they are recommended.

Then there is the issue of whether patients with dementia have the ca-

capacity to engage in consensual sex. This is a seriously gray area, and the case-by-case answer obviously depends on the degree of dementia and other circumstances. In this case, the demented female resident was known to be flirtatious, and there was nothing to suggest that she had been harmed by whatever did (or did not) happen at the time she was found, pants down, with the male resident.

Despite this, more than \$300,000 in administrative fines were assessed. In looking at a case like this, it seems that the facility might have been best served by removing the “perpetrator” from the facility immediately—yet it is very difficult in many areas to evict residents. This case certainly highlights the seeming no-win status that facility operators face: While clearly, they could have done things better, this facility’s punishment seems to be quite disproportionate to the transgression(s) it committed.

—Karl Steinberg, MD, CMD
Editor in Chief