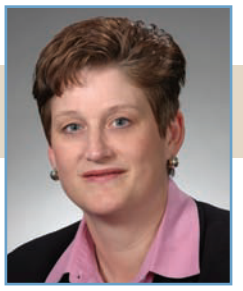
Legal Issues



By Janet K. Feldkamp, JD, RN, LNHA

Resident Elopements: Implementing and Maintaining Appropriate Safety Measures

One of the most frequently cited noncompliance deficiencies is F-tag 323, which requires a nursing facility to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receive adequate supervision and assistive devices to prevent accidents. Elopements endanger residents and nursing homes in both these areas.

Incidents of resident elopement frequently result in a finding of noncompliance with F-tag 323. Two recent Heath and Human Services Departmental Appeals Board cases highlight the importance of ensuring that appropriate safety measures are in place and being effectively monitored.

In a May 2010 case, the board upheld a finding of noncompliance at the "immediate jeopardy" level stemming from a resident's elopement (Dec. No. CR2134). One evening at approximately 5:30 p.m., a motorist found the 79-year-old man walking along a road a half mile from the facility.

He had been diagnosed with Alzheimer's disease, delirium, and visual problems. He took antipsychotic, antianxiety, antidepressant, and hypnotic drugs and was on a behavior-management program. Based on minimum data set responses, resident assessment protocols were triggered for wandering.

The resident had been issued an alarm-triggering bracelet, and his care plan directed staff members to observe the resident's whereabouts at all times and to check his bracelet for placement and function.

After the incident, surveyors from the Centers for Medicare & Medicaid Services concluded that the resident's bracelet had not set off the alarm when he wandered from the facility. The bracelets that the facility used were effective for only 90 days and required replacement at that time. However, the CMS noted that the facility did not have a system in place to keep track of when the bracelets were put into service or needed replacing.

The facility's policy was to check the bracelets three times daily. However, the CMS alleged that this policy was unlikely to discover that a bracelet had become inoperable at the precise minute of occurrence and that, therefore, some residents were likely to be moving within the facility with bracelets that would be inoperable until the next scheduled check.

The CMS also showed that the facility was aware that many residents had the code to the keypad controlling the bracelets' alarm and so could silence it. The agency argued that the facility should have changed the code more frequently, covered up the keypad whenever staff deactivated the alarm, instructed residents to stand back when the code was entered, or looked into alternative keypads that would preclude residents from learning the code.

Finally, and perhaps most disturbingly, the CMS surveyors noted that the facility did not have a procedure in place for staff action in the event that the alarm sounded. The facility "assumed" that when an alarm sounded, a staff member would investigate the reason for the alarm and deactivate it. In addition, the facility's policy did not require a staff member who deactivated the alarm to notify other staff.

Because of the facility's failure to implement policies to replace expired bracelets, prevent residents from obtaining the code to the alarm, and ensure that staff responded promptly and appropriately when alarms sounded, the CMS found the facility in noncompliance.

The Departmental Appeals Board upheld the CMS's finding as well as a civil money penalty in the amount of $3,050 per day until the time that the facility corrected the keypad-code problems and established new elopement protocols, a total of $264,200.

Hired Help That Hurt

In a separate case decided in June, the Departmental Appeals Board upheld a finding of immediate jeopardy and the imposition of civil money penalties after a demented 86-year-old male resident left a nursing facility through a door equipped with an electronic door lock (Dec. No. CR2158).

On a January day, he wandered into a service driveway connected to the facility's parking lot, where he was in danger of being struck by a vehicle. He had been assessed by facility staff as being at risk of falls and uncontrolled bleeding from anticoagulant therapy.

The door lock had been disabled deliberately 2 days earlier by a contractor's employee who was performing work at the facility.

The disabled lock was not discovered by the facility's staff during those 2 days, thus enabling the resident to leave unnoticed. CMS surveyors found, however, that there was a strong likelihood that staff knew that the door might be disabled by the contractor's employees because staff had shown the workers how to disable the facility's door locks and alarms.

Therefore, the CMS found that the facility was not in compliance with F-tag 323 because it failed to take "obvious and easy protective measures."

The board held that a facility's duty to ensure that its alarm system is operating properly is heightened when third parties have the ability to disable the system.

The facility argued that it had instructed the contractor and its employees that they were responsible for securing the doors. However, the board found that this did not relieve the facility and its staff of the legal duty it owes its residents to ensure that the alarms were functioning properly. Therefore, the board upheld civil money penalties in the amount of $3,550 for each of the 2 days the doors were unsecured plus $250 per day before the facility was fully in compliance with F-tag 323, for a total of $14,150.

These two recent cases highlight the importance of an ongoing culture of safety. The survey liability is just a portion of the liability that can occur for a facility that has a wandering resident. Civil liability can be significant for facilities if harm, either physical or emotional, occurs to a resident in circumstances deemed unsafe. Prosecutors are also keenly observing long-term care facility behavior and may charge a caregiver or the facility with criminal neglect or criminal negligence in such cases.

This column is not to be substituted for legal advice. 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.*

Lessons for Facilities

- ▶ Routinely assess exterior door security.
- ▶ Assess a resident's risk of wandering at admission and review periodically.
- ▶ Do extra monitoring of newly admitted residents; the environment is new to the resident, and staff are unaware of his or her daily patterns of behavior.
- ▶ Review and monitor elopement prevention devices such as alarm-tripping bracelets and secured doors.
- ▶ Institute a comprehensive elopement-prevention program with ongoing education of all facility staff members.
- ▶ Use magnetically locked or otherwise secured doors with alarms that may be silenced only at the doorway.
- ▶ Periodically conduct drills to ensure that the staff are implementing the facility's policies and procedures for elopement prevention.

Medical Expert Perspective

Elopement cases are fairly commonplace in the universe of nursing home negligence lawsuits, and they can result in large awards, especially when it can be shown that a facility was on notice that a resident was at high risk of wandering yet failed to take appropriate preventive measures.

We have all heard of cases where someone got hit by a car or was found days later in the woods or an alley.

These cases can even be successful when there is no evidence that the resident was confused or demented, so elopement risk needs to be assessed on every patient.

The tips suggested here are a good start, and it should always be part of the care process to discuss elopement risks and prevention strategies with family members or other decision makers so that they are fully aware.

Recommending a sitter or companion can be an option for some residents. In some instances, it is unsafe to allow a resident to remain in a facility, and this presents additional challenges.

–Karl Steinberg, MD, CMD
Editor in Chief