

Legal Issues

By Janet K. Feldkamp, JD, RN, LNHA



The Importance of Oversight and Monitoring

Recent administrative-hearing decisions arising from facilities' appeals of survey citations have reinforced the importance of ongoing oversight and monitoring by facility management. Although the decisions were based on different citations and resulted in differing sanctions, the message of each is similar. Oversight and implementation of policies are vital to a safe and compliant facility.

Late last year, the Health and Human Services Departmental Appeals Board found the residents of Qualicare Nursing Home in Detroit to be in immediate jeopardy, as the facility had failed to prevent the sexual assault of a resident by a roommate's family member and had not taken reasonable steps to protect other residents. The citation states that during an evening visit, one resident's brother inappropriately touched and sexually assaulted the woman's 65-year-old roommate, who was in a persistent vegetative state.

The nurse on duty interrupted the perpetrator and ordered him to leave the facility. The director of nursing promptly notified the police, who apprehended the man and criminally charged him. The facility also reported the incident to the Michigan Department of Licensing and Regulatory Affairs, as required. After a survey several months later, the facility was cited by the department for actual harm to one resident but not immediate jeopardy of all residents.

At a hearing on the citation, the issue was the facility's potential prevention of the abuse. The Department Appeals Board decided that the facility failed to take all reasonable steps to protect the resident from abuse. The facts included that the visiting brother was acting "oddly" by making several trips to and from a snack machine and that he pulled a privacy curtain, obscuring the view of the roommate. The staff nurse went to the room and told the visiting brother not to pull the curtain because the residents had to be seen from the hallway. Later, the staff nurse went back to the room and found the brother inappropriately touching the resident in a sexual manner. The resident was unable to call out.

The hearing examiner found that "many other reasonable steps should have been taken" to prevent abuse and "comply with the regulatory standard." Especially for residents who are dependent on the staff for all their needs, the facility is responsible for promoting the highest possible level of resident health and safety, the examiner said. The facility was fined \$2,500.

This case confirms the regulatory perspective that resident protection is a high-level requirement and that the staff must try to do as much as possible to prevent abuse. The facts in this case should cause a medical director or facility administrator to think carefully as to where the line

is between interfering with "suspicious" behavior and allowing visitors to be present without a high level of scrutiny. Although the perpetrator's behavior was suspicious, the nurse on duty never suspected that he might abuse the roommate

or that any other resident was at risk. The nurse was observant and did intervene, but the actions seem to be inadequate, from the regulatory perspective.

With a similar thought to oversight and monitoring, in January, the Department

Appeals Board upheld an administrative law judge's decision that Ridgecrest Healthcare Center in California had failed to provide a resident environment that is as free from hazards as possible. The issues in this case revolve around

faulty brakes on one resident's wheelchair, found during a state survey.

The facility argued that it had a process in place to identify equipment in need of repair and that the resident was in the hospital at the time of the survey, thus the wheelchair was not a hazard. Ridgecrest submitted a plan of correction for the wheelchair brakes and other cited equipment deficiencies, but a resurvey found that the plan was not in substantial compliance with requirements. The administrative law judge determined that there was not adequate evidence of a documented process for equipment repair.

The review of the lower-level decision of the Departmental Appeals Board was upheld, that the facility had failed to correct each safety violation. As a result, the facility had to continue paying fines to a total of more than \$200,000 for the survey cycle. The finding of one wheelchair with faulty brakes was the difference between compliance and noncompliance with an ongoing civil money penalty.

In Pennsylvania, a resident's death in the Weatherwood Nursing and Rehabilitation Center in Weatherly is being investigated as a homicide. According to news accounts, the female resident was allegedly pushed down by another resident with the result

of death from a head injury. Both residents were impaired with dementia.

In a news release, the facility said that it strives to ensure resident care and safety and cited the unpredictability of behaviors in people with dementia. Regulatory and civil liabilities are likely to come. Even if the case is not pursued criminally, the facility is at significant risk for regulatory citations, fines, and other sanctions – even if the situation occurred without forewarning.

The facts in these cases alert long-term care providers that monitoring and attention to each resident's safety are imperative. By law, facilities have a duty

to protect their residents. Attention to detail in this area is important to ongoing compliance with requirements and avoiding survey penalties. 

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.