due to the changing dynamic in the health care industry, the number and percentage of elderly patients admitted to skilled nursing facilities with mental illness (schizophrenia, bipolar disorder, depression, or anxiety) and dementia (along with the accompanying behaviors) will continue to increase in the next 10 years.

This trend presents patient behavior challenges to SNFs, both in terms of resources and increased level of risk exposure. To adapt to the trend, SNFs need to ensure the correct decisions are made in deciding whether to admit a patient at the outset. They must determine whether they are able to provide the level of care required by the individual patient; if so, they must ensure appropriate patient-centric care plans are developed, implemented, and updated as needed. This is increasingly important now that SNFs are virtually obligated to readmit residents who have been discharged but want to return as soon as a bed becomes available, except in specific and unusual circumstances. The importance of frequent communication and a collaborative approach between the SNF and attending and consulting practitioners in the care of such patients is imperative, as outlined in the following case study.

Case Study
Mrs. W had a complex medical history, including long-standing psychiatric diagnoses of bipolar disorder with psychotic features and a history of self-harm. She had four prior incidents of self-harming behavior, including attempted suicide via slashing one or both wrists. The last incident had occurred just seven weeks before her admission to a SNF. She was admitted to the SNF directly from a secured psychiatric facility.

Mrs. W committed an act of self-harm in the SNF — she cut and stabbed both her wrists with a metal eating utensil, resulting in significant blood loss. There was also a delay in finding her after the incident because she had been left unsupervised with the utensils in her room during meal service. The staff’s care plan had failed to provide one-person assistance or supervision during meals, despite the patient’s prior episodes of self-harm.

Mrs. W was being followed closely by an external mental health therapy service. Before the incident at the SNF, her therapist had spoken with the director of nursing (DON) and expressed concern about the patient being left unsupervised with metal eating utensils. She also had reminded the DON about the patient’s history of self-harm.

The resident’s records also demonstrated that her mental health therapy team had been aware of Mrs. W’s active suicidal and self-harming ideations in the days before her injury. Her mental health team had considered a further 5150 hold (involuntary due to being a danger to herself or others) but ultimately had declined to initiate it. More importantly, the psychologist on the team had failed to report Mrs. W’s suicidal and self-harming ideation to the SNF staff. Had such communications been made, the outcome in the case probably would have been different. Significantly, the mental health therapy team was not named in the lawsuit, providing an “empty chair” defense and helping to reduce the overall exposure of the SNF in the case.

The patient and her family sued the SNF for elder neglect, alleging among other things that the SNF had failed to properly assess the patient and failed to implement appropriate plans of care to address the potential for further episodes of self-harming behavior, which had culminated in her injuries.

Best Practices
- A preadmission assessment should have been considered to determine whether the SNF was capable of providing the level of care necessary for a geriatric psychiatric patient who had exhibited significant psychiatric behavior before admission to the SNF.
- Although the SNF administrator had told the family that staff would not provide the 24-hour, 1:1 supervision that had been provided in prior acute facilities, this statement was not documented anywhere. Better charting would have memorialized this discussion before the resident’s admission. It’s also not clear that telling a patient or family that 1:1 supervision will not be provided can prevent liability if in fact at some point that appears to be the level of care that the resident requires; the regulations state (somewhat vaguely) that SNFs must be staffed “sufficiently” to meet the needs of the residents.
- The SNF team should have had much greater integration with the patient’s behavioral health services team and primary care physician from the date of admission.

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Nursing Facility Influenza Study Opens Enrollment

A team of nationally recognized long-term care researchers from Brown University Stefan Gravenstein, MD, MPH, and Vincent Mor, PhD, are undertaking a large-scale quality improvement study to evaluate the impact of the annual influenza vaccine choice on long-term care facility residents hospitalization risk for the 2019-2020 influenza season. Nursing facilities that meet eligibility and agree to participate will be allocated to one of two CDC recommended influenza vaccines for adults. Facilities will also receive a free supply of vaccine for staff. The Foundation for PALTC Medicine will receive a donation of $100 for each facility that enrolls in this study based on their referral.

If you are interested in this important project, please contact the study coordinating center, Insight Therapeutics, LLC at 757-625-6040 or NNFStudy@intner.com.
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recalled with a laugh. The intervention significantly improved the participants’ physical performance (measured using the Short Physical Performance Battery) at 12 months (P = 0.02). Although the number of fall-related fractures did not differ significantly between the groups, exercise did reduce the number of injurious falls (those resulting in pain, bruising, laceration, or fracture). In other words, exercise helped the participants to avoid falls; even when those in the exercise group did fall, their falls were not as bad as those experienced by the group who did not exercise.

Their study happened to be published around the time of policy review in Australia. Dr. Hewitt presented her team’s findings to the Minister of Aged Care, who connected her with the policymakers in charge. The outcomes of their study and others, along with the lobbying efforts of the Australian Physiotherapy Association, helped to tip the scales. The draft of new policy currently under consideration now includes therapeutic exercises for aged care in Australia.

Recognizing the impact of her research, Dr. Hewitt admitted, “My hope for my work is to change the way people live. While recognition and policy are important, I find the greatest reward in the feedback my residents and their families give me when I go in (to the community) to conduct an exercise session. I hear and see something rewarding every time.” That positive feedback and the obvious improvement in the residents’ well-being is what has kept her in the field of elder care for almost 30 years after her transition from sports physical therapy. “For athletes, my work is a joy to boost performance, maybe, by several percent, while for the elderly, exercise can be a life-changer.” She recalls a resident with cerebral palsy who “walks tall and doesn’t drag his foot anymore,” now at the age of 91. “His walking is better than it was when I first met him at age 80!”

Aside from providing positive physical changes, her exercise program has boosted morale in the communities. “Residents were so proud of themselves. The activity also gave them something to talk about before and after each session. Some of them said it had changed their lives; others needed to buy workout clothes for the first time ever.”

Dr. Hewitt hopes that her findings will inspire additional research in the field and support the policy changes needed for residents to reap the benefits of exercise. While policy varies broadly, the effectiveness of exercise in preventing falls and its value to seniors remain high, regardless of the geography.

— Barbara Resnick, PhD, CRNP

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including representative(s) of her mental health therapy team in the interdisciplinary team and care-planning decisions.
• One helpful approach is to establish regularly scheduled behavioral rounds for the mental health providers, social worker, and supervising registered nurse.
• The number of psychiatric patients admitted should not overwhelm the SNF’s capability to appropriately address their needs.
• In-service training should be implemented for staff to upgrade their skills to better understand and manage the emotional and behavioral issues of geriatric psychiatric patients. With Phase 3 of the new Requirements of Participation going into effect in November, SNFs will also need to train staff in trauma-informed care.
• As always, proper documentation of these efforts is a must. Documentation may not prevent a lawsuit, but it will minimize the SNF’s risk and provide the best defense possible if a claim is made.

This column is not to be substituted for legal advice. Mr. Wilson is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.