Resident Elopement, Death: Facility Charged With Involuntary Manslaughter.

The Supreme Court of Massachusetts reviewed the unsettling series of events leading up to a nursing home resident's tragic death, only to conclude that under the circumstances the law does not support a prosecution for involuntary manslaughter against the nursing home's parent corporation.

That is, the system in place at the nursing home failed this resident, but the actions of no single employee, although negligent, could be pointed to as grounds for a criminal prosecution.

The Court dismissed the charges that the local prosecutor had filed against the parent corporation.

Resident Known to Wander

The resident was admitted to the facility with medical diagnoses that included organic brain damage and dementia.

Three years later she was found by staff sitting in her wheelchair in the front entrance foyer, the small space between the inner and outer front doors.

She was recognized at once as an elopement risk. The nursing staff obtained an order from her physician for a specific brand of signaling device she was to have on her person at all times. It sounded an alarm and automatically locked the front door any time the resident came into close proximity with the entrance way.

At least twice after she got the device, probably more often, she tried to wheel herself out the front door but was stopped cold. Staff at the facility were fully aware she was an ongoing elopement risk.

Documentation Mix Up
Physician's Orders
Removed From the Chart

The resident's treatment sheet had to be initialed once each day, among other things, to document that she had her WanderGuard on her person and that it was checked to verify it was working properly.

Each month two nurses independently audited the treatment sheets to insure they were being reviewed and checked off each day by the patient's nurse. The patient was consistently using her WanderGuard and the nurses were documenting it.

However, at some point the director of nursing had someone "clean up" the treatment sheets. The person to whom that task was delegated mistakenly thought it meant deleting certain physicians' long-standing orders including those for WanderGuards.

One night a fill-in nurse was working. She had no way of knowing the resident was supposed to have a WanderGuard, did not see it on the treatment sheet and did not verify that the resident was wearing it. An aide left the resident near the front entrance, presumably thinking there was no problem since she had a WanderGuard.

The resident quickly wheeled herself through both front doors, fell down the eight front steps, hit her head and died from her injuries. **Commonwealth v. Life Care Centers, __ N.E. 2d __, 2010 WL 1964627 (Mass., May 19, 2010).**

An avoidable series of failures within the system resulted in this resident, a dementia patient, wheeling herself out the front door, falling down the front steps and being killed.

No single error or omission or the actions of a single nursing home staff member can be singled out to as the reason this happened.

The prosecution wants to aggregate all the separate errors and omissions which occurred into a single indictment of involuntary manslaughter committed by the nursing home's parent corporation, but that is not a valid legal premise.

SUPREME COURT OF MASSACHUSETTS
May 19, 2010