

Nursing Care Standards: Court Sees Immediate Jeopardy, OK's Civil Monetary Penalties.

The US Court of Appeals for the Eleventh Circuit upheld civil monetary penalties against a nursing facility for violations of Federal standards in the care of two separate patients.

The first patient was an eighty-three year-old woman who suffered from congestive heart failure, diabetes and obesity.

Failure to Follow Care Plan

Her care plan called for the use of a mechanical lift in all transfers. Nevertheless, two aides attempted to transfer her from her bed to her wheelchair without using the mechanical lift, in violation of her care plan. The patient was either dropped or lowered to the floor. It was not clear from the court record whether the patient was actually injured.

The Court ruled that this violation rose to the level of "immediate jeopardy" because members of the nursing home staff directly violated the care plan in the transfer of an elderly obese patient who suffered from serious medical conditions which made her unable to stand on her own even momentarily.

The second patient was an eighty-five year-old woman who suffered from congestive heart failure and dementia.

She managed to wiggle out of her wheelchair while two aides were standing by with her preparing to transfer her from the wheelchair. She fractured her wrist in the incident.

The patient was in a frail physical condition and had limited mobility and limited range of motion in her lower body, needed extensive assistance with transfers, had poor cognition and judgment and was known to fidget during care. Her diagnosis of osteoporosis made it extremely dangerous for her to fall.

The Court upheld a civil monetary penalty levied against the nursing facility, finding that this second violation also rose to the level of immediate jeopardy.

Failure to Provide Adequate Supervision to Prevent Accidents

The patient was not provided with adequate supervision to prevent accidents, a violation of the express language of Federal Medicare/Medicaid standards, the Court said.

That failure to provide supervision came in two forms. The aides who were with the patient when she wiggled out and fell should have been watching her more closely.

It also came to light that the patient was known to have the tendency to wiggle while in her wheelchair and had wiggled out of her chair on to the floor on previous occasions.

The patient's well-known tendency to wiggle in her wheelchair pointed to a need to address the issue of restraints for her own safety, but that was never done. [Golden Living Center v. US Dept. of Health & Human Svcs](#), 2011 WL 2308564 (11th Cir., June 10, 2011).