Sexual Abuse Of Patients: Court Rules Skilled Nursing Facility's Investigations Were Substandard, Upholds Civil Monetary Penalty.

During a random survey inspection by the state department of health a skilled nursing facility was found to be in violation of Federal standards for the substandard manner in which the facility handled allegations of staff sexual abuse involving three residents.

The charges against the facility were upheld by the US Department of Health and Human Services Appeals Board and, in an opinion recently handed down, by the US Circuit Court of Appeals for the Sixth Circuit.

In these legal proceedings residents are referred to by numerical aliases to protect their right to confidentiality.

Resident #6

A female nurses aide witnessed a twenty year-old totally dependent quadriplegic female resident being abused in her bed in her room by a male nurses aide.

The aide right away reported it to the director of nursing who told her to write a written report of what she saw. The aide later told investigators she wrote and submitted a report. However, the report never made it into the chart. The resident was not examined by her physician and the authorities were not notified.

The aide wrote a second report five months later which did make it into the chart. An internal incident report was generated by the aide's second written report.

In response to the report there was no nursing assessment or physical examination and the incident was not reported to law enforcement. The resident was actually seen by her physician and by a pediatric gynecologist more than six months after the incident.

The court ruled the facility did an "abysmal" job of investigating the alleged incident. The female aide was quite emphatic that she witnessed the male aide abusing the resident and also insisted that she went immediately to the director of nursing with that information and submitted a written statement of what she saw.

The court believed the female aide did in fact twice report the incident in writing as she claimed. The facility had the obligation to collect, retain and safeguard any and all evidence pertaining to the allegations of abuse and the facility was at fault for the disappearance of the female aide's written report, in the court's judgment.

The court pointed out the facility did not notify the family – a violation of the facility's own policies – until more than a month after the abuse was reported. The physician, administrator and the family should have been contacted within one hour.

A medical examination six months after the fact was grossly inappropriate, the court went on to say.

Federal regulations require skilled nursing facilities to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. 42 CFR § 483.13 (c).

There is no doubt the facility had the required policies in place.

In cases of sexual abuse of residents by staff members:

The resident's statement should be taken.

Witnesses should be interviewed.

Evidence should be collected.

The attending physician should be notified.

The family should be notified.

Law enforcement should be notified.

Detailed reports should be issued to the state.

Unfortunately, the records show that these procedures were <u>not</u> followed in response to the allegations of abuse at issue here.

It was not an abuse of discretion for Federal inspectors to impose a $3,400 civil monetary penalty.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
December 8, 2005

Resident #124

This resident is a thirty-seven year-old woman diagnosed with schizophrenia and dementia. She informed the nursing staff of multiple instances of sexual abuse by one male nurses aide and at least one instance of abuse by the same aide involved in Resident #6's case.

The facility's social worker spoke with her the day she first went to the nursing staff. The social worker reported the incidents to the administrator three days later. The next day the social worker contacted the family and spoke with a sister-in-law who told the social worker the resident was known to make all sorts of allegations against African-American males wherever she went for her health care.

The resident's complaints were put to rest by the administrator with no further action beyond checking a box on a preprinted form to the effect that, "Suspect that an abuse, neglect/misappropriation incident occurred but were unable to confirm it." The physician was not notified and did not examine the resident and law enforcement was not notified.

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Sexual Abuse, Substandard Investigation

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The court pointed out that the family was notified the same day as the resident reported the allegations of abuse, proper procedure under the circumstances. However, she was not examined by her physician and law enforcement authorities were not notified as they should have been.

Resident #141

A seventy-four year-old woman with a history of mental illness reported to a nurses aide that she had been touched inappropriately. The resident identified the man as the same aide who would be identified as involved in the other two cases. The aide reported the incident to her charge nurse and to the unit manager.

The social worker spoke with this resident later that day.

Following this incident the aide was banned from the facility and his agency and the state Department of Aging and Department of Health were notified, according to the internal incident report generated for this incident.

However, law enforcement was not notified. No nursing assessment or physical examination was performed. The physician was not contacted until more than four weeks later. He did not perform an examination, noting in the chart that an exam done untimely would not be of any value.

Complaints Discounted
Residents Had Mental Illnesses

The court soundly rejected the arguments put forth by the facility that allegations of sexual abuse made by mentally-ill patients do not have to be taken at face value. The facility argued that, "If the facility were to call the police each and every time such a person made such a mere accusation, whether because of attention-seeking behavior or simply because the resident was delusional, both police and the facility would quickly tire."

The facility claimed it should be permitted to exercise some judgment whether or not to follow through based upon the mental condition of the resident making the accusations.

The court ruled, however, that Federal regulations do not allow such so-called exercises of judgment by facility personnel in cases of claimed or suspected abuse. A facility must follow Federal standards and its own internal policies or face legal penalties, the court said.

The court conceded the facility had reason to believe that one of residents, #124, was motivated by racial prejudice and may have been trying to get herself transferred out of the facility.

However, those are merely factors to be taken into consideration and reported to the administrator, physician, family, law enforcement, state health department, etc., in the course of a proper investigation. They are not grounds to dismiss a resident's complaints out of hand.

The facility's dismissive attitude was especially troubling to the court because the same aide had been implicated in allegations involving three residents, who could not possibly have been acting in concert with one another, a fact which would have come to light immediately if all three incidents were being promptly and properly investigated. **Park v. Leavitt, 2005 WL 3334522 (6th Cir., December 8, 2005).**

Code of Federal Regulations Title 42, Part 483 Requirements for Long-Term Care Facilities

Sec. 483.13 Resident behavior and facility practices.

(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must--

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(ii) Not employ individuals who have been--

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.