Skilled Nursing: Facility Failed To Prevent Sexual Abuse.

An elderly male resident of a facility which provides skilled nursing services assaulted his elderly girlfriend in her room, giving her slight bloody nose.

The man lived across the hall from her and facility staff knew they considered each other boyfriend/girlfriend.

After the assault the facility investigated and took steps to correct the situation. That included moving the woman to another room, looking to place the man in another nursing facility and revising the man's care plan to monitor his whereabouts and activities frequently.

Nevertheless two days later he was seen in the hallway kissing and fondling another female resident, one who was nonverbal and unable to consent to sexual activity. This time facility staff called the local police who came in and told him they would arrest him on felony charges if he did not leave the women alone.

The man's care plan was also modified to state expressly that his whereabouts and activities would be checked and documented on a q 30 minute basis.

During the month-long period it took to transfer him to another nursing facility he was seen in the hall and separated from the girlfriend at least five times. State survey inspectors actually saw them together on two occasions holding hands. However, there were no further episodes of physical assault.

Facility Permitted Abuse
Penalties Upheld

The US Court of Appeals for the Tenth Circuit (New Mexico) upheld civil monetary penalties levied by state survey inspectors and approved by an administrative law judge from the US Centers for Medicare and Medicaid Services.

The Court ruled the facility failed to prevent sexual abuse of the second female resident after the assault on the first. The male perpetrator was not kept away from his girlfriend. There was no actual documentation of "frequent" checks on him per the first care plan modification or every thirty minutes per the second care plan modification. Staff training was deficient as to the necessity of strict implementation of such care plan modifications. **Sunshine Haven v. US DHHS, __ F. 3d __, 2014 WL 563599 (10th Cir., February 14, 2014).**

Federal regulations specify that each resident of a nursing facility has the right to be free from verbal, sexual, physical or mental abuse.

Nursing facilities must develop and implement written policies and procedures that prevent mistreatment, neglect and abuse of residents.

Lawmakers had a choice between rule-based and outcome-based approaches and decided that an outcome-based approach offers the better alternative to ensure quality of care for nursing facility residents.

Lawmakers opted away from checklists of actions that facilities must take to comply with Federal regulations, toward a focus on the actual quality of care patients receive.

Facilities have flexibility to select the most appropriate methods, and the corresponding responsibility to ensure that the selected methods are effective for achieving the outcomes required in the statutes and regulations.

Care planning and implementation is required to prevent abuse of residents, including non-consensual sexual interactions, regardless of the source.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
February 14, 2014

Intubation: Nurse Anesthetist Violated The Standard Of Care.

The pediatric patient was brought to the hospital for acute exacerbation of her asthma and respiratory difficulty from tracheal stenosis and pneumonia. She was admitted for tracheal dilation to be performed under general anesthesia.

A certified registered nurse anesthetist attempted to intubate the girl with a #6 endotracheal tube, but failed. An anesthesiologist tried again and succeeded.

For reasons the Court of Appeals of Texas said were not clear from the medical chart, the nurse anesthetist then removed the #6 tube and tried to re-intubate the patient with a larger #8 tube. After several unsuccessful attempts, a #7 tube was tried and that also failed. Then the nurse anesthetist put back the #6 tube.

The patient deteriorated rapidly and died after unsuccessful attempts at resuscitation. The autopsy revealed a 2 cm x 2cm perforation of the trachea.

The entire surgical team should have realized prior to the intubation that the medical condition of the patient was related to her narrowed trachea.

Trying to replace the smaller endotracheal tube with a larger one was below the standard of care.

COURT OF APPEALS OF TEXAS
March 6, 2014

The Court ruled the family's case could go forward based on the opinion of the family's medical expert.

The expert faulted the nurse anesthetist for removing the smaller endotracheal tube and attempting to insert two that were larger, the anesthesiologist and the surgeon for allowing that to happen, and the whole team for not revising the plan to account for the fact a larger tube was apparently necessary. **Wiley v. Baylor All Saints, 2014 WL 888452 (Tex. App., March 6, 2014).**