Skilled Nursing Care: Court Sees Substandard Practices With Restraints, Skin Care, Incontinence Care, Upholds Penalties.

The US Court of Appeals for the Sixth Circuit recently upheld a total of $83,100 in civil monetary penalties imposed on a Medicare-participating skilled nursing facility by state survey inspectors for multiple violations of Federal standards for nursing facilities.

A nursing facility has the right to appeal at two levels within the US Department of Health and Services and then can appeal to the US Court of Appeals.

However, the US Court of Appeals pointed out that in these cases the court usually believes what state survey inspectors claim to have seen and usually defers to their judgments whether or not patients are receiving safe and effective nursing care. The Court of Appeals generally will not second-guess survey inspectors' expertise in applying Medicare standards.

Patient Restraints – Supervision

Federal regulations found at 42 CFR § 483.25 (h)(2) require nursing facilities to provide adequate supervision and assistance devices to prevent accidents.

According to the court record, restraints were found attached to immovable objects in a manner warned against by the restraint manufacturer and residents thus restrained were not supervised by facility staff, creating immediate jeopardy to the health and safety of six residents.

One resident had impaired cognitive status and a history of falling out of bed. Survey inspectors five times saw her trying to get out of a bed with lowered side rails while restrained but unsupervised. While doing so she was at risk for suffocation.

Another resident was seen trying to remove her restraint while not supervised, placing herself at risk of suffocation.

State health agencies, acting under agreements with the US Department of Health and Human Services, conduct surveys of nursing facilities participating in Medicare to monitor the facilities' compliance with provider requirements set out in Federal regulations (42 CFR § 488.305).

Deficiencies in compliance with Federal standards can result in civil monetary penalties ranging from $50 to $10,000 per day, depending on the seriousness of the offense.

A deficiency constituting immediate jeopardy to a patient's health or safety is eligible for a penalty of 3,050 to $10,000 per day.

A deficiency which does not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm but had the potential for more than minimal harm, qualifies for a penalty in the $50 to $3,000 per day range.

Penalties run from the day the violation is found until the day substantial compliance is achieved.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
November 3, 2006

Yet another resident was placed in an improperly-sized vest restraint and repeatedly became suspended in his restraint while unsupervised.

The court agreed with the survey inspectors decision to discount the facility's explanation. The necessity of restraints for these patients' safety did not justify improperly-sized restraints or inadequate supervision.

Likewise, the fact no actual harm occurred was irrelevant. The residents were in immediate jeopardy of serious harm. Immediate jeopardy is the only legal issue.

Patient Restraints
Ongoing Assessment

Federal regulations at 42 CFR § 483.13 say that nursing-facility residents have the right to be free from physical and chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's symptoms.

Restraints may only be used if they are used consistent with the physician's original orders. Beyond that, orders for restraints must be continually evaluated for their necessity and effectiveness, to avoid unnecessary immobilization in violation of Federal standards.

The court agreed with the inspectors that the facility violated Federal regulations by failing to provide ongoing assessment and re-assessment of the impact and appropriateness of patients' restraints.

One resident was ordered restrained in bed pending healing of a hip fracture. The fracture had fully healed three months earlier, but she was still being restrained.

Two other residents were to be released from their restraints at least every two hours, but were kept in their restraints for three and four hour intervals while the survey inspectors were on the premises.

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Skilled Nursing, Penalties Upheld (Cont.)

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Pressure Sores

Federal regulations found at 42 CFR § 483.25 (c) state that:

Based on the comprehensive assessment of a resident, the facility must ensure that -

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Survey inspectors observed one resident's pressure sore increase in size over a nine-day period. He was left in a chair with no pressure relief for two and three hours on two separate occasions.

The court endorsed the surveyors' judgment that this resident's pressure sore had to have been aggravated by these long periods without movement. Furthermore, the pressure sore was not dressed, in contravention of the physician's orders, and the patient was found wearing a urine-soaked incontinence brief, which caused additional harm.

Another resident whose pressure sore also increased in size had feces come in contact with his wound.

Another resident with a growing lesion was restrained in a wheelchair without pressure relief, and yet another resident, similarly restrained in a wheelchair without pressure relief, was not toileted in time and was left sitting in his own urine.

Incontinence Care

Federal regulations found at 42 CFR § 483.25 (d)(2) require nursing facilities to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

The court found one resident's care substandard in two respects: her care plan only provided for toileting in advance of need three to five times per week, and even still she was not offered toileting in advance of need as per her care plan.

That is, she spent two hours in her chair after dinner, then was put directly to bed. She soiled herself in bed about forty-five minutes later, and was not changed for forty-five more minutes.

Two other residents were not offered help to the restroom after meals and before bed as they should have been. Other residents were only cleaned and had their soiled briefs changed after they had asked to be taken to the restroom or commode and had successfully voided. **Lakeridge Villa Health Care Center v. Leavitt, 2006 WL 3147250 (6th Cir., November 3, 2006).**