Understaffing: Court Looks At Widespread Pattern, Orders Large Judgment Against Nursing Home's Management Company.

Two elderly residents were taken to the doctor's office by one staff member of the nursing home.

On arrival at the doctor's office both residents were placed in their wheelchairs by the one staff member.

The resident in question was left unattended while the staff member went back to assist the other resident.

While unattended, the resident in question began rolling down the sidewalk at a rapid speed. A witness would later state the resident had a really scared expression on her face as her wheelchair veered off the sidewalk and she was thrown onto the concrete surface of the doctor's office parking lot.

She died four days later from her injuries. The family sued the nursing home and obtained a $1.7 million jury verdict. The Court of Appeals of Texas ordered the damages reduced to $1.3 million and assessed the damages only against the corporation that managed the nursing home and not against the parent corporation which owned the nursing home.

Understaffing Was the Issue

The family's attorneys were able to present a case to the jury of a widespread pattern of understaffing at the facility. That pattern was behind the decision to send only one person to the doctor's office with the two residents, they claimed.

Numerous employees and former employees were called to court to testify as to the difficulties they had experienced. The jury concluded that understaffing in fact was the factor which caused the tragic event which killed this resident.

Treating Physician / Medical Director

The resident's treating physician testified that a facility which cares for persons, like the resident in question, who have a high risk of falling have a responsibility to see that sufficient staff are available to meet the residents' needs for supervision and assistance when transferring and being transported.

There was a widespread pattern of understaffing at the nursing home.

The nursing home management company was under considerable pressure from the corporation which owned the nursing home to reduce personnel costs to a minimum. The management company received frequent line-item directives over excessive staff-expense issues.

However, the ownership corporation had no direct control over management or staff-allocation issues. The evidence is inconclusive that the ownership corporation, as opposed to the management corporation, is the party at fault.

The owners will be affected indirectly by the verdict against the facility which they own. The verdict will have a substantial negative impact upon their investment in the nursing home, but they are not directly responsible for payment of the judgment.

The jury's verdict will be reduced from $1.7 million to $1.3 million and will apply against the management company alone.

COURT OF APPEALS OF TEXAS
March 11, 2005

CNA Coordinator

The facility's CNA coordinator testified she was told to keep CNA staffing to the state-allowed minimum despite complaints from nursing staff that CNA staffing levels were insufficient to meet the residents' needs.

Payroll Clerk

The facility's payroll clerk testified the facility's pay rates were the lowest in the area. This contributed to high staff turnover, which in turn contributed to the facility often being short-handed.

Staff Nurse

A staff nurse testified the facility was constantly understaffed, due primarily to low wages and poor working conditions.

The understaffing had an effect on the resident in question and other residents. High fall-risk patients like her were instructed to use their call buttons to summon assistance rather than trying to get up on their own. But when no one responded they would have to try to get up on their own. When they tried to get up on their own they would often fall.

The jury heard testimony that the resident in question had not made it to the bathroom and had fallen in her own urine on at least one occasion with no one available to help her.

Former CNA

A CNA who had formerly worked at the facility testified the resident in question was known to try to get out of her wheelchair by herself and to try to do things by herself when no one would come to help her.

This was a common occurrence because the facility more often than not was short handed.

The CNA testified she was told after the fact to go back and fill in blanks in CNA flow charts after she was unable to render all the personal care that was expected of her. **Sunbridge Healthcare Corp. v. Penny, __ S.W.3d __, 2005 WL 562763 (Tex. App., March 11, 2005).**

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