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Thank you, again, for allowing Medical Update to meet your continuing education needs.

Sincerely,  
Genie Hamlett

## **Tag#F223.Abuse – Protecting the Resident and the Facility**

**In long term care, the words “abuse” and “neglect” can cause even the most seasoned administrator to shudder. As a professional, charged with protecting the residents in our care, we have a moral, ethical and legal responsibility to follow the law. F Tags 223 through 226 in the “Guidance to Surveyors-Long Term Care Facilities, Guide to Survey Tag Numbers” explains the law, the CMS interpretation of the law and our responsibilities as health care professionals.**

**Read F 223. In very simplistic form it means that no one has the right to abuse the resident regardless of their relationship to the resident. For example:**

**Mr. S comes in daily to feed Ms. S her meals. While they are in the dining room the aide notes that Mr. S is yelling obscenities at Ms. S and is cramming food in her mouth, then holding her nose so she will swallow. The aide asks Mr. S to stop and he states, “I am her husband. I can do as I please”. What should the aide do?**

**If you answered, remove Ms. S from the situation immediately and report the incident to the administrator, you would be correct. In you answered anything else, you need to read F223 again.**

**Please note in the guidelines that abuse is defined as the “willful infliction of injury, unreasonable confinement, intimidation, or punishment” . . . . The word “willful” becomes a determining factor in your decision for substantiation or not substantiated at the conclusion of your investigation.**

**Read the definitions of abuse as defined in the guidelines. Answer the following question:**

**You overhear a nursing assistant tell a resident, “If you don’t quit calling for help,**

**I am not coming back in here tonight!” By definition, is this verbal abuse?**

**The answer is YES. It is saying something to frighten the resident. It could even be considered mental abuse because there is an implied threat of punishment – no one is coming back in the room tonight.**

**Read F 224 concerning written policies and procedures for the facility concerning abuse, neglect or misappropriation of personal property.**

**F226 states that policies and procedures must be developed and must be followed in the facility. There are seven components:**

**Screening**

**Training**

**Prevention**

**Identification**

**Investigation**

**Protection**

**Reporting /Response**

**Screening: All potential employees must be screened prior to employment. This includes criminal background checks, reference checks from former employees, and check of applicable licensing boards and registries.**

**Example:**

**Linda J has been an RN for years and Director of Nursing for three facilities close to yours. Because you know her the screening requirements don't have to be met.**

**True \_\_\_\_\_ False \_\_\_\_\_**

**This is false. The law requires all potential employees to be screened prior to employment.**

**Training: All employees are to receive training about abuse and reporting requirements.**

**Read II. Under Guideline 483.13(c) F226, then answer the question:**

**The employer has a responsibility to train all staff in the regulations pertaining to abuse, neglect and misappropriation of the resident's property.**

**True \_\_\_\_\_ False \_\_\_\_\_**

**This is a true statement.**

**Prevention: This regulation requires that the facility have procedures in place to prevent abuse, neglect, and misappropriation of property. After reading this part of the regulation, answer this question:**

**John Doe was admitted from the county jail where he had been serving a sentence for assault and battery. The personnel at the jail express that he still had episodes of unpredictable anger behavior but your census is very low and you really need to fill the bed. The resident is admitted to the general population and on his first full day in the facility he strikes another resident causing them to fall and break a hip. If this goes to court could you prove that you had followed the law before admission to the facility.**

**The interpretation of the rule states: (The facility has the responsibility for) the assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff.**

**Identification: Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.**

**Investigation: Any and all allegations of abuse, neglect and/or misappropriation of resident's property must be investigated and documented. The proper authorities for your state must be contacted.**

**Who: Resident or residents involved**

**Who is the alleged abuser?**

**Who are the witnesses, if any?**

**When: When did it happen?**

**Where: Where did it happen?**

**Why: Is there a reason for the behavior? Any extenuating circumstances?**

**How: Exactly what happened? Get signed statements from all involved parties, including the resident, alleged abuser, witnesses, etc.**

**Protection: The resident is to be protected at all times.**

**Reporting: All alleged violations must be reported and all substantiated incidents must be reported to the proper authorities. Each state may have a different set of requirements and those can be found in the state rules and regulations. Can you quote your state's regulations? Find them now. If the report is substantiated and involves an employee, they must be reported to the state nurse aide registry.**

**From this experience, analyze whether changes are needed to any policies and procedures to prevent the occurrence from happening again. Educate the staff on any changes made.**

**F225 contains very specific regulations about what needs to be screened for potential employees**

**The facility must not hire a potential employee with a history of abuse if that information is known to the facility.**

**True \_\_\_\_\_ False \_\_\_\_\_**

**This is a true statement.**

**483.13 (c) (2) and (4) states that reporting of both alleged violations and the results of the investigations to the State Survey agency must be done.**

**Abuse, neglect, and/or misappropriation of property of a resident in a long term care facility are considered very serious crimes and must be dealt with timely and in accordance with rules and regulations as state in the federal guidelines as well as the individual state guidelines.**

## Guidance to Surveyors- Long Term Care Facilities

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F223	<p>(b) Abuse – The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion.</p>	<p><b><u>Intent: §483 13(b)</u></b></p> <p>Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members of legal guardians, friends, or other individuals.</p> <p><b><u>Guidelines: §483 13 (b) and (c)</u></b></p> <p><b>“<u>Abuse</u>” means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. “(42 CFR 488.301) This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.</b></p> <p><b>“<u>Verbal abuse</u>” is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of “harm”; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</b></p>

**TAG NUMBER**

**REGULATION**

**GUIDANCE TO SURVEYORS**

**F223**

**“Sexual abuse” includes, but is not limited to, sexual harassment, sexual coercion or sexual assault.**

**“Physical abuse” includes hitting, slapping, pinching and kicking. It also include controlling behavior through corporal punishment.**

**“Mental abuse” includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.**

**“Involuntary seclusion” is defined as separation of a resident from other residents or from her/his room or confinement to his/her room (with or without roommates) against the resident’s will, or will of the resident’s legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs.**

**Investigation of possible involuntary seclusion, may involve one of two types of situations: that in which residents are living in an area of the facility that restricts their freedom of movement throughout the facility, or that in which a resident is temporarily separated from other residents.**

**Abuse- As previously stated**

- **If the stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired, then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences.**
- **If a resident is receiving emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staffers or others in the facility), this is not considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, and is being done according to resident needs and not for staff convenience.**

**If a resident is being temporarily separated from other residents, i.e., for less than 24 hours, as an emergency short-term intervention, answer these questions:**

1. **What are the symptoms that led to the consideration of separation?**

2. Are these symptoms caused by failure to:
  - a. Meet individual needs?
  - b. Provide meaningful activities?
  - c. Manipulate the resident's environment?
3. Can the cause(s) be removed?
4. If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation?
5. If these alternatives have been tried and found ineffective, does the facility use separation for the least amount of time?
6. To what extent has the resident, surrogate or representative (if any) participated in care planning and made an informed choice about separation?
7. Does the facility monitor and adjust care to reduce negative outcomes, while continually trying to find and use less restrictive alternatives?

**If, during the course of the survey, you identify the possibility of abuse according to the definitions above, investigate through interviews, observations, and record review. (For investigative options, refer to the *Guidelines for Complaint Investigation* which outlines the steps of investigations for various types of suspected abuse and misappropriation of property.)**

**TAGF223**

**REGULATION**

**GUIDANCE TO SURVEYORS**

**Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act, the nature of the abuse and where and when it occurred. Ensure the facility addresses the incident immediately.**

**TAG  
NUMBER  
F224**

**REGULATION  
(c) Staff treatment of residents**

**GUIDANCE TO SURVEYORS**

**Intent: §483.13(c) F224**

**Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility’s identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.**

**“Neglect” means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.**

**“Misappropriation of resident property” means the deliberate, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent. (42 CFR 488.301)**

**TAG  
NUMBER  
F225**

**REGULATION  
  
(1) The facility must develop and**

**GUIDANCE TO SURVEYORS**

**Intent: §483.13(^1)and**

**Implement written policies and Procedures that prohibit mistreatment, Neglect, and abuse of residents, and Misappropriation of resident property.**

**(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**

**The facility must not hire a potential employee with a history of abuse, if that information is known to the facility. The facility must report knowledge of actions by a court of law against**

**an employee that indicates the employee is unfit for duty. The facility must report alleged violations, conduct an investigation of all alleged violations, report the results to proper authorities, and take necessary, corrective actions.**

**Guidelines: §483:13 (c)(n(ii) and (iii)**

**Facilities must be thorough in their investigations of the past histories of individuals they are considering hiring.**

**In addition to inquiry of the State nurse aide registry or licensing authorities, the facility should check information from previous and or current employers and make reasonable efforts to uncover information about any past criminal prosecutions.**

**“Found guilty. . .by a court of law” applies to situations where the defendant pleads guilty, is found guilty, or pleads nolo contendere.**

**“Finding” is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents, or misappropriation of their property.**

**A certified nurse aide found guilty of neglect abuse, or mistreating residents or misappropriation of property by a court of law, must have her/his name entered into the nurse aide registry. A licensed staff member found**

**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.**

**guilty of the above must be reported to their licensing board. Further, if a facility determines that actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), then the facility must report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authorities (if a license staff member). Such determination by the facility is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment.**

**A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.**

**The facility's reporting requirements under 483.13(c) (2) and (4) include reporting both alleged violations and the results of investigations to the State survey agency.**

**TAG F226**

**REGULATION**

**GUIDANCE TO SURVEYORS**

**Use TAGF226 for deficiencies concerning**

the facility's development and implementation of policies and procedures.

**Guidelines: §483.13(c).F226**

**The facility must develop and implement policies and procedures that include the seven components: screening, training, prevention, identification, investigation, protection and reporting/response.**

**The items under each component listed below are examples of ways in which the facility could operationalize each component.**

**I. Screening (483.13(c)(1)(ii)(A)&(B): Have procedures to:**

- **Screen potential employees for a history of abuse, neglect or mistreating resident defined by the applicable requirements at 483.13(c)(1)(ii)(A) and (B). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.**

**II. Training (42 CFR 483.74(e): Have procedures to:**

- **Train employees, through orientation and on-going sessions on issues related to abuse prohibition practices such as: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents;**

**How staff should report their knowledge related to concerning the facility's development allegations without fear of reprisal; and implementation of policies and . . .**

**How to recognize signs of burnout, frustration and stress that may lead to abuse and what constitutes abuse, neglect and misappropriation of resident property.**

**III. Prevention (483.13(b) and 483.13(c):  
Have procedures to:**

- **Provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and provide feedback regarding the concerns that have been expressed. (See 483.10 (f) for further information regarding grievances.**
- **Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur.**
- **This includes an analysis of:**
  - **Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility;**

**The deployment of staff on each shift in sufficient numbers to meet the needs of residents, and assure that the staff assigned have knowledge of the individual residents' care needs.**

- **The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds; and**
- **The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff.**

- VI. Protection (483.13(c)(3): Have procedures to:**
- **Protect residents from harm during an investigation**

**VII. Reporting/Response(483.13(c)(1)(m), 483.13 (c)(2) and 483.13 (c) (4): Have procedures to:**

- **Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation.**
- **Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and**
- **Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.**

**TagF#223 – Case Study**

**Let's begin our case study with two definitions:**

**'Abuse or neglect' means *the infliction of physical pain, injury, or mental anguish, or the deprivation services by a caretaker* that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare.'** (emphasis added)

**Medical malpractice is an action for damages for personal injury or death as a result of any medical malpractice by a health care provider, whether based upon tort or contract law. The Medical Malpractice Act requires that the plaintiff prove that the defendants failed to act in accordance with the recognized standard of acceptable professional practice and that “as a proximate result of the defendant’s negligent act or omission, the plaintiff suffered injuries which would not otherwise occurred.” Acts of omissions complained of in a medical malpractice action should involve matters of the medical arts and/or sciences that require specialized skills not ordinarily possessed by a lay person.**

**Analyze this case as you read and see if you believe there was “Infliction of physical pain, injury or mental anguish” upon Mrs. Stinson. In this situation mental anguish can be interpreted as abuse or neglect by the nursing home upon Mrs. Stinson. Then, try to determine if you believe the response of the nurse’s aide to be a type of deprivation of services by a caretaker or an “infliction of physical pain, injury or mental anguish.”**

### **THE FACTS**

**Mr. Johnson attacked Mrs. Stinson while the two were residents of CF Nursing Home, a nursing home owned and operated by CLF Homes for the Aged. Although the events leading up to the assault on January 1, 2000, are controversial, it is undisputed that Mr. Johnson struck Mrs. Stinson while they, along with other residents and care**

givers, were gathered in the dining area. Moments before the attack, Mr. Johnson dropped a piece of paper on the floor, immediately following which he displayed signs of agitation and engaged in what were described as “boxing-like” motions. When Mrs. Stinson stepped forward to pick the paper, Mr. Johnson struck her, knocking her to the ground. Mrs. Stinson was immediately transported to a hospital where she was treated for a broken hip and other traumatic injuries. She remained in the hospital for several days. Upon discharge from the hospital, Mrs. Stinson was transferred to a rehabilitation facility. She never returned to CF Nursing Home. Mrs. Stinson died four months later, in April of 2000. Pneumonia was identified as the cause of death.

The matters at issue are not limited to alleged acts and omissions of CF on the day of the assault. They also pertain to alleged acts and omissions of CLF Homes for the Aged and the State of residence occurring over a period of months leading up to the assault. Accordingly, \*720 we will review the relevant history prior to the day of the assault.

Mrs. Stinson was admitted as a resident to CF Nursing Home on March 23, 1998. She was 75 years of age at the time. It was her first admission to a nursing home. Mr. Johnson was admitted to CF Nursing Home in August 1998, when he was 78 years of age. It was not his first admission to such a nursing home or health care facility. Mr. Johnson had been a resident of an in-patient psychiatric facility prior to being admitted to CF Nursing Home.

**It is relevant to the matters at issue that the Preadmission Screenings and Annual Resident Review Program Division of the State screened applicants seeking admission to health care centers (nursing homes) in the State. The purpose of the screening was to place each applicant in an appropriate health care center, nursing home and/or skilled nursing facility. Mr. Johnson was evaluated by the State on at least two occasions prior to his admission to CF.**

**He was evaluated by the State in 1996 and 1997 as part of its annual retention review protocol, and on each occasion Mr. Johnson was found to be appropriate for admission to the general population of a nursing home like CF.**

**In its evaluations, the State considered whether Mr. Johnson posed a threat to other residents and whether he required specialized mental health services. When Mr. Johnson was to be discharged from a psychiatric hospital in 1998, the State evaluated and approved him for placement at CF. Following his admission to CF, the State conducted an annual evaluation of Mr. Johnson in February of 1999 and determined he was appropriately placed and could remain in the general population at CF. (FN1)**

**FN1. Additional evidence suggesting that Mr. Johnson was appropriately placed a CF was that after his admission to CF in the Fall of 1998, but prior to the review by the State in the Spring of 1999, a Senior Care program from a major hospital came to CF to evaluate whether**

**Mr. Johnson would qualify for an out-patient intensive mental health day care service offered by the hospital. Only persons with serious mental health conditions qualified for the partial hospitalization program offered by this hospital. The program brought Mr. Johnson to the hospital for a trial visit, and after the examination, the program found Mr. Johnson did not qualify for the partial hospitalization for mental health services.**

**In addition to evaluation by the State, Mr. Johnson was evaluated periodically by the psychiatric hospital, prior to and during his residency at CF. Moreover, the psychiatric hospital was under contract with CF to provide mental health services for the residents of CF, which it provided through its staff of psychiatrists and psychologists. Pursuant to the contract with CF, the psychiatric hospital provided these services for Mrs. Stinson and Mr. Johnson throughout their residency at CF. (FN2)**

**FN2. The psychiatric hospital had also provided similar services for Mr. Johnson when he resided at their facility.**

Following his admission to CF, psychiatric hospital staff visited Mr. Johnson on a weekly basis. This continued throughout his seventeen-month residency at CF. At no time did the psychiatric hospital recommend that Mr. Johnson be discharged or segregated from the general population at CF. To the contrary, following a routine visit with Mr. Johnson in December 1999, which was one month prior to the assault, a psychiatrist from the psychiatric facility, noted that Mr. Johnson was doing well, that he did not require routine specialized mental health services, and that he did not pose a danger to himself or others.

\*721 As for Mrs. Stinson, other than the tragic events that occurred on January 1, 2000, Mrs. Stinson's twenty-two month residency at CF was generally satisfactory, with a few exceptions. (FN3)

FN3. Mrs. Stinson walked away from the facility without permission or supervision on a couple of occasions.

These events are referred to as elopements.

#### Interpretation of the Facts

Under applicable standards of care, the Administrator of defendant's nursing home was charged with the responsibility of acting as gate-keeper of the facility, therefore was responsible for making the ultimate decision whether to not to admit a residents [sic].

**The decision to admit a patient to a nursing home is an administrative decision, not a medical one. It is important to note that an Administrator is not a health care practitioner but is a health care provider.**

**Prior to Mr. Johnson being admitted to defendant CF, the Administrator knew or should have know of Mr. [sic] Johnson's medical history. He had attacked and injured multiple patients and care providers. He had sexually assaulted both residents and staff members. He had threatened to kill numerous people and had been diagnosed with homicidal intentions. His own psychologist warned defendant's staff that he represented an extreme risk of danger to staff and other residents. Notwithstanding this risk the Administrator of CF engaged in willful, wanton, and reckless conduct by accepting Mr. Johnson into the general nursing home population. Such conduct constituted a substantial and unjustifiable risk to patients of defendant's nursing home, including Martha Stinson, constituted a gross deviation from \*727 the standard of care that would be exercised by an ordinary person.**

**The ultimate decision to discharge a patient is also an administrative decision. Throughout his stay, Mr. Johnson displayed aggressive and delusional behavior that put defendants on notice that he represented a serious threat of injury to residents.**

**Medical records of Mr. Johnson reflect numerous instances of inappropriate and aggressive sexual and physical behavior. Staff assessments indicate the he was combative and swinging at the staff. In March, 1999, he threatened to strike a CNA. Mr. Johnson was frequently concerned about people trying to kill him. In early July, 1999, the staff noted that he was becoming more combative. In late October, it was noted that Mr. Johnson had been physically abusive to staff and residents.**

**Despite the clear risk that Mr. Johnson posed to residents, the Administrator of CF, in breach of applicable standards, failed to discharge Mr. Johnson. The decision not to pursue the discharge of Mr. Johnson was an administrative and economic decision, and was not a medical decision. Such conduct constituted a substantial and unjustifiable risk to the patients of defendant's nursing home, including Martha Stinson, and constituted a gross deviation from the standard of care that would [sic] exercised by an ordinary person.**

**As a direct result of the administrative breaches in the standards of care, as outlined above, Martha Stinson sustained great pain of body and mind, suffered severe emotional distress, incurred medical and out of pocket expenses, and sustained personal injuries including multiple fractures, contusions, bruises, hematomas and other injuries which lead [sic] to her untimely death.**

**On or about January 1, 2000, James Johnson and Martha Stinson were allowed to interact with each other in the cafeteria.**

**On that day, Mr. Johnson and Mrs. Stinson were being monitored by nurse aids who were acting in a custodial capacity. Such aids provide basic assistance with acts of daily living, and supervision, and are not health practitioners as contemplated by the State Medical Malpractice Act. They are caretakers as defined under the State Adult Protection Act.**

**[sic] On January 2, 2000, Mr. Johnson was displaying agitated behavior. At that time, Mr. Johnson dropped a piece of paper on the floor. The nurse aid who was monitoring Mr. Johnson at that time stated that she was not going to pick of [sic] the piece of paper for fear that Mr. Johnson would strike her. This nurse aid, who was operating within the scope of her employment for defendant CLF Homes for the Aged, proceeded to allow Mrs. Stinson to attempt to pick up the piece of paper, who was promptly assaulted by Mr. Johnson. The nurse aid committed simple negligence in not separating Mr. Johnson from Mrs. Stinson, and allowing Mrs. Stinson to pick up the piece of paper.**

**As a direct result of the negligence committed by this nurse aid, Mrs. Stinson sustained great pain of body and mind, suffered severe emotional distress, incurred medical and out of pocket expenses, and sustained personal injuries including multiple fractures, contusions, bruises, hematomas and other injuries which lead [sic] to her untimely death.**

**The actions, as described above, constitute abuse and neglect as defined under the State Adult Protection Act. Mrs. Stinson was deprived of proper \*728 administrative and nurse aid services which were necessary for her to maintain proper health.**

#### **Of Interest to Administrators**

**In medical malpractice cases, courts look to whether the decision, act, or omission complained of required the assessment of a patient's medical condition and whether the decision, act, or omission required a decision based upon medical science, specialized training or skill**

**Medical malpractice cases typically involve a medical diagnosis, treatment or other scientific matters. The distinction between ordinary negligence and malpractice turns on whether the acts or omissions complained of involve a matter of medical science or art requiring specialized skills not ordinarily possessed by lay persons or whether the conduct complained of can instead be assessed on the basis of common everyday experience of the trier of fact.**

**The Plaintiff contends the decision “to admit a patient to a nursing home is an administrative decision, not a medical one” and that an Administrator “is not a health care practitioner, as defined under State law.” The State Health Care Association, which filed an amicus *curiae* brief, insists the applicable federal and state regulations make the appropriateness of placement of a resident a medical decision, not an administrative decision, for which a TAPA claim is unavailable.**

**The *amicus* makes the point that every person admitted to a State nursing home, such as, CF must be medically diagnosed**

**. It additionally makes the point that a physician must personally approve a written recommendation that an individual be admitted to a nursing home and remain under the care of a physician while a resident of a nursing home. As the regulations provide, a nursing home must complete, prior to admission, a Medicaid Pre-Admission Evaluation that must be signed by a physician and contain sufficient medical substance so that nurses in the Pre-Admission Evaluation Unit of the State Bureau may evaluate the assessment.**

#### **Further Definition**

**Applicable regulations establish as a matter of law that the protocol to determine whether to admit a resident to a nursing home is, in the first instance, a matter of medical science or art requiring specialized skills. As the Court case explained, acts or omissions complained of which involve matters of the medical arts and/or sciences, requiring specialized skills not ordinarily possessed by a lay person, is medical malpractice.**

**In spite of the Plaintiff's contentions that the decisions to admit and retain Mr. Johnson were administrative decisions that were based on economics, we have concluded that the key decision, whether Mr. Johnson was appropriate for placement in the general population of CF's nursing home, involved matters of the medical arts and /or sciences, requiring specialized skills not ordinarily possessed by a lay person. The fact the Administrator of CF was also involved in the decision to admit and retain Mr. Johnson as a resident does not eviscerate the decisions and recommendations by the medical personnel that Mr. Johnson was appropriate for placement in the general population of CF's nursing home. To the contrary, the Administrator of CF is also a licensed healthcare professional under State code. As a consequence, for medical malpractice purposes, the Administrator's licensure places him/her in the same status for purpose of the State code as that of "a person in the healthcare profession requiring licensure."**

**FN10. The requisite qualifications for licensure as a licensed nursing home administrator are subject to the criteria set forth in State Code and preliminary education requirements satisfactory to the Board of Examiners**

**for Nursing Home Administrators. The subjects of examination for applicants for licensure are determined by the Board of Examiners for Nursing Home Administrators.**

**Considering all of the above, we have concluded that the decisions to admit and retain Mr. Johnson fall within the scope of the Medical Malpractice Act, which precludes a claim under TAPA. Therefore, Count IV of the proposed Second Amended Complaint fails to state a claim for which relief can be granted under TAPA.**

**FN11. Based upon our ruling, we find it unnecessary to discuss whether the alleged acts or omissions of the nurse's aide on the day of the assault fall within the purview of the Medical Malpractice Act.**

#### **Plaintiff's Specifics**

**Pursuant to 42 C.F.R. §483.10 the nursing home had a obligation and a duty to assure that resident's [sic] rights are followed and to assure that each residence [sic] has a dignified existence and the right to exercise his or her rights as a resident and as a citizen of the United States.**

Pursuant to 42 C.F.R. § 483.13(c) the nursing home had the duty to develop and implement written policies and procedures that prohibit mistreatment, neglect, abuse of residence [sic], and misappropriation of resident's [sic] property.

Pursuant to 42 C.F.R. §483.25 (f) the nursing home had a duty to ensure that the residents who display mental or psychological adjustment difficulties, receive appropriate treatment and services to correct the assessed problem.

Pursuant to 42 C.F.R. § 483.25 (h) the nursing home had a duty to ensure that resident's [sic] environment remain free of accident hazards and that each resident receives adequate supervision and assistance to prevent accidents.

Plaintiff contended that CF was required to maintain the nursing home in compliance with the minimum statutory standards and failing to do so constituted negligence per se. (FN12) CF disagreed, arguing the federal regulations are too vague and general to be enforceable as standards. CF also contended the federal regulations, if applicable, would constitute a national standard of care. We have concluded CF is correct on both grounds.

FN12. Plaintiff also contended the regulations served as a basis for its breach of contract claim.

The federal regulations are simply too vague and general to constitute a standard of care by which a jury, or for that matter a court, can effectively judge the acts or omissions of health care providers and nursing home operators. As aptly stated in *Smith vs. Bowen*, “[t]here is no legislative definition of ‘quality health care,’ and there can be none.” The *Bowen* court also held that federal nursing home regulations are so vague that enforcement arguably violates “commonly accepted principles of fundamental fairness” and gives rise to “a procedural due process concern.” Furthermore, in a case dealing with the admissibility of the Nursing Home Patients’ Bill of Rights, another court held, “The patients’ rights are so broadly stated that submission of them to a jury as the standard of care would result in speculative, ad hoc verdict completely unguided by any rational legal standards.” *Makas vs. Hillhaven, Inc.* In the matters of *Stogsdill v. Manor Convalescent Home, Inc.*, the plaintiff brought a claim against a nursing home contending regulations established the standard of care as a matter of law, the court held the regulations were “too vague to be sufficient indicators of the standard of due care . . .”

The trial courts summarily dismissed Plaintiff’s claims relating to Mrs. Stinson’s dietary maintenance, toileting, resident assessment activities, grooming, hygiene, and care planning. We have concluded as the trial court did that the evidence fails to demonstrate how the alleged errors or omissions had any bearing on or relevance to the assault by Mr. Johnson. Therefore, summary dismissal of these claims was proper.

**In summary, we are unable to conclude that the allegations in Count IV state a claim that CF, its employees, or agents abused or neglected Mrs. Stinson. To constitute abuse or neglect, CF – as distinguished from Mr. Johnson – had to inflict “physical pain, injury, or mental anguish” on Mrs. Stinson, or in the alternative, CF had to deprive Mrs. Stinson of services that were necessary to maintain the health and welfare of Mrs. Stinson. No matter how Plaintiff characterizes the acts or omissions of CF, its employees or agents in the proposed Complaint, CF’s decision to admit and retain Mr. Johnson did not constitute an infliction of physical pain, injury or mental anguish (abuse or neglect) by CF upon Mrs. Stinson. Moreover, no matter how Plaintiff characterizes the sufficiency of the supervisory role played by the nurse’s aide or the rapidity of her response when Mr. Johnson dropped the paper and then began to “shadow box” as Mrs. Stinson approached to pick up the paper, the response of the nurse’s aide was neither an infliction of physical pain, injury or mental anguish on Mrs. Stinson by the nurse’s aide nor was it the type of deprivation of services by a caretaker contemplated in State Code. Further, having failed to prove abuse and neglect by CF, Plaintiff is not entitled to present a claim for attorney’s fees.**

### **Final Thoughts**

**As long as the law pertaining to abuse and neglect is not specific regarding what constitutes physical pain, injury and mental anguish, and there have been no lawsuits which establish precedence, nursing homes and their administrators and medical directors will be safe from attorneys who attempt to twist the definitions.**

**Pain and anguish cannot be measured objectively; yet in pain management settings, anyone reading the chart must rely heavily on subjective reports. Examples of subjective data which would be recorded in a resident's chart would be:**

**Mr. J says, "My pain is a 5 on a 1 – 10 scale."**

**A staff member may observe that the patient appears anxious and restless.**

**Mrs. S says, "My side is burning" or "My left ankle aches."**

**A staff member may observe that the resident's pain appears to take his breath away and the resident seems to be short of breath.**

**Until this type of data is measurable, it will not be considered objective and quantitative (using numbers, graphs, charts and patterns). If the data cannot be validated, it is difficult to uphold arguments in court relating to pain caused by abuse or neglect.**

**One type of abuse which is easier to prove in a court of law and therefore can result in the family members being charged are those involving the elderly residents' sons or daughters, spouses or other relatives. Most abusers of the elderly are their children or spouses not health care providers. According to the National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, of the two million elderly Americans abused, women, 75 years or older, who are physically or mentally impaired, suffer the most abuse. These statistics include not only**

physical, emotional and sexual abuse but financial abuse and overt neglect. Most abuse victims experience two to three forms of abuse at the hands of the caregiver on which they are dependent. When a patient that fits this description enters the nursing home, it is the staff's job to determine if a patient has been abused. If their suspicions of mistreatment are correct, the patient, in fear of retaliation, may not report the family members, often, even covering up for them. The love/hate relationship cycle so many abuse victims are involved in, coupled with a lack of mental capacity if dementia is part of the diagnosis, may make the patient's self-report unreliable. It is up to the activity director, social worker and at least one staff member to become the trustworthy friend the abuse victim may never have had. The administrator needs to stay abreast of state laws and keep his/her staff informed. They will be able to assure the patient of his/her safety and his/her rights in the facility once they are familiar with the laws of their particular state regarding both guardianship and financial and health care power of attorney. The administrator and chosen staff members can work together, with the state ombudsman's blessing, with an attorney (pro bono) or the state prosecutors to navigate the process. Once the power of attorney is transferred from the abusive family member to another family member or a representative appointed by the state, the abuser will no longer have any power over the patient. At that point, the abusive party will be unable to move the patient to another nursing home, spend the patient's money on themselves versus the patient's needs or even to visit. The abusive cycle will then be broken. This will enable the nursing home to provide the patient the protection necessary for the patient to feel safe and therefore, improve the patient's quality of life and care in their final days.

