Risks in Long Term Care – Part Two

by John C. West, JD, MHA, DFASHRM, CPHRM, Principal, West Consulting Services, LLC

The nature of long term care (LTC), in whatever form it is provided (skilled nursing, assisted living, independent living), makes it extremely challenging. Unlike acute care facilities, LTC facilities are the resident's home, and to a greater or lesser extent depending on the services provided, the resident's dignity and autonomy must be respected. LTC facilities do not have the luxury of telling residents what to do (e.g., "Do not try to get out of bed without calling for assistance") in the same way that acute care facilities do. Additionally, the population tends to be older adults who are metabolically, physiologically and physically fragile. The risk of death or debilitating injury due to an adverse event is much greater than in the general population.

This article is Part 2 of a two-part series on risks inherent in long term care. Although there are myriad risks in long term care, this article discusses risks that must be addressed in any LTC risk management program.

Medication Errors

In *People v. Einaugler*, 208 A.D. 2d 946, 618 N.Y.S.2d 414 (NY App. Div. 1994), the resident was transferred to the nursing home with a peritoneal dialysis catheter in place. Dr. Einaugler, an employee of the facility, mistook the dialysis catheter for a gastrostomy (feeding) tube and directed that the resident be fed through it. When the mistake was realized some days later, Dr. Einaugler telephoned the chief of nephrology at the local hospital for advice. He was told to transfer the resident to the hospital immediately, but he delayed doing so for 10 hours. The resident died of peritonitis shortly after the transfer. Dr. Einaugler was charged and convicted of reckless endangerment in the second degree and willful violation of health laws in connection with his failure to transfer the resident to the hospital in a timely manner.

According to one source, a medication error is made when it is different from the doctor's order or the manufacturer's instructions or when it falls below accepted professional standards for the medication. The nursing home medication error rate must remain below five percent of doses administered. While it is inevitable to have minor errors, all nursing facility residents must be free of significant medication errors.

Many residents are on treatment regimens that involve the administration of numerous medications and treatment modalities that may have been prescribed by many providers and may need to be administered by persons who are not licensed professional health care providers, such as certified nursing assistants (CNAs) or medication assistants, where allowed. Self-administration is often difficult due to failing eyesight or cognitive decline. Additionally, many of the technological improvements used by hospitals (e.g., scanning bar codes on wrist and bottle labels) may not be available in a LTC facility. All of this can lead to error.

Medication regimens and treatment modalities need to be carefully reviewed for every resident. Each resident's regimen should be reviewed periodically by a licensed pharmacist or provider to determine whether there are duplicate medications or medications that are contraindicated. If the resident is allowed to self-administer medications, his or her ability to do so should be monitored. Any person who administers medications to residents needs to be carefully trained in how to do it and what to look for if the resident has an adverse reaction. If possible, high-risk medications should be administered by a licensed nurse. In one study, seven drugs were implicated in a third of all errors: lorazepam, oxycodone, warfarin, furosemide, hydrocodone, insulin and fentanyl.

Abuse

In *Doe v. Carmel Operator, LLC*, No. 19A-CT-2191 (Ind. Ct. App. March 17, 2020), a resident with cognitive impairment was allegedly sexually abused by a caregiver. The decision was focused on whether the matter should be taken to arbitration. While cases involving the misdeeds of employees are generally brought against the employer under the doctrine of Respondeat Superior, this is only true if the employee was within the course and scope of his employment. Since the facility did not employ the employee to sexually abuse its residents, the employee was decidedly not in the course and scope of his employment. Consequently, the plaintiff will be required to show that the defendant either

(1) Negligently hired the employee, or
(2) Negligently supervised the employee.

It must be remembered that sexual abuse of a demented elder is not a crime of passion – it is a crime of violence.

Elder abuse is prevalent in the elderly population. The most recent major studies on incidence reported that 7.6% - 10% of study participants experienced abuse in the prior year. Estimates vary, but it is widely believed that four million older Americans are victims of physical, psychological or other forms of abuse and neglect every year. While many abuse cases occur in private residences, and the abusers may be spouses or partners, abuse does occur regularly in LTC facilities.

Vulnerable adult abuse is an unseemly aspect of long term care, but it does happen. There are different types of elder abuse, including:

- Physical abuse;
- Sexual abuse or abusive sexual contact;
- Emotional or psychological abuse;
- Neglect and
- Financial abuse or exploitation.

Every staff member must be familiar with these types of abuse, including prevention of abuse, the signs and symptoms of abuse, reporting of abuse and caring for the victim of abuse.

LTC facilities have an obligation to observe and monitor a number of factors that can be indicators of abuse, such as unexplained bruising, pressure ulcers, unexpected weight loss, falls, fearfulness of contact with a staff member. Additionally, caregivers in an institutional setting usually need to be certified, and part of the certification process is undergoing a criminal background check, as well as a

registry check. It does not matter how pleasant a care giver appears to be in an interview, they should still be checked out for episodes of abuse in the past.

Appropriate Care Setting

In *Feinstein v. Norwegian Christian Home & Health Center, Inc.*, 135 AD 3d 699, 135 A.D.3d 699, 24 N.Y.S.3d 660 (NY App. Div. 2016), the resident resided in an assisted living facility (ALF) and suffered multiple falls with injury. Following her last fall at the ALF, she suffered seizures, was bedridden, and was unable to communicate. She was ultimately transferred to a nursing home at which she died a few months later. The jury returned a verdict for the resident's estate of $1,500,00. The plaintiff had argued that the resident should have been put on fall precautions and that she should have been moved to a higher level of care. The ALF had argued that she could not be placed on fall precautions, because that level of care was not consistent with the care provided at the ALF. In short, the ALF admitted that the resident should have received care at a higher level of care, such as a nursing home.

The above case involved a resident of an ALF, but there are levels of care within skilled nursing facilities (SNF), as well. For example, a SNF may not necessarily accept ventilator-dependent residents. If the SNF does accept ventilator-dependent residents, it must have an uninterruptible power source or the resident's health may be in jeopardy if there is an extended power outage. All facilities, even SNFs, must continually assess and re-assess their residents to ensure that they are meeting the residents' needs.

LTC facilities exist in a graduated hierarchical system of levels of increasing care. Residents frequently enter at a lower level of care and progress to higher levels of care over time. However, many facilities become attached to residents for any number of reasons and are loath to discharge them to a higher level of care, even when it is obvious that the resident requires a level of care not provided by the facility. Facilities need to regularly monitor each resident's care requirements and adjust the setting appropriately. It is not appropriate, for example, to wait to place a resident in a memory care unit until after the resident has eloped numerous times. Facilities need to be proactive in meeting the residents' needs.

Sometimes it is the family that is resistant to transferring the resident to a higher level of care. They may like the facility and its staff, they may not realize that their loved one requires a higher level of care, or they may be reluctant to undertake the bother of moving the resident. In these cases, it is prudent to undertake an informed refusal of care with the family or the resident. The family/resident must be aware of the risks of remaining at the present level of care. The family/resident should be aware of the benefits of higher levels of care. And, the resident/family must be made aware of all of the alternatives to remaining at the present level of care. This discussion should be documented in the resident's chart and, if possible, the resident/family should acknowledge (in writing) that the discussion took place and they are presently refusing to move to a higher level of care.