Long-Term Care Survey Alert

Abuse Detection: WATCH OUT FOR CONDITIONS THAT MIMIC ABUSE

You know that Mrs. Jones always has bruises on her arms and legs because she takes a blood thinner. Don't count on surveyors to reach that same conclusion, however.

And survey day may be too late to start explaining that the resident bruises easily or has some other condition that mimics abuse if the medical record and care plan don't back you up in that regard.

The facility should also be able to show surveyors how it has investigated the cause of bruising or other incidents, such as skin tears, advises **Karen Clay**, a long-term care consultant in Brimfield, MA.

Otherwise, an abuse tag or immediate jeopardy may be in the offing.

Surveyors Big On Bruises, Skin Tears

According to Clay, facilities should be on the lookout for four conditions that can cause surveyors to jump to a false conclusion of abuse:

1. easy bruising in residents on anticoagulant therapy (Coumadin or heparin);
2. unavoidable skin tears in the resident with very fragile, thin skin;
3. spontaneous fractures in osteoporosis;
4. paranoid delusions of mistreatment or misappropriation of belongings which can occur in Alzheimer's disease, for example. "Surveyors are especially big on bruises and skin tears," warns **Kathy Hurst**, principal of **Hurst Consulting Group** in Chino Hills, CA. "Their immediate assumption is that the resident has been abused. They don't put the condition in the context, for example, that the skin thins as we age, so that a skin tear can occur when someone just turns or moves the resident," she says. Someone with osteoporosis can experience a spontaneous fracture with normal movement.

Care Plan the Risks

Since the care plan is the facility's first line of defense to avoid allegations of abuse when caring for residents with these conditions, care plans should note that "the patient is at risk for unavoidable bruising secondary to Coumadin therapy or skin tears secondary to thin skin or spontaneous fractures secondary to osteoporosis," Hurst suggests.

The care plan for residents at risk for such problems should always include standing interventions such as a two-person assist and a focus on fall prevention. "Use of a gait belt can help staff move a patient without lifting the person by a body part, which helps prevent bruising and risk of fractures," advises Clay.

"Mechanical lifts for residents who cannot weight bear can also help eliminate direct stress to skin and bones," she adds. Facilities can also use products that pad the resident's arms, such as so-called "geri-sleeves." Some of these products come lined with a cool emollient that softens the skin.

Hurst advises conducting weekly skin rounds on all residents to document any little bruises or skin tears before anyone else does.

In addition, the care plan should include interventions specifically aimed at the underlying condition for example, a focus

on nutrition and hydration for the resident at risk for skin tears. "Prophylactic Vitamin C therapy can sometimes help with skin maintenance," says Hurst (see p. 52). "And there are now also a lot of new medical treatments for osteoporosis" to increase bone density.

Don't Make Assumptions

Just because the resident is on anticoagulant therapy doesn't mean the staff shouldn't try to figure out the origin of a bruise. Clay advises checking the bruise's location and size and for the shape of fingerprints to get an idea of what might have caused the markings (see following story).

The physician can determine if the bruising is consistent with the resident's level of anticoagu-lation. If that's the case, Clay recommends asking the physician or medical director to write a note in the medical record to that effect, as physician documentation tends to carry weight with surveyors.

The care plan should include directives for nurses to check for signs that the resident's clotting time is moving into the danger zone. Signs and symptoms include increased bruising or pinpoint hemorrhage under the skin, bleeding gums and blood in the stools.

Hurst also advises facilities to ask physicians to document their rationale for not ordering blood coagulation studies for a resident in a particular instance.

Survey experts generally advise facilities to maintain a separate file of their investigations into the causes of any bruising, skin tears or fractures. Hurst says she verbally shares the results of the investigation with surveyors and shows them the written report but doesn't provide them a copy unless requested.

Clay recommends including an "objective and nonconclusive note" in the resident's chart outlining what happened and describing the bruise or skin tear. The medical record documentation should also include any immediate and follow-up care and any changes to the plan of care.

Address Paranoid Delusions

Paranoia, a symptom commonly seen in the middle stages of Alzheimer's disease, is another common clinical condition that can imperil a facility with false accusations of abuse, reports **Susan Scanland**, principal of **GeriScan** in Clarks Summit, PA.

Patients with AD often exhibit hoarding behaviors stemming from paranoid delusions that other people are out to steal their items. "Also, due to memory deterioration, the AD resident often forgets where he has placed items. The possibility also always exists that another wandering AD resident did indeed lift an item," Scanland says.

As the saying goes: Just because you're paranoid doesn't mean they aren't after you. "Delusional or dementia residents may be at higher risk for someone actually hurting them because a perpetrator knows the person isn't likely to be believed," Clay cautions.

Thus, the facility must perform a reasonable investigation of the resident's allegation.

"You look into it within the context of what is going on with the resident," which would include the resident's psychiatric diagnosis and whether he has made similar accusations in the past, says Washington attorney **Marie Infante,** with **Mintz Levin.** "But you never dismiss the complaint," she emphasizes.

The resident's care plan in such a case should include a psychiatric consult, behavioral interventions and antipsychotic medication, if appropriate, to treat the paranoid delusions and increase the resident's sense of safety. The care plan should also include ongoing revaluation of the effectiveness of the interventions, with revisions as needed.

Yet if repeated investigations of a resident's allegations turn up no evidence of abuse, it may be time to take a different tack, Clay suggests. "The facility can convene a team meeting including mental health services and a psychiatrist to determine how best to investigate and respond to the allegations," Clay says. "Staff can also call the state survey agency

for advice" and document that they took that step.