Long-Term Care Survey Alert

State Legal Trends: CASE STUDY: CONNECTICUT CRIMINAL CASE TELLS A CAUTIONARY TALE

If you think a resident has to suffer grievous harm for a nurse or administrator to end up in handcuffs, think again. A criminal prosecution of a Connecticut nursing home DON and administrator shows how a case that did not involve a resident's death or serious physical injury can nevertheless catch the attention of state prosecutors when combined with negative survey findings.

The two nursing home professionals were arrested for allegedly preventing an elderly Medicaid resident from receiving adequate physical care.

"The defendants were actually charged with 'cruelty to persons' under anarchaic Connecticut law," explains attorney **Michael Kogut** with **Murtha Cullina LLP** in Hartford, CT. "The case never went to trial, as the administrator and DON entered a pre trial probation process that resulted without a conviction," Kogut tells **Eli**.

Here are the basic facts of the case, according to a summary presented by Kogut at the recent **American Health Lawyers'** conference in Phoenix:

The resident was admitted to long-term care on June 1, 1999, suffering from dementia and incontinence. While the resident's ability to care for himself had declined in recent months, his son complained about his father's hygiene, lost dentures and claimed his father was not being properly fed.

After allegedly lodging complaints with the facility for two years, the resident's son finally took his complaints and secret videotape of his father's care to law enforcement authorities. After reviewing the son's allegations and the video in the light of the facility's survey deficiencies, state prosecutors filed criminal charges against the administrator and DON. State authorities also referred the deficiencies to federal authorities for a possible False Claims Act lawsuit, although no charges were filed as a result, Kogut reports.

Among the survey findings and violations included in the affidavit and application for the arrest warrant:

1. The facility failed to promote care in a manner and environment that maintains or enhances each resident's dignity and individuality.This citation was based upon the videotape showing the resident's unkempt condition, exposed wires protruding from the wall over the bed, siderail protective pads on the floor and the resident's identification bracelet on the floor.

2. Recreation documentation identified that the resident was only seen 13 out of 30 days in the month of September 1999.

3. The video revealed the resident was poorly positioned during meals and "at risk for choking and aspiration of food and fluids and had difficulty feeding himself," according to a nurse consultant.

4. The care plan failed to address a pre-existing pressure sore with goals and interventions.

5. The intake and output records over a six-week period identify 14 days when the resident failed to consume the recommended fluid intake.The video failed to show the resident being assisted or encouraged to drink fluids or offered fluids by any staff members.

6.The nursing notes showed that the resident had been moved from a private room and placed on isolation precautions on May 7, 1999, due to a methacillin-resistant Staph in his sputum. An epidemiologist questioned the necessity of this isolation, since the resident was already in a private room and did not appear to have a productive cough or runny nose. The resident showed a loss of physical functioning during the isolation period.

7.On Oct. 15, 1999, a nurse's aide told the nursing consultant that the resident did not receive a shower or a weekly gel shampoo during the isolation period, even though these hygiene measures had been ordered by the resident's physician.

Lesson Learned: Respond immediately to family members who are dissatisfied with a resident's care. "Today families are much more consumer-oriented and cognizant of their legal rights and remedies," Kogut notes. It's also a good idea to keep a log of each complaint from a resident or family member, the facility's response and any action taken. Ask the family member to sign the log entry. **Editor's Note:** For additional tips on how to work with families, see article 6.