Pat:    Hi, this is Pat Iyer with Legal Nurse Podcast, and today we're going to be talking about an interesting topic that gives rise to some lawsuits, particularly in the long-term care industry. This is when one resident starts attacking or hitting on another resident in a long-term care facility.

I have with me an expert who is very familiar with a long-term care environment. She has worked for more than 25 years in the geriatric setting in the capacity of product development, operations, and clinical roles both in the local community, as well as regional and corporate levels spanning several states across the United States.

In 2009, Gina formed GD Solutions LLC, which is a clinical consulting firm. She works with nursing homes, senior living facilities, and provides expert witnesses to attorneys. She has multiple nursing home and senior living case reviews that she's completed. And she helps attorneys and clinicians and owners and operators understand the nuances of risk and exposure in the long-term care industry. She's also developed an interdisciplinary team concept comprised of medical nursing therapy, wound social work, MDS, which is "Minimum Data Set," and administrative subcontractors when other experts are required.

Gina and I have talked about her business, and I've watched and helped her with her business growth over the years. She has developed quite an expertise in this area. So, I think you'll enjoy hearing her today as we talk about one of the specific and special problems for long-term care.

Gina, welcome to the show. Thank you for being with me today.

Gina:    Thank you, Pat.

Pat:     Let's talk about why this is a timely topic.
Gina: Pat, it is. Well, thank you for having me on your recording today. I'm very honored that you invited me. It's a timely topic because so many of the demographics of our nursing home environment and assisted living are changing. While we are used to seeing older women, who are frail and in their 80s coming into these environments, it is now changing dramatically. We're seeing more mental health patients. We're seeing more veterans. As a result of that, we're seeing more men coming into these settings when families just don't know what else to do or where to turn. People are coming into environments that aren't like their homes. They're no longer in their community. They lose their network of friends. For the most part, they make new ones, but it can be a very stressful time.

Think about any moves you've made in your life from high school to college or being single to being married. I remember when I got married, I think the most difficult change for me was sharing drawers with my husband. I wanted to have my own chest of drawers the way that I had always had it. That alone really set me off—or having the mail come in with his name and not mine. So, imagine heightening that to the level of somebody's world being completely turned upside down. You can see how there's a perfect recipe for resident-on-resident altercations.

Pat: And I'm thinking as you were talking about the population, the mix in long-term care of frail elderly people and perhaps younger mentally ill men or stronger men, how that would give rise to some of the uneasy mix of people. Tell us about the factors that lead to these altercations other than what I just mentioned in terms of mixing two very diverse populations.

Gina: When I teach courses on this topic, I like to talk about the brain a little bit, and I'm going to just give you a very quick version of how the brain works. And when I think of the brain, I think of the outside of the brain being like a football helmet. It's there to serve our functions that make us more sophisticated and make us human versus our animal friends.

And then as you go further down in the brain, those cortexes that are kind of like your helmet protect the things that are much more vital to your staying alive, like your ability to breathe or your blood pressure control. So, when you look at the brain and you look at diseases that
happen to the brain that cause aggression, many of our listeners who are nurses have certainly heard before of the four different cortexes of the brain: the frontal, parietal, the temporal, and the occipital parts of the brain. And so, I want to touch on those a little bit.

So, your frontal lobe is where you start to see a lot of behavioral changes. This is what I tell my daughter or my niece whom I cycle with. She crosses roads earlier than she should, and I'm always fearful she's going to get hit by a car. I tell her that when you turn 21, you will have a more developed frontal cortex, and you won't do high-risk behaviors. Or when you go to college, maybe you won't enjoy yourself so much that when you fall, you won't have a facial injury, like some of my family members have had because they've had too much of a good time.

That's called the area of the frontal lobe that controls your spontaneity and your motor function and your judgment and your initiation. That part of the brain doesn't develop until you are in your twenties. So, when you have a disease process going on in there, like a tumor or a stroke that causes some sort of obstruction to that area of the brain, you start to see loss of judgment happen or impulsivity, which is what we see a lot in our setting.

The temporal lobe is kind of like the earmuffs. That's how I refer to it, and that controls your hearing and your auditory and your speech. They all work together, and that's why speech therapists are so involved in the cognitive aspects of functional decline when it happens. So, again, when you have people who have some sort of disease or functional loss to that area of the brain, to the earmuffs, you're going to have somebody who may have expressive aphasia or receptive aphasia.

And in a nutshell what that means is, "I can't understand you” or “I can't express the way I feel. Therefore, it's frustrating to me and I might act out." You can imagine going through your day and not being able to say what you think. Imagine how frustrating that must be. Or if you're in a room with somebody who can't do those things and they annoy you; you can see how that can create what I call that perfect storm for one resident to act out on another.
The next part of the brain is the parietal lobe. And the parietal lobe, that involves your sensation, your cognition. It's how you integrate sensory input and visual systems. I'll give you an example of that.

I remember when I was a young nurse, I had a resident with a brain tumor. Another nurse and I were fixing her hair about 4:30 in the morning because we couldn't stand the way it looked. She was of African American descent, and we were doing a horrible job of fixing her hair and making it look nice. And we started to laugh at our inability to be able to do this, and the resident completely misinterpreted what we were doing.

And she ended up completely losing it, if you will, emotionally, and looked at me as that perpetrator or that person who was making fun of her. And that was a real turning point for me about maintaining your professionalism in front of a patient because they can misinterpret your good deeds, if you will.

Your occipital lobe, which is in the back of your brain, that controls your visual processing in your visual cortex. So, when we do sensitivity training in our settings sometimes, we'll fog up glasses with Vaseline. Or we'll put a patch over a person's eye, and we'll have somebody walk in front of them to the side of them that they can't see out of or stand in front of them, but instead of bending down to get eye level with them, they're talking at waist length.

So, the person, all they see is basically their shirt and not the whole being or not the eyes. That can also be an issue if a resident has a visual deficit of some sort, and you say, "Hey, it's time to go to dinner," or you mispronounced their name, and all they hear is a voice and not a human being taking the time to stand in front of them and get down where their eyes are and see them.

So, again, understanding the brain is extremely important. There's also an area of the brain that I just want to touch on for a minute, and that's called the limbic system. And the limbic system, again, sits under the helmet and whoever our creator is created it that way so that these areas would be protected by the cortexes I just touched on. And some of these areas are called your hypothalamus, your hippocampus area, and your amygdala.
Your amygdala is something I just want to touch on for a minute. Your amygdala controls anger and your rage. So, when you're reviewing a record as a nurse, and you see that they have damage to the limbic system, or this area of the brain, it should make you think a little bit about this person's emotional center and whether or not you need to investigate the record more before you take them in as one of your residents.

Further on down into the brain, we go into the lower part of the brain that controls those primary functions that we don't have to think about, like blinking and blood pressure, your cardiac system. You don't have to think about your heart rate, right? It just happens until you cease to exist. There are motor aspects of your body, like when you get frightened and you vasovagal and you lose consciousness right away. That's your body taking over for whatever reason. So, if you have a lesion or something to that area of the brain, it might cause physical manifestations to occur, like all of a sudden the person's there and then they drop to the ground, or they have respiratory issues or in many circumstances they never even make it to a long-term care setting. They're in an ICU on a ventilator.

So, I touch on these things so that people can understand that when you see behavioral things going on, the difference between a good nurse and a great nurse, or a good social worker and a great social worker, or anybody else on the IDT (interdisciplinary team) is to understand before I judge this person, what's happening with them, what diseases do they have.

"Could there be a disease that hasn't even been diagnosed that I think might be going on, and I need to get a doctor to make that determination?"

"What meds have they had changed, because maybe it was something there that's going on?"

"Do they have something called delirium?” This is not dementia. It's a resolvable condition, usually from an infection. In most cases in our settings, it's a urinary tract infection or pneumonia that's causing this behavioral change. And I refer to that as critical thinking. Do we have a nurse, an IDT, that can be good critical thinkers and try to figure out in a fun detective way what's going on rather than rolling their eyes
and saying, "I can't believe Joe Blow is giving us a hard time again; when's this shift over?"

**Pat:** And that's a great review for us to think about the different parts of the brain that can be damaged. I've seen several people with traumatic brain injuries who've had frontal lobe damage and they have problems with impulsivity, which could certainly be a factor in an altercation. If a legal nurse consultant is getting involved in a case, it's usually because somebody has assaulted somebody else.

**Gina:** Correct.

Before I continue, listen to this: nursing home cases are specialized. This area of litigation has its own rules, regulations and language. Who better to learn from than an attorney who spends his time litigating assisted living and nursing home cases?

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This program is called Reducing the Risks of Nursing Home Care. Purchase this program’s transcript at this link: http://LNC.tips/NHC and use the code Listened to get a 25% discount on the price.

Pat: I can remember cases that I reviewed in which the resident had dementia and was telling people, after he was found with bruises all over his body, he said, "A man came in the dark and hit me." And the defense of this case was, "Oh, he was on Coumadin, and therefore the bruises on his body came from him hitting his arms against the side rails." So, give us some guidance in that situation. How do we as legal nurse consultants try to tease out and figure out what happened?

Gina: Well, that comes with being a very good investigator and I'm going to go through some of the F-Tags in a minute. But you know, it's a data point. So, when you see someone with bruises on their arms, what's the first thing you do?

It's pretty much what you said. You review the medical record to try to see did they start a new anticoagulant, some of the newer medications today like Xarelto, or were they on aspirin, or did they hit the side rail? And if that's the case, and that's what you determined by the area of the markings on the body, then you only do that through the investigative process. So, it's why you collect that data. Anyone involved in the care of that resident must be interviewed and I'm going to share with you some interview techniques that I've used, but you must do a structured interview.

That means that their roommate, their roommate's family, or friends, residents in front of them, meaning across the hall, residents to the side of them. That means certainly all the staff who worked on the floor. And I generally like to look at about a three-day span, and it's generally the same staff, but I'll give you an example.

We had a resident's family member who heard a slap across the hall, and this was in a very affluent area in Maryland, and then we heard a resident start to cry. Well, he was just appalled. After an investigation of him, the resident, his mother, all the staff involved, the aide who fled the country and did not come back, interestingly, we learned that this relationship had been going on for 10 years where this aide had
slapped this resident. I can't even explain the relationship because it was so bizarre to me, but it was kind of the dynamic that they got into, and you know the good news was we had a family member step up right away. And then we also stepped up right away and did the investigation that we needed to conclude where we ended up.

But these sorts of things can happen in any facility, so it's very important that you respond to it appropriately because resident-on-resident, resident-on-staff, and resident-on-visitor altercations can occur. So, it doesn't have to be just between the resident and the resident themselves. I've had situations where visitors have been a little too verbal or physical with residents, family members or otherwise. And I've had certainly staff-to-resident and resident-to-staff.

So, another important factor is understanding how your state regulations guide you to report. I was just in one state, working there this summer. And in that state, they did not require us to report when a resident was physical with a staff member. In other states, it doesn't matter who the altercation is with, they would want you to report it. So, that was a learning piece for me.

**Pat:** Yes, and I think we're probably, or many people on this call, are familiar with the case in Arizona with an employee who impregnated a woman who was in a long-term care facility long-term. Now, that's not an altercation, but certainly sexual activity between staff members and residents is a whole other topic that just came to mind. And he was identified because of DNA testing.

**Gina:** Yes, unfortunately, while rare, thankfully, those situations can happen. By the same token, if you have two residents who are fully alert and they want to engage in a consensual relationship, as part of our resident rights and the dignity of two individuals who need the services of a long-term care environment, you need to care plan those things.

And my biggest advice to people is have open and good communication with your families and make sure that everyone is on board. Social services certainly guides that process, and the physician, so that you can allow people to be human beings in these settings and at the same time protect their safety. And that can be a little bit of a
slippery slope, but, again, my feeling is with open communication and honesty and a show of compassion, you know these things can be weighted.

**Pat:** Well, you mentioned earlier about federal regulations, and I know that the legal nurse consultants listening to us would want some background in terms of where they would look in the federal regulations for the information that addresses the altercations that we're talking about. And we'll leave the sexual contact aside but focus on the physical violence or maybe verbal violence that can occur and result in lawsuits. Can you give us some details about that?

**Gina:** Sure. So, in preparation for our call this afternoon I did pull some regulations and I'll tell you if you can see it behind me, you'll see something we call a watermelon book.

**Pat:** Yes.

**Gina:** That is a long-term care survey. I believe that book was created in 1987. It goes back to the Reagan administration when the first set of COMAR regs were written and those regulations have been drastically revised in the last three years. 2017 was when all the regulations changed the way that we conduct our abuse investigations, but what I want to do right now is just go through some of the F-Tags.

You have to remember, and the more that I do these cases, the more it becomes so clear to me that really any time I review a record, or maybe it's just because I'm so sensitive to the issue from being a legal nurse consultant, anything can be construed as neglect, anything can be construed as mistreatment. It's really the eye for knowing what to dig for and how to apply the regs that I think, again, takes that legal nurse consultant from a good one to a great one because it is a complex field.

So, there's a couple of regulations that I would point people to and in the new F-Tags, the regulations that fall under abuse and neglect are the 600 level F-Tags. And F604, and F-Tag stands for federal tag, and again found in the watermelon book, and I say that jokingly. That's more of an internal phrase we use. F604 speaks to resident respect and dignity. And under that definition it says,
"That the resident has the right to be treated with respect and dignity, including the right to be free from physical or chemical restraint imposed for purposes of discipline, convenience, and are not required to treat the resident’s medical symptoms that are consistent with…"

and then they cite a statute, Statute 483.12, on which many of the statutes are based.

I mentioned this because this regulation relates to the use of psychoactive medication. If you have a resident with behavioral manifestations, and that person is considered a bully or that person is considered aggressive, one of the last things you want to resort to is the use of mind-altering medications. You first want to peel back that onion and find out what were the triggers that caused this aggressive behavior to occur.

I've been in some buildings that when I go in as a consultant, they feel zooey to me and I'll tell people that this building just feels zooey. And when I get up on the floor, I see why. Because activities aren't occurring, residents aren't engaged in doing things that are meaningful. The staff may be sitting behind the desks instead of out in the floors. There may not be enough staff, and those basic needs might be unmet like keeping people cleaned, making sure that they're eating their meals in a safe and clean environment and making sure that they have enough rest.

It's very much like the care of a small child. You know if you do that, those three things well and they still have colic, well then, you've got a different problem. And that's kind of the way I approach… the way that I care for the elderly. So, in this regulation it focuses on the convenience of one of these drugs versus the disciplinary use of it. You have someone in a situation where they are either chemically restrained or physically restrained and it's very, very innocent on the part of the facility like wheeling a resident underneath a table where they can't get out. That can be a caregiver who's just not as educated on it and the next thing you know you have an altercation when somebody throws a cup of ice water on another person. And I'm giving you real life examples that I've dealt with.
So, what you want to do, again, is understand what the triggers were and sometimes it's the restraint. Some buildings, and I've been to a building where when I saw this, I loved this staff, but they had a cart and they went down a hallway. And I thought the cart had like games and things for the residents to get engaged with, but what it had was an entire cart of different monitors to put on people. A chair monitor for her, a cushion for him, a bed alarm for her. And that unit, again, was a zooey environment. It took us about 30 days, but we did get what I would call a form of a restraint eliminated and started to figure out what can we do to engage people a little bit more.

As part of the new regulation, the physician can order a mind-altering drug or psychoactive medication and that would include any anxiety, any dementia, and a hypnotic medication. But they must review it every 14 days. My rule of thumb is if you don't have to give it, then don't. If you're going to give something, then give a one-time order of something and then reevaluate the person. That's only after you've met all their unmet needs. You've looked at behavior management approaches. You separated the residents, if there's an altercation between two people. You've moved the resident's room to a calmer place. You've done a million other things before you call the doctor up and say, "We need a one-time order of such-and-such Ativan or whatever."

**Pat:** All right, and it sounds like a lot of factors to consider. The easy solution may be to sedate a person, but it's not the best solution from what I'm gathering from what you just shared.

**Gina:** Absolutely, because sedating a person now means that they're a higher fall risk. You go in a circular fashion in the wrong way. You're going backwards instead of forwards because then you're looking at, for example, if the doctor says, give them Ativan, well then you better have somebody near that room watching them a lot. Suppose they try to get up and go to the bathroom, and it's the first time they've ever had the drug, and on top of that, they may have sensory problems. They could be in a new room that's not well lit. They could have a roommate that gets on their nerves. Imagine what a perfect recipe that is now for that person to fall.

**Pat:** Absolutely. Well, we've covered a lot of territory today, Gina, and I have a feeling that we could go on for another hour and not even
touch the surface of this topic. Can you tell our listeners how they can find out more information about your company and the services that you offer?

**Gina:** Absolutely. So, you can reach me on LinkedIn, and you can reach me… I'm an old AOL scout. I'm afraid if I switched from AOL, people won't be able to reach me. So, my email is "G" for Gina, "D" for D'Angelo, which is my name, solutions, which is plural with the number one after it. So, it's gdsolutions1@aol.com. I don't have a website up yet. I plan to do that down the road and those are the best places to reach me right now.

I'm very responsive to people. I love what I do. I travel around the country. I learn so much from people in my field, and I will tell you that we have such great, great individuals that take care of the residents, mainly at the bedside. And I don't mean to say mainly, but the folks at the bedside are really truly are heroes, and whatever we can do to support them, that's through education and staffing and teaching them what is abuse and going through nuances of it, the more we will build up confidence in our family members and in society in general.

Because many people really don't know abuse or neglect when they look at it. It's until somebody explains to them that matted hair is a form of neglect or two people yelling is a form of verbal abuse. Watch the way they react to each other. This isn't pleasant. It's only going to get worse, right.

Also translating, and I'll just say this very quickly before we go. Also translating this environment that we are blessed to work in that place. When I teach abuse and neglect classes, I always say to the audience, "If your child came home with a bite mark, if your child came home with a bruise, if your child's behavior changed in any way or their school marks, what would you do?" "Well, I'd be appalled. I'd go to the school. I'd do this and that." I said, "Okay, so take that emotion and apply it to our setting. If everybody went to work every day and thought like that about the elderly, we would really be hitting the ball out of the park. So, thank you for having me on today, Pat.

**Pat:** Well, thank you, Gina. This has been Gina D'Angelo and Pat Iyer talking about resident-on-resident altercation, and we've also touched
on some other subjects as well. Gina, your passion for taking care of
the elderly really comes through when you talk with us and I
appreciate that. We are all going to need some type of services as we
age, and we would really hope that the people taking care of us have
that same passion.

Gina: Well, thank you Pat.

Pat: And be sure as you're listening to this program to take advantage of
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well as see our webinars, read our articles, take our courses, watch our
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We'll be back next week with a new interview and thank you for
listening.

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