LPN's Appalling Conduct Leads to Lawsuit

written by Nancy Brent | July 1, 2018

Avoiding Liability Bulletin – July 1, 2018

I recently came across a narrative Online of a shocking case involving an LVN.[1] The author changed the names of those involved to protect their privacy, but the facts are accurate. Despite my inability to review the actual case, I thought the situation was one that has implications for all nurses, including LVNs.

The LVN (I'll call her Mary) involved in this situation was hired to provide the residents with care that included help with bathing and with meals.

Mary had a questionable work history at the nursing home. She had been "verbally reprimanded for nurse negligence" on three separate occasions within a short time after her employment began. These incidents involved being "non-responsive to a guest's inquiries".

Two months into her employment, Mary had received two written reprimands. The first involved her pushing a resident in a wheelchair into a wall (her excuse was that she slipped on a wet floor and was unable to avoid the wall). The second was for hitting a resident when the resident openly complained about Mary's rudeness. Her explanation was that she did not hit the resident but rather was trying to "settle the man down" and her hand may have "accidently hit his face". Neither resident was injured.

A 71-year-old patient (I'll call him John) decided to admit himself to this nursing home after his hip replacement surgery. The nursing home cared for residents who needed only "very basic" help with their daily routines. As such, state law required at least one RN be on staff, so most of the nursing care was done by LVNs and orderlies.

John was confined to his wheelchair. An important role of the LVN staff was to help him get out of bed and into the wheelchair and back into bed.

On the day of the incident, John "called out" for an LVN to help him use the restroom to no avail. After several minutes of asking for help, Mary, who was assigned to provide care to John, came into the room.

Prior to responding to John, Mary was watching her regular television show and was not happy about not being able to continue watching it when she went to John's room.

Another LVN (I'll call her Jane) also broke away from the television to check on another resident and followed Mary into John's room. The LVN heard Mary say, "I'm tired of yo' ass", and struck him about his head and mouth again and again with the phonebook in John's room.

Jane overheard Mary's comment and turned to see her hitting John. Jane immediately attempted to stop Mary from attacking John but was not able to do so. The tumult was heard by others down the hall and was seen on the home's surveillance cameras.

Several administrator's and LVNs ran into John's room and were able to curb her behavior, but Mary continued to curse and spit at John.

One of the administrator's called 911 and the police and paramedics arrived. John was bleeding from his mouth and nose and was taken to the hospital. Mary was placed under arrest and charged with a second degree felony, "Abuse of the Elderly". Mary was released on bond, which her family raised.

Mary then went to her boyfriend's apartment and told him she had to "get out of town". The boyfriend told her he would get the money from the ATM and to stay in his apartment until he returned.

Instead of getting the money, the boyfriend called the bail bond company who in turn called the police. Mary was rearrested and bond set at $100,000.

The family filed a lawsuit against the nursing home and Mary, alleging "nurse negligence, nursing home neglect, assault, breach of contract, and negligence". Depositions of each LVN who was working the day of the incident were taken. The attorney for the family also subpoenaed Mary's personnel records and the video tape of the incident.

During the pre-trial proceedings, it was discovered that although it was "customary procedure" for the nursing home to check references and run a criminal background check before hiring an individual, this was not done when Mary was hired.

Had the nursing home done so, Mary's three convictions for assault, including one felony conviction for assault on an elderly person, would have been discovered.

The video was substantiated as accurate by the nursing home administrator during discovery as well.

The nursing home and Mary settled the case with John shortly thereafter.

Mary's misconduct was truly criminal. It is surprising that she still held an active LVN license, especially when she had three prior convictions and one was for an assault on another elderly person. Much can be gained by remembering Mary's conduct which underscores these principles:

1. Never, ever strike a resident or patient;
2. Never, ever curse, spit or otherwise communicate inappropriately with a resident/patient;
3. Treat each/resident humanly and with dignity, following the tenants of the Code of Ethics for Practical/Vocational Nurses (1991);
4. If you work with someone like Mary, you need to share your knowledge of her misconduct with your superiors confidentially but immediately;

5. If you work with someone like Mary, consult with a nurse attorney or attorney and file a report with the state board of nursing;
6. Even though you were not directly involved in the unprofessional behavior that Mary displayed, you may be required to provide a deposition under oath as to what you knew, what you saw and what you did surrounding a patient event or events;
7. Both your criminal history and employment history, including personnel records, can be used in a lawsuit; and,
8. In most instances, a state board of nursing would render harsh discipline to an LVN or RN in this circumstance, most likely a revocation of the LVN's or RN's license.

FOOTNOTES

1. Injury Claim Coach (n.d.),"Lawsuit Involving Nurse Negligence & Failure to Adequately Screen Staff", https://www.injuryclaimcoach.com/nurse-negligence.html.