

**COMMON TYPES OF CLAIMS IN
LONG-TERM CARE FACILITY MALPRACTICE CASES**

**J. Paul Sizemore
Beasley, Allen, Crow, Methvin, Portis & Miles, P.C.
105 Tallapoosa Street
Montgomery, Alabama 36103
334.269.2343**

I. BACKGROUND

A. Historical Prospective

Over the last decade nursing homes, and to a lesser extent assisted living facilities, have become common and often easily preyed upon targets for litigation. Quite frankly, the plaintiff's bar was initially very reluctant to invest both the time and resources (especially the money) necessary to aggressively pursue long-term care related litigation. An historical bias that devalued the life of elderly citizens created the false impression that jurors would not award substantial verdicts in litigation involving aged individuals. This callous viewpoint has proven to be a great misconception.

The recent popularity of long-term care lawsuits, coupled with well publicized, fantastically large jury verdicts in our state and throughout the nation have both plaintiff and defense attorneys "vigorously discussing" the issue of long-term care litigation. Plaintiffs attorneys now aggressively seek long-term care cases through the use of advertising. Moreover, the plaintiff's bar has discarded the traditional medical malpractice approach to the litigation of long-term care cases. They instead rely upon the general public's suspicion of the care provided at nursing homes to provide the "heat" for their cases.

This wide spread distrust of the long-term care industry is no doubt justified in some situations, but appears to be related more to the guilt felt by the massive numbers of baby boomers who have been forced to engage the services of the long-term care industry for the care and treatment of their parents and relatives. This situational guilt, coupled with a perceived effort by jurors to “reform the system” before they are in need of long-term care, is a tumultuous mixture that has the potential for monumental verdicts.

The defense bar and the long-term care industry bemoan the effects of this new wave of litigation. However, they have done little to examine the actual cause of increased long-term care litigation: nearly exponential growth in long-term care populations. With the sudden and ever increasing growth in the number of residents receiving long-term care, there is inherently increased contact among residents, family members, long-term care providers and regulatory authorities. This increased interaction and the continuing growth of the population of long-term care residents foretells the continued growth of long-term care litigation.

B. Growth in the Long-Term Care Population

Both national and local media constantly report on the “graying of America.” Indeed, the parents of the baby boomer generation have now reached the age where long-term care usage is quite common. More importantly, both federal and state statistics show that the baby boomer population, one of the largest generational segments of our overall population, is fast approaching the age where they will also need to utilize the services of the long-term care industry. Within the next twenty years our country will have a larger number of individuals age sixty-five and over than in any other point in our history.

Persons aged sixty-five and over constitute a disproportionate percentage of admissions to long-term care facilities. Federal statistics show that an estimated 43% of all persons who were age sixty-five in 1990 will use nursing facilities at some point in their remaining years. Moreover, approximately 5% of persons age sixty-five and older are in a nursing facility at any one point in time. This is partially a result of the wonderful advances in medical technology that have increased life expectancies. The darker side of this increase in life expectancy is that for some this will result in a decreased quality of life that necessitates the usage of a long-term care facility.

II. COMMON TYPES OF LONG-TERM CARE CLAIMS

A. Decubitus Ulcers And Other Progressive Failures And Omissions of Care

1. Decubitus Ulcers

Decubitus ulcers (also known as pressure sores, bed sores or decubs) are injuries to the skin and tissue underneath it, which occur when a resident sits or lies in the same position for an extended period of time. The term pressure sores is perhaps more useful than bed sores, since it includes injuries caused by being in bed, as well as those that result from sitting in a wheelchair or using an orthopedic device that presses against the skin. Decubitus ulcer is a term that doctors use to describe any such sore. Most decubitus ulcers form on the buttocks, tail bone, shoulder blades, behind the knee or ankle or on the heel of the foot as these spots incur the most pressure while a patient lies in bed.

In layman's terms decubitus ulcers are caused when a resident lies or remains in the same position for an extended period of time. The pressure exerted by the resident's weight on a relatively small part of their body can cause the blood vessels in that area to

squeeze shut. Oxygen and other nutrients do not reach the skin and it begins to die. If the condition remains untreated, a decubitus ulcer will form. During this process, layers of skin, the underlying fat beneath the skin and the muscle may all die or become necrotic. Treating Pressure Sores, Agency for Healthcare Policy and Research, 1994.

Prolonged pressure from a bed or chair on one side and bone on the other makes it impossible for the affected area of skin to be properly nourished by tiny blood vessels called capillaries. The greater the pressure, the more likely that damage will occur. Friction is also another potential cause of decubitus ulcers. Movement that causes skin to rub roughly against bedding may damage the capillaries and diminish blood supply at a particular point. Dragging someone across a surface instead of lifting the person can cause such problems.

Excess moisture on the skin that results if the person suffers from incontinence of the bowels or bladder can also contribute to skin breakdown. Such individuals must be constantly monitored by long-term care staff to assure that any excess moisture is removed in a timely manner.

In a person whose nerves and muscles are healthy, the nervous system conveys a signal of discomfort to the brain whenever a part of the body has remained in one place too long and its receiving excess pressure. However, in those with spinal chord injuries, various conditions associated with the loss of mobility and the loss of sensation, or in those individuals suffering from dementia, the individual may not be able to move to relieve the pressure and may not even be aware that a part of the body is under duress.

Claims involving decubitus ulcers are one of the most common, if not the most common, claims made in long-term care litigation. This popularity appears to be based

upon both the perceived preventability of the condition, and also upon the undeniable fact that literally thousands of patients and residents are afflicted by this condition every year. For example, a nursing journal recently conducted a study which concluded that pressure sores or decubitus ulcers take a heavy toll both on their victims and on our nation's healthcare system affecting up to 15% of all hospitalized patients and up to 35% of nursing home residents throughout the country. Preventing Pressure Sores Keeps Patients and Economy Healthier, Research Directions Nursing: Managing Symptoms Capsule Descriptions of Selected Studies, 2000. But cf., Holmes and Di Maio, Pressure Sores in a Christian Science Sanatorium, The American Journal of Forensic Medicine and Pathology 14(1): 10-11 (1993).

2. Regulations Applicable to Decubitus Ulcers

To fully understand the regulations governing decubitus ulcers it is important to review regulations concerning resident assessment. Both state and federal guidelines mandate that a "comprehensive assessment" must be performed on each and every long-term care resident. 42 C.F.R. § 483.20(b). The comprehensive assessment details a resident's capability to perform daily life functions and significant impairments in functional capacity.

The comprehensive assessment must be completed within fourteen days of admission of a resident, must be conducted once every twelve months thereafter and must be reviewed quarterly or at the time of any "significant change." The comprehensive assessment is prepared using minimum data sets (MDS) which must include at the least following: (1) medically defined conditions and prior medical history; (2) medical status measurement; (3) physical and mental functional status; (4) sensory and physical

impairment; (5) nutritional status; (6) special treatments or procedures; (7) mental and psychosocial status; (8) discharge potential; (9) dental condition; (10) activities potential; (11) rehabilitation potential; (12) cognitive status; and (13) drug therapy.

Based upon the information obtained in the comprehensive assessment and the conclusions based thereon a long-term care facility must insure that:

- (a) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- (b) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

42 C.F.R. § 483.25(c).

3. Staging of Decubitus Ulcers

Decubitus ulcers are medically charted through four stages of development. The nursing staff at any long-term care facility is charged with the accurate and continuous staging of any decubitus ulcer once it develops. These skin assessments are an invaluable source for determining not only the current condition of a resident's skin or skin related problems, but also the past history of treatment and any care planning associated with the treatment or prevention of such sores.

The various stages of decubitus ulcer development can be described as follows:

Stage I- Constant warm, pink or red area of unbroken skin, usually over a bony area.

Stage II- The sore resembles a blister, small break in the skin or a shallow crater. The surrounding tissue may be bright pink or red.

Stage III- The sore intrudes all the way into the inner layer of fat just underneath the skin. It may be whit or black in color, may have a foul odor or may be draining puss.

Stage IV- The sore extends into the muscle or bone. It may be white or black in color. The surrounding area may be warm to the touch or red.

There will more than likely be a foul smelling drainage.

One cannot stress enough how important the comprehensive assessments, skin assessments, nurses notes, physical therapy notes and care plan are in reviewing a decubitus ulcer case. For the plaintiff's attorney these materials provide necessary background information on the development of the sore and those precautions and preventative measures taken by the long-term care staff in reference to the resident. Items to look for from the plaintiff's perspective include the status of the resident's skin when the comprehensive assessment was performed shortly after the resident was admitted to the facility. If the resident's initial comprehensive assessment indicated no skin related problems, why and how did the decubitus ulcer develop? Moreover, one should closely monitor the chronology of the decubitus ulcer staging. For example, was a potential ulcer discovered early on or was it initially diagnosed as a Stage III or Stage IV decubitus ulcer? If so, this may be indicative of substandard care.

From the defendant's standpoint properly documented records can go a long way towards establishing proper prevention and treatment procedures for a resident. For example, if the records and skin assessments show adequate prevention techniques and

adequate treatment upon development you will be able to easily provide your defense expert with some ammunition. Moreover, if the records indicate the usage of a specially designed bed, bed cover or mattress this will obviously be helpful. These devices include air-filled, alternating-pressure mattresses. They adjust to the body's shape and help to spread pressure over a wider area. It is important to remember, however, that these devices do not eliminate the need to change the position of a resident every two hours.

4. Decubitus Ulcer Outcomes Frequently Associated With Substandard Care

Most decubitus ulcer claims arise out of one of the following three categories: (1) Stage III, Stage IV or infected decubitus ulcers; (2) osteomyelitis as a result of a decubitus ulcer; and/or (3) sepsis as a result of a decubitus ulcer.

Under both the federal and state regulations long-term care facilities have the duty to prevent the development of pressure sores (unless the resident's condition makes them unavoidable) and have the further duty to prevent new sores from developing and to properly treat existing sores. Consequently, when a resident develops a Stage III or Stage IV decubitus ulcer, either as a result of the progressive failure of an outside-developed decubitus ulcer or as the result of the ineffective treatment provided to an "in house" decubitus ulcer, liability claims are not far behind. Generally speaking, once a decubitus ulcer has developed to this stage is it characterized by purulent drainage (a liquid or gelatinous fluid that is a product of inflammation and consists primarily of the debris of dead cells and enzymatically liquefied tissue elements), necrotic tissue (dead tissue normally characterized by a gray, white, black or brown discoloration) and slough (necrosed tissue separated from the remaining living portion). Needless to say these

types of images can be quite disturbing to both attorneys and jurors. Both plaintiff and defense attorneys should always review the medical records in reference to a particular resident with an eye towards locating these “magic words.” They can be the key to determining whether or not a decubitus ulcer was properly staged, monitored and treated.

Osteomyelitis is clinically defined as an inflammation of the bone or bone marrow, usually caused by infection. In the case of decubitus ulcers the microorganisms caused by the infected decubitus ulcer reach the bone through the blood stream or through the degradation of the necrosed tissue and infect the bone. The acute inflammation caused by this infection results in softening erosion and death of the hard portions of the bone. Osteomyelitis usually occurs only in the worst cases of decubitus ulcers.

Another of the more troubling and devastating complications that can result from an infected decubitus ulcer is sepsis. Sepsis is a generic clinical term for describing the presence of various pusses forming and other pathogenic organisms, or their toxins, in the blood or bodily tissues. It is basically a severe infection in the body and blood stream that can lead to shock and death. Sepsis can occur when any person develops a severe infection and is a well-known hazard associated with severely infected decubitus ulcers. The treatment provided to the infected resident should be of the highest level available which normally means admission to the intensive care unit of a hospital. Symptoms of septic shock include: (1) very low blood pressure (hypotension); (2) fast heart rate (tachycardia); (3) weak pulse; (4) fever; (5) flushing of the skin; (6) sweating; and (7) changes in mental status. The staff at any long-term care facility should be constantly vigilant for any of these signs in any resident with an infected decubitus ulcer. Further,

any attorney with a case involving an infected decubitus ulcer should be wary of these symptoms in any nurses' notes. They are usually indicative of a very grave illness and the activities and reactions of the nursing staff should be judged accordingly.

B. Other Progressive Failures and Omission of Care

1. Dehydration and Malnutrition

Based upon the resident's comprehensive assessment (discussed above) a long-term care facility must insure that a resident both:

- (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
- (2) Receives a therapeutic diet when there is a nutritional problem.

42 C.F.R. §§ 483.25(i) (1) and (2).

State and federal regulations also require that "the facility must provide each resident with sufficient fluid intake to maintain proper hydration and health." 42 C.F.R. § 483.25(j).

Obviously, the potential for a valid claim based upon inadequate hydration and/or nutrition is high unless the resident' clinical situation is grossly abnormal. Counsel for both the plaintiff and defense should closely inspect any and all resident weight charting, nutritional evaluations and dietary consultations. The key is to closely examine whether or not facility adequately monitored the potential dehydration or malnutrition problem, what steps were taken to prevent such an occurrence and, perhaps most importantly, what steps were taken to alleviate the problem.

C. Injuries Precipitated By Medication, Prescription and Administration Failures

Potential claims falling within the scope of this section run the gamut from incorrectly administering drugs to a resident to the misuse of chemical and/or physical restraints. Each of these problems will be discussed below.

1. Medication Errors

Both state and federal regulations require that any long-term care facility must insure that:

- (1) It is free of medication error rates of 5% or greater; and
- (2) Residents are free of any significant medication errors.

42 C.F.R. § 483.25(m).

2. Unnecessary Drugs

State and federal regulations require that a resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- (1) In excessive dosage (including duplicate drug therapy); or
- (2) For excessive duration; or
- (3) Without adequate monitoring; or
- (4) Without adequate indications for its use; or
- (5) In the presence of adverse consequences which indicate the dosage should be reduced or discontinued; or
- (6) Any combination of the reasons above.

42 C.F.R. § 483.25(I).

3. Unnecessary Anti-Psychotic Drugs

Both state and federal regulations require that based on a resident's comprehensive assessment, the facility must insure that:

- (1) Residents who have not used anti-psychotic drugs are not given these drugs unless anti-psychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical records; and
- (2) Residents who use anti-psychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

42 C.F.R. § 483.25(1)(2).

4. Misuse of Chemical and/or Physical Restraints

A resident "has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."

42 C.F.R. § 483.13(a).

D. Injuries Precipitated by Untoward Incidents

1. General Discussion

It should be noted initially in this section that according to both federal and state standards a "resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion." 42 C.F.R. § 483.13(b).

To prevent this problem each long-term care facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse

of residents and misappropriation of resident property.” 42 C.F.R. § 483.13(c). More specifically, the long-term care facility must:

- (1) Not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusions;
- (2) Not employ individuals who have been: found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
- (3) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

Id.

All long-term care facilities must also insure that all alleged violations involving mistreatment, neglect, or abuse, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency). The facility must further have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his or her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within five working days of the incident and if the alleged violation is verified appropriate corrective action must be taken. Id. Examples of such abuse include physical

abuse and/or assault, rape or sexual assault, resident wandering situations where a resident incurs a significant injury after wandering from the facility, etc.

2. Accidents and Falls

In both federal and state regulations a long-term care facility must insure that:

- (1) The resident environment remains as free of accident hazards as is possible; and
- (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

42 C.F.R. § 483.25(h).

The proliferation of litigation under this section appears to be a function of both the ease with which this theory may be propounded, as well as procedural requirements that any and all accidents or falls be reported within an institution. These accident investigation forms provide a plethora of information about the facts surrounding an accident, as well as witness observations. The thorough plaintiff's attorney will no doubt wish to track down any and all employees mentioned on the accident investigation form as at least one of them will more than likely be a "former employee" at this time. Prudent counsel for both sides will also wish to examine the comprehensive assessment and activities of daily living reports to assess a resident's ability to "transfer and ambulate." One should examine the restrictions placed upon a resident's ability to "transfer and ambulate" to determine the proper restrictions and/or restraints that should have been applied to the resident and could perhaps have prevented the accident or fall.

III. CONCLUSION

The above outline of common claims associated with long-term care litigation is by no means exhaustive. This industry is thoroughly regulated at both the state and federal level and, accordingly, both common law and regulatory/administrative claims abound in this arena. For the plaintiff's bar, potential causes of action are limited only by the imagination and a thorough understanding of the applicable regulations. From the defense standpoint, prevention is the key. Proper treatment, prevention and record keeping are crucial. The same is true for in-house counsel in the long-term care arena. A proper defense therefore will be a function of proper treatment, preparation and an understanding of potential areas of concern. Let us all hope that any litigation or resulting modifications to our system will inure to the benefit of the current generation of long-term care residents, as well as those to follow.