

**NURSING HOME LITIGATION  
CASE EVALUATION AND PREPARATION - PLAINTIFF'S PERSPECTIVE**

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*The misery of a child is interesting to a mother, the misery of a young man is interesting to a young woman, the misery of an old man is interesting to nobody.*

**Victor Hugo, *Les Miserables***

Over 1.5 million people in the United States wake up every day in a nursing home, dependent on others to meet most or all of their needs. They are a helpless, vulnerable population whose numbers will increase dramatically in coming years as more baby boomers begin entering retirement. This growth will require that the quality and quantity of care offered by nursing homes be increased proportionately.

The demand for more and better care is not unfamiliar to nursing homes. The increase in acuity level of the nursing home population during the last decade is well documented. Yet, in the opinion of many, the long-term care industry was not responsive during that time to the increased needs of the residents. As a result, nursing home litigation increased dramatically during this time and continues to grow.

Few people dream of one day living in a nursing home. Typically, it is a decision made when all other care options have been foreclosed. A competent individual's decision to admit himself or herself into a nursing home requires a painful and immediate acceptance of their mortality. If the family must make this decision, it is equally distressing. The family of a nursing home resident may experience guilt and feelings that they have failed their loved one.

By definition, nursing homes are places where nursing personnel serve residents that need continuous assistance with their basic activities of daily living. Nursing facilities should be adequately staffed by employees committed to teaching residents how to cope with their disabilities and functional incapacities, as well as monitoring the chronic, multiple illnesses of the residents. If the staff is not committed to these duties, or if the staffing is inadequate to perform these duties, nursing standards of care are inevitably breached and residents suffer.

This paper will discuss how to evaluate a potential nursing home case and the work that must be accomplished to determine if a case is meritorious.

## **A. EVALUATION OF NURSING HOME CASES**

Nursing home litigation is complex and requires a great deal of time, money, and effort. There are several reasons for this, not the least of which is the fact that nursing homes are governed by numerous Federal and State Regulations. These Regulations are extensive and detailed as to the type of documentation that is necessary for the home to maintain its license to operate the facility. Next, the people who live in nursing homes typically have complex medical problems, which is why they are there. The medical records you must review are kept on a day-to-day basis, three shifts a day, and can be confusing and difficult to understand. To be effective in pursuing and presenting a nursing home case, the attorney must have a basic understanding of medicine, particularly as it relates to geriatrics, and an understanding of the applicable regulations. Finally, the attorney must be intimately familiar with the law of these cases, which is constantly changing.

### **Regulations and Standards**

The Federal Regulations governing nursing homes are contained in and created by the Omnibus Budget Reconciliation Act of 1997, also known as the Nursing Home Reform Act. The Federal Agency responsible for their enforcement is the Health Care Finance Administration (HCFA) of the Department of Health and Human Services. Federal nursing home regulations are located at 42 USC § 1396 (the Nursing Home Reform Act), and 42 CFR § 483 (the Requirements for Long Term Care Facilities). These regulations, along with corresponding state law, create standards which heighten the expectations of nursing home care from a minimum maintenance goal, to the goal of maintaining the “highest practicable physical, mental and psychosocial well being” of nursing home residents. 42 C.F.R. § 483.25. The regulations, in part, require:

- Adequate numbers of nursing personnel to provide for the needs of the residents;
- Adequate amounts of food, supplies, equipment and medication;
- Competent nurses, aides, and orderlies who are screened when hired and who have been monitored throughout their employment to eliminate unfit personnel;
- Adequate and systematic planning to create an individualized plan of care for each resident;
- Continuous systemic assessment of each resident and notification of the attending physician when necessary;
- A record keeping system that accurately documents the clinical condition and progress of residents as well as delivery of care; and

- Adequate quality assurance programs that identify and correct care deficits.

A facility's failure to ensure that these minimum requirements are enforced can result in systemic neglect in the home, which can be devastating to the residents who are unable to help and protect themselves. The intent of these laws are to require the nursing home to pay heed to the needs of the individual resident and adjust accordingly, rather than require the resident, who is least able, to adjust to the nursing home.

The following list includes some specific standards promulgated under federal and state law in the areas of general policy and administration. This list is by no means exhaustive. These are just some of the standards with which a lawyer representing any nursing home resident on a personal injury or death claim should be familiar.

1. **Quality of Life:** A nursing home is required to "care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." 42 C.F.R. § 483.15.

2. **Quality of Care:** This regulation spells out the bedrock or "bottom line" duty of the nursing home to provide appropriate nursing services to each and every resident, to maximize each resident's well being.

Under this standard: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25.

Under this standard the facility has a duty to ensure that a "resident's abilities in activities of daily living do not diminish unless the circumstances of the individual's clinical condition demonstrate that diminution was unavoidable." 42 C.F.R. § 483.25(a)(1).

The facility's duties with respect to the comprehensive assessment and plan of care are discussed in further detail below.

3. **Facility Administration:** "A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75.

4. **Resident Rights:** This standard protects a resident's rights to "a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility."

The regulations protecting resident rights address such matters as access to records, refusal of treatment, notification of changes (e.g., health status, treatment,

transfer or discharge), transfers, management and protection of resident's funds, free choice (e.g., personal physician, care and treatment), grievances, and examination of survey results. These and other resident rights are spelled out in detail in 42 C.F.R. § 483.10.

**5. Access to Records:** The regulations clearly give “the resident or his or her legal representative” the right to review and obtain copies of that resident's records:

“Upon an oral or written request to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays” and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days advance notice to the facility” -- 42 C.F.R. § 483.10(b)(2).

For obvious reasons, this right of access to records is a critical tool in attempting to evaluate whether a resident or her representative has a viable cause of action.

**6. Notification of Changes:** Federal and state regulations require a facility to “immediately notify the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is –

(a) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(b) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(c) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(d) A decision to transfer or discharge the resident from the facility ...” 42 C.F.R. § 483.10(b)(11).

**7. Comprehensive Assessment/Plan of Care:** The comprehensive assessment of a resident, and the individual plan of care developed to address any nursing care needs identified in that resident's assessment, are the foundations upon which any resident's care is built. The assessment and care plan provide a benchmark against which the care actually received by the resident may be evaluated.

**Assessment:** The requirements of the comprehensive assessment are spelled out in detail in the regulations. *See* 42 C.F.R. § 483.20. Generally, the assessment is based on a uniform or minimum data set specified by the government regulators, and must describe the resident's ability to perform daily life functions and any significant impairment in the resident's functional capacity. *See* 42 C.F.R. § 483.20(b).

A comprehensive assessment must be done (a) no later than 14 days after admission; (b) “promptly after a significant change in the resident’s physical or mental condition”; and (c) always at least once every 12 months. 42 C.F.R. § 483.20(b)(4).

**Care Plan:** Based on the resident’s “medical, nursing, and mental and psychosocial needs” as identified by the assessment, the facility must develop a “comprehensive care plan for each resident” to meet each such need.

The comprehensive care plan must describe “the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under § 483.25.” 42 C.F.R. § 483.20(d)(1).

The care plan must be developed within 7 days after completion of the assessment, must be prepared by an interdisciplinary team, and must be periodically reviewed and revised after each assessment. 42 C.F.R. § 483.20(d).

**Services:** Services provided under the care plan must “meet professional standards of quality” and must be provided “by qualified persons in accordance with each resident’s plan of care.” 42 C.F.R. § 483.20(d)(3).

8. **Staffing:** Insufficient staffing, or lack of qualified staff, often contributes to abuse, mistreatment, neglect or other substandard care. Related issues include the training, monitoring and supervision of such staff.

**General standard for staffing** (federal regulations): “The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.” 42 C.F.R. § 483.30.

The requirement that a facility provide sufficient staff applies on a 24-hour basis, and requires that the facility provide “sufficient numbers” of both “licensed nurses” and “other nursing personnel .. to provide nursing care to all residents in accordance with resident care plans.” 42 C.F.R. § 483.30(a).

“Other nursing personnel” typically refers to nurse aides, i.e., “any individual providing nursing related services to residents in a facility who is not a licensed health care professional, a registered dietician, or someone who volunteers to provide such services without pay.” 42 C.F.R. § 483.75(e)(1).

**Required staff include** (but are not limited to):

- (a) **Medical Director:** A physician designated by the facility, who is responsible for implementing resident care policies and coordinating medical care in the facility -- 42 C.F.R. § 483.75(I).
- (b) **Director of Nursing:** The facility must designate a registered nurse to serve as director of nursing on a full-time basis -- 42 C.F.R. § 483.30(b)(2).
- (c) **Licensed Nurses:** At least one (1) registered nurse must be used “for at least 8 consecutive hours a day, 7 days a week,” 42 C.F.R. § 483.30(b)(1); and the facility must designate a licensed nurse (which includes licensed practical nurses) to serve as a charge nurse on each tour of duty -- 42 C.F.R. § 483.75(a)(2).

**Competency requirements for nurse aides:** Among nursing facility staff, nurse aides normally have the most direct contact with facility residents; and are responsible for most “hands-on” care in assisting residents in the basic activities of daily living (e.g., eating, bathing, grooming, bowel and bladder function).

The facility’s general duty is to “ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.” 42 C.F.R. § 483.75(f).

Generally, a facility may not use an employee as a nurse aide for more than four (4) months unless that individual has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program. 42 C.F.R. § 483.75(e)(4).

Generally, before allowing an individual to serve as a nurse aide, the facility must receive verification from the state nurse aide registry that the individual has met competency evaluation requirements. 42 C.F.R. § 483.75(e)(5).

**In-service education:** To ensure continuing competence after initial certification, a facility “must complete a performance review of every nurse aide at least once every twelve (12) months, and must provide regular in-service education based on the outcome of these reviews.” 42 C.F.R. § 483.75(e)(8).

9. **Record-keeping requirements – clinical records:** The facility’s general duty is to “maintain clinical records on each resident in accordance with accepted professional standards and practices that are (i) complete; (ii) accurately documented; (iii) readily accessible; and (iv) systematically organized.” 42 C.F.R. § 483.75(I).

The clinical record must contain the following:

- (a) sufficient information to identify the resident;
- (b) a record of the resident's assessments;
- (c) the plan of care and services provided;
- (d) the results of any pre-admission screening conducted by the State and progress notes. 42 C.F.R. § 483.75(I)(5).

The clinical record must be retained, for an adult resident, for five (5) years from date of discharge when there is no other requirement under State law. 42 C.F.R. § 483.75(I)(2).

As a general matter, nurse aides chart entries with respect to activities of daily living, while licensed personnel chart nearly all other record entries. Common records may include medical records, nursing notes, progress notes, medication administration records, physician orders (including medication orders) activities of daily living records, assessments, and care plans.

10. **Reporting and investigation requirements—suspected abuse or neglect:**

**Duty to report:** “A facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries or unknown source, and misappropriation of resident property 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).” 42 C.F.R. § 483.13(c)(2).

**Duty to investigate:** “The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.” 42 C.F.R. § 483.13(c)(3).

**Timing of report to state licensing agency:** Results of all investigations must be reported to the administrator and the Division of Licensure and Certifications within five (5) working days of the incident. 42 C.F.R. § 483.13(c)(4).

**B. SPECIFIC STANDARDS – AREAS OF NURSING CARE**

The regulations provide specific standards of care in various areas of nursing care for conditions that occur with regularity. The following is an illustrative, but again not exhaustive, list.

1. **Pressure Sore:** Based on the comprehensive assessment, a facility must ensure two things:

- (a) a resident who enters the facility without pressure sores does not develop pressure sores unless they are clinically unavoidable; and

(b) a resident with 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).

2. **Falls and fractures:** A facility must:

(a) ensure that “the resident’s environment remains as free of accident hazards as possible”; and

(b) ensure “each resident receives adequate supervision and assistance devices to prevent accidents.” 42 C.F.R. § 483.25(h).

3. **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). *See also*, 42 C.F.R. § 483.25(I)(1) (unnecessary medications).

4. **Dehydration, malnutrition, choking:** Again based on the resident’s comprehensive assessment, the facility must ensure that a resident “maintains acceptable parameters of nutritional status, such as body weight and protein levels” unless clinically not possible. The facility likewise “must provide each resident with sufficient fluid intake to maintain proper hydration and health.” 42 C.F.R. § 483.25(I)(j).

5. **Care of “tubes” – catheters, feeding:** A resident who enters a facility without an indwelling catheter should not be catheterized unless clinically necessary. Similarly, a resident who has been able to eat alone or with assistance should not be fed by naso-gastric tube unless clinically unavoidable. In both instances, the facility has the duty to provide appropriate treatment and services to prevent related medical problems (e.g., urinary tract infections, aspiration pneumonia) and to restore as much normal bladder function or eating skills as possible. 42 C.F.R. § 483.25(d)(g).

### **Gathering the Information**

Most families who are able frequently visit their loved ones in a nursing home. Some family members may visit every day. The first thing you must do in evaluating a case is to spend time with the family and listen to them. They can provide you with information you may never discover elsewhere.

In nursing home cases, the initial client interview is typically with a resident’s family member (spouse, child) or guardian since the resident is often deceased or incapacitated. Ask the family to bring all available information concerning the resident to the interview. Encourage over-inclusiveness. You are in a better position to determine whether certain information is pertinent. The basic information that the family needs to provide concerning the resident is:

- Age
- Date of birth
- Date of death (if applicable)
- Marital status
- Children
- Social Security number
- Medicare/Medicaid numbers
- Medical provider's names
- Medical and nursing home records (if they already have them)
- Any documentation provided by the nursing home
- Legal documents (Power of attorney, letters of guardianship, estate papers, wills)
- Certificate of death (if applicable)

Obtain a history from the client of the resident's health conditions. Listen carefully as the family relates the story of what occurred at the nursing home. Be patient and understanding, as this is usually an extremely emotional ordeal for them. It often serves as a cathartic experience for the family and a fountain of information for the attorney. Remember, the family has been waiting to tell their story to someone who understands.

When dealing with the family of a nursing home resident, you need to be aware that they may have strong feelings of guilt because it was necessary for them to put their loved one in a nursing home, even though a physician recommended it. In addition, the choice of nursing home was often made quickly, under stressful circumstances, and the family may not have had sufficient time to evaluate various homes. If the care at the home was substandard, this likely compounded the family's guilt. It is common for families to experience extreme frustration in dealing with the staff of the nursing home concerning their complaints. Although there may have been numerous instances of bad care, family members often continue to trust the staff of the nursing home when the staff says that the care will get better.

The family will have knowledge that cannot be obtained from a resident's nursing home chart or other sources. As you gain a factual understanding of the case, you should begin to ask questions in order to jog their memory and to build a strong foundation for the injuries and damages.

Areas of inquiry:

A. Instances of indignities/bad acts which may prove to be relevant:

- Sitting in body waste for extended periods of time
- Dirty or missing clothing
- Missing/stolen possessions
- Ignored requests for care
- Knowledge of falls or pressure sores

Lack of turning and repositioning  
Missed treatments, therapies and medications  
Skin problems  
Missed meals and/or water  
Weight loss  
Improper restraints  
Verbal or physical abuse

B. Names of nursing home employees

C. Prior medical conditions

D. Persons with additional knowledge

Gathering information from a family member is especially important in nursing home cases since a nursing home admission may span several months or years. The complaint is often not based on one incident or occurrence, but on numerous incidents of neglect that transpired over an extended period of time.

You should also use your judgment to envision how the jury will view your client. Does your client want to bring a lawsuit to elevate the standard of care given to residents at nursing homes? Or, are they only seeking to better themselves monetarily down the line? If you cannot figure out the answers to these questions, I assure you, the jury will.

**Clinical Outcomes Frequently Linked with Neglect:**

- A. Injuries precipitated by progressive failures and omissions of care
- Decubitus ulcers – Stage III or IV
  - Infected decubitus ulcers
  - Severe dehydration
  - Severe protein-calorie malnutrition
  - Septic shock
  - Gangrene
  - Aspiration pneumonia
- B. Injuries precipitated by medication prescription and administration failures
- C. Injuries precipitated by untoward incidents
- Strangulation
  - Drowning
  - Scalding
  - “Wander-off” cases, where resident suffer serious injury or death after wandering from the facility

- Falls and fractures resulting from failure of staff to follow accepted protocols and implement necessary preventive measures
- Rape and/or sexual assault
- Physical abuse and/or assault

## **B. INVESTIGATION**

### **Probate Work**

You must consider at the time of your initial interview the legal authority that the family member has to represent the resident, or the estate of the resident. In order to obtain nursing home and other medical records you must have a legal representative, unless the resident is alive and competent. If the resident is alive but incompetent, it will be necessary to have a guardian appointed for the purpose of obtaining the nursing home chart. If the resident is deceased, it will be necessary to open an estate. If the resident is alive and competent, they have the right to access all records in the nursing home pertaining to themselves within 24 hours, or they can request a copy of the chart and it must be provided within two (2) working days advance notice to the facility. 42 C.F.R. § 483.10(b)(2).

You should discuss with the family the cost and the process of establishing a guardianship or opening an estate for the purpose of investigating whether there is a valid claim. Obviously, there is a risk to the client and/or the attorney of putting in the time, effort and expense of obtaining records and determining ultimately that no cause of action exists.

You should consider whether or not you want to handle your own probate work. My experience has been that it is preferable to retain the services of another attorney with significant experience in probate to handle those matters. The work that must be done in establishing the guardianship or opening the estate is not difficult or time consuming, but there are potential problems that may occur once a settlement is reached in a case. If you separate yourself from these matters with a probate attorney's involvement from the onset, you will not become embroiled in this "after the fact" litigation.

### **The Records**

The interview process should provide enough information to determine whether medical records should be ordered. If the decision is made to go forward, request a copy of the resident's entire nursing home chart and intervening hospital admissions. This could be very expensive for an extended nursing home residency; however, obtaining the records and reviewing them is absolutely necessary for a firm grasp of the medical issues involved in the case.

The records request should be detailed to maximize the chance of getting the most complete record early on in the evaluation process. The medical records of current residents can be found on the nursing unit or wing where the resident is assigned. The records of discharged residents will be found, hopefully, in a secured area of the facility. Medical records must be retained for five (5) years from the date of discharge when there are no other requirements under state law. 42 C.F.R. § 483.75(1)(2).

Medical records personnel will periodically review the medical charts of current nursing home residents to determine if there are any missing or incomplete records. This is referred to as “auditing” the chart. If the resident you are investigating has been in the facility for a long time, the records will be voluminous. In such situations, the medical records custodian will typically remove certain portions of the chart and store it as it becomes less useful to the nursing personnel. This is sometimes referred to as “thinning the chart”. When you make a records request concerning a living resident, make certain that you receive all of the records.

Once you have received the records, the key to evaluation is having the willingness to READ the records. This can be overwhelming when faced with six thick notebooks of poorly written nurses notes and stacks of group sheets. Nevertheless, read your medical records with a ruler.

### **Evaluation of the Chart**

As you review the chart, remember that the accuracy of the information contained in it cannot be assumed. Unfortunately, it is not uncommon to find false entries of various types in nursing home charts. Keep this in mind when you read through the chart and compare information from various sections of the records.

### **The Foundation Documents of Resident Care**

- Minimum Data Set (MDS)

Unless the resident you are investigating was in the facility for only a very short stay, you should see a document called a Minimum Data Set (MDS). This standardized national assessment tool is unique to long term care. It is intended to produce a comprehensive, accurate, standardized assessment of each resident’s functional capacity. Its purpose is to help the nursing home staff assess the resident’s capability, needs and strengths. It is a collection of resident information regarding demographic, physical, mental and psychosocial functional information and forms the basis for the care plan.

- Resident Assessment Protocol (RAP)

After completion of the MDS, a Resident Assessment Protocol (RAP) is prepared from the data contained in the MDS. The RAP will contain a list of certain problems likely to exist that were “triggered” by the MDS and will need to be addressed in the resident’s care plan.

- Care Plan

The MDS and RAP are prepared in order to develop a care plan for the resident. The care plan should identify the resident's major problems and include interventions designed to maintain and improve, if possible, the resident's current functional capacity and prevent injury. Typically, the care plan is prepared by a care plan team which is comprised of persons from several disciplines in the facility such as the Activity Director, the Social Services Director, Nursing, etc. The care plan is then required to be revised anytime that a "significant" change in the resident's status is identified. 42 C.F.R. § 483.20(b)(4).

A Care Plan should also be revised anytime it appears the care plan is not working. After you read the care plan, look further in the chart to see if the care plan was followed and if its goals were being met. For instance, if the care plan calls for turning and repositioning of the resident in order to maintain skin integrity and prevent skin breakdown, was it done? Check the Activities of Daily Living flow sheets to see if the staff turned and repositioned the resident in accordance with the directives of the care plan. If the problems identified in the care plan were becoming worse, what was the response of the care plan team?

### **Look for Inconsistencies**

Compare the nurse's notes to the activities of daily living flow sheets and see if the information is consistent. Review the doctor's orders and compare them to the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) to determine if the orders were correctly carried out. If the resident was losing weight or was malnourished, look at the percentage of food consumed each day. Does it make sense? Things to look for include:

- Absent charting
- Inconsistent charting
- False charting
- Failure to recognize changes in the condition of a resident
- Failure to notify the Physician and family of condition changes

You should obtain medical records from sources other than the nursing home as well, such as the doctor and the hospital. Compare these records with the nursing home chart. You should also compare the chart with the billing records of the nursing home, and compare the Medication Administration Record with the pharmacy bills.

### **State Surveys**

Under Federal Law, nursing homes that participate in the Medicaid and Medicare programs are to undergo an annual survey/inspection and certification process. The purpose of the survey is to assess whether the type of care intended by the law and

regulations, and as needed by the resident, is actually being provided. Nursing homes must be in substantial compliance or they can be denied payment for new admissions, civil monetary penalties can be assessed, Medicaid and Medicare certificates can be revoked, residents can be transferred and temporary management can be imposed on the facility. Certification surveys are, by law, to be unannounced.

The reports generated from these surveys can be obtained from the state agency that inspects the homes. A quick evaluation of a particular home's compliance with state and federal regulations can be found at the Medicare web site. This site has a database that contains information on Medicare and Medicaid certified nursing homes with survey results for most recent surveys. The web site is located at [www.medicare.gov/NHCompare/home.asp](http://www.medicare.gov/NHCompare/home.asp)

### **The Survey Process**

In a typical inspection, the surveyors arrive, tour the facility, observe and interview residents and staff, and review a sample of the residents' medical records. The inspectors rely on resident's charts during the surveys to evaluate compliance. If deficiencies are found, a deficiency statement will be written and discussed with staff in a conference. On-site visits are also performed by the State to investigate complaints that deserve further inquiry.

The survey and complaint inspections are intended to be random, surprise visits without any advance notice to the nursing home. In my experience, this is not always the case. There is much evidence that indicates in many homes charts are often "amended" to prepare for a survey visit. It is not uncommon for a corporate pre-survey team or consultants to visit a home to prepare them for a survey.

Nevertheless, survey information is particularly valuable because state inspectors may go where no consumer is allowed. Surveyors have access to confidential medical records of all residents and may even perform physical examinations, checking for bedsores and other signs of deterioration or injury. The facility is required to post their most recent survey results at the facility.

### **The Legal Nurse Consultant (LNC)**

If you are new to nursing home litigation you should consider retaining the services of a legal nurse consultant to review the nursing home chart and any other medical records. Be aware there are many nurses who will review medical records for attorneys. However, I would strongly suggest that you investigate and ask your colleagues for references. You need to find a nurse that not only is experienced in reviewing medical charts for attorneys, but who also has a great deal of experience in long term care.

You may want to retain a nurse certified by the American Association of Legal Nurse Consultants. This association requires a certified LNC to have a current nursing

license as a registered nurse and a minimum of a bachelor's degree or the equivalent of five (5) years experience as a legal nurse consultant. Applicants must also pass a comprehensive examination developed by the AALNC that insures the LNC has mastered a body of knowledge on the subject and developed consulting skills through extensive experience. An LNC can prepare a case summary for you, which will be used for identifying key information concerning the case and will be of invaluable assistance to you as discovery begins.

If you decide to retain the services of an LNC, you should not forego reviewing the chart yourself in detail. Although an LNC's review is invaluable, the LNC's review can never replace an attorney's judgment. You must review the chart yourself page by page. Not only will you have a better understanding of the case but you will also become familiar with long-term care documents and charting. It is extremely time consuming.

#### **D. CASE ANALYSIS**

It is very important to sift through the information the family relates to you and separate it into acts/omissions that would support feasible claims and those that, unfortunately, only constitute extremely poor care. For example, the family may be very upset because their loved one was left lying for long periods of time in their own waste. Although this is substandard and inhumane, it is not necessarily a claim that can practicably be pursued without some type of significant associated injury. In these types of situations, I typically urge the family to be vocal with the staff about their concerns and to contact their local eldercare hotline and Ombudsman. An Ombudsman is an individual employed by the State who is responsible for addressing such concerns with the nursing home on behalf of the resident. The name and contact information of the Ombudsman will be posted somewhere in the facility.

#### **The Effect of A Settlement on Public Assistance Benefits**

An issue that needs early consideration is the effect that a settlement will have on a living resident's public assistance benefits. You should address with the client before any case is filed, the possibility that a settlement could make it impossible for the resident to continue to receive Medicaid benefits. A Supplemental Needs Trust, depending on the age of the injured resident, may preserve public assistance benefits. Often, the client realizes that a significant settlement will enable the family to insure that their loved one receives better care at another long-term care facility or with private nursing. You may wish to consult an elder law attorney who could advise the family on these matters. You should also consider whether your States laws would be subject a recovery to Medicare liens and Medicaid subrogation for the reimbursed medical expenses related to the injuries that formed the basis of the lawsuit and possibly for the resident's entire long-term care expenses.

### **Distributions of Settlements**

Discuss with the client how any recovery in the case will be distributed. If the resident is still alive and a guardianship has been established, the money will likely be placed under Court supervision for the benefit of the resident.

A more difficult situation could lie in the distribution of a wrongful death settlement. The client you are dealing with may be outraged to learn that his or her sibling who never visited Mom or Dad, has not seen them for ten (10) years, and provided no assistance whatsoever in caring for the parent, will nevertheless receive an equal portion of any recovery. This issue must be addressed at the beginning of the lawsuit. I have had more than one good case come into my office where the client chose ultimately not to pursue it for these reasons.

### **Fear of Retaliation**

Some family members fear that if they file a complaint and the resident is still alive, the staff at the facility may retaliate. No one can be at the nursing home 24 hours a day; therefore, this could be a critical concern, particularly in the case of residents who cannot communicate.

Personally, I have not seen this occur. Often, the care becomes better once a lawsuit has been filed and the conduct of the nursing staff is placed under a microscope. Nevertheless, this is a difficult issue and one you must be prepared to discuss.

### **Expert Witnesses**

Even though you may have retained the services of an LNC to assist you in reviewing the nursing home chart, it is advisable at this point in your analysis that you also retain the services of an expert to review the chart and tell you whether they can support the claims of substandard care. In almost every nursing home case you will need an expert nurse and a doctor. I prefer experts who have experience in geriatrics and long-term care.

The nurse expert will of course, review the chart and render opinions on substandard care. Your doctor should be able to opine that, but for the negligence of the nursing home, the resident would not have died when they did. In some states, your doctor expert may be able to render opinions concerning the care provided at the facility as well.

There are numerous other types of experts, which could be very helpful in a nursing home case. If your case involved a leg amputation, it would be very helpful if you had the favorable testimony of a vascular surgeon who could establish that the wound on your resident's foot that led to amputation was caused by pressure and not lack of blood flow. A dietician is often very helpful. Most pressure sore cases have a nutritional component to them that should be given serious consideration. A registered

dietician can review the chart and render opinions as to whether the facility's nutritional care, or lack thereof, "set up" the resident for development of pressure ulcers.

If your case involves a large nursing home chain, you may wish to retain the services of a long-term care corporate expert. This maybe someone with an accounting background in long-term care who can review corporate documents and budgets to render opinions on where the money was going in the corporation.

#### **D. IDENTIFICATION OF CORRECT PARTIES**

##### **Plaintiff**

The plaintiff's designation is largely dependent on the law of your State. In most states, if you have had a guardian appointed or a personal representative established you should file suit in the name of that person on behalf of the resident or the estate. If the resident is competent and you have not had a guardian appointed, some states allow for the filing of the complaint by an individual as "next friend", or similar designation, of the incompetent nursing home resident. This is important in states where injury claims are extinguished concurrently with the death of the resident.

##### **Defendants**

The following are potential defendants in a nursing home case:

##### **Licensee/Owner/Parent**

In determining who is the appropriate defendant to sue in a nursing home case, you should begin with the entity that is licensed to operate the facility. Contact your state agency that handles licensure of long-term care facilities and request a copy of the licensing documents for the facility. These documents should reflect the name of any licensee during the year that is at issue in your case. In addition to naming the licensee, you need to determine the owner of the facility. One good resource online is Dunn and Bradstreet. If the licensee and the corporate owner of the facility are two different entities, name both as defendants. If the corporate owner has a parent company, investigate whether you can pierce the corporate veil by showing that the parent is actually the entity that controls and runs the facility and the corporate owner is nothing more than a shell.

##### **Management Company**

If a management company was involved in running the nursing home during the time at issue in your case they are a necessary defendant and may be a separate corporation unaffiliated with the owner or the licensee.

##### **Physician**

A decision must be made as to whether the physician who cared for the resident should be made a defendant. The medical director of the facility will typically take the position that they are an independent contractor. You should discuss this issue carefully with the family. They may not want to sue the doctor.

### **Administrator**

When you review the State and Federal Regulations that specifically address the duties and responsibilities of a nursing home administrator you will see that the law charges them with the responsibility of developing and implementing policy and procedures to ensure that all the residents in the nursing home receive appropriate care. All of the regulated duties imposed on the nursing home are the responsibility of the licensed nursing home administrator. If you name the administrator as a defendant it can be argued that the administrator is responsible for ensuring the quality of each resident's care in the facility.

### **E. IDENTIFYING CAUSES OF ACTION IN INITIAL PLEADINGS**

Some of the most common theories available to the plaintiff in a nursing home case include:

- A. Negligence and wantonness
- B. Wrongful death
- C. Breach of express contract/third party beneficiary
- D. Fraud
- E. Civil Conspiracy
- F. Assault and Battery
- G. Unfair Business Practices
- H. Violation of Consumer Protection Laws

The most common claim against a nursing home is a negligence claim. However, you should pay close attention to other theories that may be available in your state. For instance, in some states a breach of contract claim will allow certain damages that may not be available to you in the typical negligence/wrongful death action. Georgia law provides that a cause of action exists for violation of specified residents rights. Florida has a very extensive act available to nursing home litigants, however it has been modified in recent years through tort reform efforts.

### **ARBITRATION ISSUES**

Today when a potential nursing home resident or his or her family seeks a nursing facility to provide the resident 24-hour nursing care, the resident or family is sometimes faced with more than the question of which facility to choose or how the resident will pay; the resident or family must also make the choice to waive the resident's right to a jury trial arising from any future negligent acts of the nursing home. Faced with the choice between immediate medical care and retaining the resident's right to a jury trial,

of course the resident and family are more than eager to do everything necessary to ensure that the resident receives immediate medical care. However, once a resident has been injured by the negligent conduct of a nursing facility, the resident and his or her family are often astonished to find that a clause buried within the resident's admission agreement will forever prevent the resident from seeking redress in a court of law for any claims against the nursing home, including the wrongful death of a resident.

Nursing homes and other healthcare organizations and professionals have begun a nationwide campaign to limit a resident's right to sue nursing facilities through both tort reform legislation and arbitration agreements.

### **Federal and state law enforcement of arbitration agreements.**

Both federal and state law governs the question of whether an arbitration agreement is enforceable. Congress enacted the Federal Arbitration Act (FAA) in 1925 to address the perceived disparity in treatment of arbitration agreements 9 U.S.C. § 2. Prior to 1925 courts were very hostile toward arbitration agreements, and rarely enforced them. According to the United States Supreme Court, the FAA was intended to "overcome courts' refusals to enforce agreements to arbitrate" and to "place such agreements upon the same footing as other contracts." *Allied-Bruce Terminix Companies, Inc. v. Dobson*, 513 U.S. 265, 270-71 (1995).

The FAA was enacted pursuant to the power of Congress to regulate interstate commerce. Although the FAA compels the enforcement of arbitration agreements in the same fashion that other agreements are enforced, the FAA also provides a method to invalidate or rescind an arbitration agreement. Under the FAA, arbitration agreements may be invalidated upon any ground that exists at law or in equity for the revocation of any contract. In determining whether to enforce an arbitration agreement, state and federal courts are free to invalidate an arbitration agreement on any state law ground that exists for the revocation of a contract. The basic premise of the FAA is that courts are not allowed to treat arbitration agreements differently than other contracts when determining whether the agreement is enforceable.

### **Upon What Grounds May An Arbitration Clause In A Nursing Home Contract Be Invalidated?**

#### **A. Non-signatory**

A basic principle of contract law is that in order for a valid agreement to exist there must have been mutual assent between the parties to enter into that agreement. If there is no proof that parties assented to be bound by an agreement, including an arbitration agreement, courts will not enforce that agreement. Assent is manifested by some act or behavior of the parties. Generally, assent to enter into a contract is manifested through a party's signature on the contract. When there is a written contract and one person who is alleged to be a party to that contract fails to sign the contract,

assent is harder to prove. The party who fails to sign the contract is called a non-signatory.

In the nursing home context, the non-signatory argument is a very good argument against enforcement of an arbitration agreement. Often when a resident is admitted to a nursing facility, a family member signs the resident's admission agreement. Rarely does the resident sign his or her own admission agreement. If the nursing home intends to bind the resident to an arbitration agreement, that arbitration provision will generally be contained within the admission agreement. The person who signs the agreement admitting the resident to the nursing home also signs the arbitration agreement, waiving the resident's right to a jury trial. Thus, the question arises whether the resident has assented to the arbitration clause when the resident has not in fact signed the agreement.

Courts have generally agreed that a non-signatory to a contract may be bound to that contract if an agent signed the contract on the non-signatory's behalf or if the non-signatory was a third-party beneficiary of the contract. Under the agency theory, a nursing home resident's best argument is that the individual who signed the agreement was not the resident's agent because the resident was incapacitated due to his or her illness, and lacked the ability to control the alleged agent's actions. In order for an agency relationship to exist, the principal, the nursing home resident, must be in control of the agent. If the nursing home resident is incapacitated due to his or her medical condition, the resident is unlikely to have control over the individual signing the agreement.

Further, an agent's authority is usually based upon the conduct of the alleged principal, not that of the agent *Brannan & Guy, P.C. v. City of Montgomery*, 828 So. 2d 914 (Ala. 2002). Where the potential resident is incompetent, nursing home administrators may not observe or talk with the potential resident prior to the signing of an admission agreement. More often than not, the potential resident is not present when the family member signs the admission agreement on her behalf; thus, it is impossible for the resident to have exhibited any conduct which would lead the nursing home to believe that the resident consented to an agency relationship.

In *Pagarigan v. Libby Care Center*, 99 Cal.App.4<sup>th</sup> 298, 120 Cal.Rptr.2d 892 the heirs of a deceased woman sued the woman's former nursing home alleging that the facility wrongfully caused her death. The defendant nursing home moved to compel arbitration based on two arbitration agreements signed by the resident's daughters after the woman was admitted to the nursing facility. The resident was mentally incompetent at the time she was admitted to the nursing facility, and there was no evidence that she had signed a durable power of attorney. Based upon those facts, the court found that the resident lacked the capacity to authorize either daughter to enter into the arbitration agreements on her behalf. According to the court, "[a] person cannot become the agent of another merely by representing herself as such. To be an agent she must actually be so employed by the principal or the principal intentionally, or by want of ordinary care, caused a third person to believe another to be his agent who is not really employed by him." 99 Cal.App.4<sup>th</sup> at 301-02, 120 Cal.Rptr.2d at 894-95.

Although arbitration agreements may be invalidated when the resident did not sign the agreement and showed no assent to arbitrate his or her claims, arguments based upon the theory that the nursing home did not manifest assent to be bound by the agreement, because the facility representative failed to sign the agreement, have not fared as well. In *Integrated Health Services of Green Briar, Inc. v. Lopez-Silvero* 827 So.2d 338 (Fla.Dist.Ct.App. 2002) the court upheld an arbitration agreement that the nursing facility had either failed to sign or signed on an improper line, opining that a contract is binding, despite the fact that one party did not sign the contract, where both parties have performed under the contract. According to the court in both cases, the resident and the nursing facility acted as if they had a valid contract. The nursing facilities performed under the contracts by admitting the resident and providing the resident with nursing home care. In both cases the courts held that the nursing facilities' performance of the contract indicated a clear intent to be bound by the admission contract, which included the arbitration clause.

### B. Unconscionability

Another contract defense that may be used to invalidate an arbitration provision in a nursing home admission agreement is the theory of unconscionability. Unconscionability can be in the form of substantive unconscionability, which pertains to contract terms that are unreasonably favorable to one side, or procedural unconscionability that pertains to the process of contract formation, the use of fine print and convoluted language, lack of understanding, and inequality of bargaining power.

In the nursing home setting procedural unconscionability is almost always a good argument. Often when a family admits a resident to a nursing home, the resident is in need of immediate placement. Sometimes families have little choice of placement in a particular facility because either there is no other nursing facility for miles or other nursing facilities have no available bed for the resident.

Moreover, even if a family member sought out other nursing homes for possible placement, it may have been difficult to find one that did not require the resident or that resident's sponsor to sign an arbitration agreement. Thus, families are faced with the choice of retaining the resident's right to a jury trial versus getting the resident the necessary nursing care that he or she needs. The choice is not really a choice at all for the resident in need of immediate care.

Further, the actual process of admitting a resident to a nursing home often does not provide the kind of informative setting necessary for the resident or the resident's sponsor to consider the pros and cons of arbitration. Arbitration agreements may be in a stand-alone document that the resident or the resident's sponsor is asked to sign. But, more likely than not, the agreement is buried in the middle of the admission contract, making the arbitration clause inconspicuous. Moreover, the arbitration clause may not have bold or italicized language, thus failing to draw the signor's attention to the provision. Nursing home representatives have even been known to hold the agreement in their hand explaining sections of the nursing home admission agreement without

mentioning the arbitration clause. Each of these factors makes the case that the arbitration clause is unconscionable and therefore unenforceable.

The Court of Appeals of Tennessee considered the question of whether an arbitration agreement in a nursing home admission contract was unconscionable and therefore unenforceable in *Howell v. NHC Healthcare-Fort Sanders, Inc.* 109 S.W.3d 731 (Tenn.Ct.App.2003). In *Howell*, the estate of a nursing home resident sued the nursing facility alleging that the facility abused and neglected the resident. The nursing facility moved to compel arbitration based upon an arbitration provision contained within the admission agreement signed by the resident's husband at the time of admission. The trial court conducted an evidentiary hearing on the motion, during which evidence was admitted indicating that the admitting contract signed by the resident's husband was the only one used by the nursing home at the time, that a patient or the patient's legal representative was required to sign the contract before being admitted to the facility, that the facility representative had purported to read the contract to the resident's husband but failed to read the entire agreement; rather, she paraphrased the agreement and then pushed the agreement in front of the resident's husband to sign, and that the resident's husband was unable to read.

The Court of Appeals found that the arbitration agreement was unenforceable based upon the circumstances under which it was signed. The Court found several factors significant in its determination, including: the fact that the admission agreement was eleven pages long and the arbitration provision, rather than being a stand-alone document, was "buried" within the larger document and was written in the same size font as the rest of the agreement; the fact that the resident had to be placed in a nursing home expeditiously and that the admission agreement had to be signed before this could be accomplished; that the agreement was presented to the husband on a "take-it-or-leave-it" basis; the fact that the nursing home representative took it upon herself to explain the admission agreement, rather than asking the husband to read it and that in her explanation of the arbitration provision she failed to mention that the provision meant that the husband was giving up the resident's right to a jury trial.

Substantive unconscionability arguments, with regard to arbitration agreements in the nursing home setting, may be made by arguing that it is unconscionable to require a nursing home resident to give up his right to a jury trial in exchange for nursing services. Substantive unconscionability arguments generally do not fare as well as procedural arguments because courts must enforce arbitration agreements in the same manner as other contractual agreements. For instance, in *Consolidated Resources Healthcare Fund, I, Ltd. v. Fenelus*, 853 So.2d 500 (Fla.App.2003) the court rejected the argument that an arbitration provision in a nursing home admission agreement was substantively unconscionable because the agreement required that in order to retain the resident's right to a jury trial, the resident had to affirmatively indicate so within the admission agreement. The court held that an arbitration clause need not be optional in order to be valid.

### C. Claims of Estate Had Not Arisen

Many state courts have interpreted their wrongful death statutes to create a new and independent cause of action. The injured party's claim after death is an asset of the estate while the wrongful death statute creates a new cause of action for the benefit of designated persons who have suffered the loss of a loved one and provider. *See Crosby v. Glasscock Trucking Co.*, 340 S.C. 626, 628, 532 S.E.2d 856 (2000) (holding that South Carolina's wrongful death statute creates a new cause of action. A wrongful death cause of action does not exist before death and arises only upon the death of the injured person.); *Thompson v. Wing*, 637 N.E.2d 917, 922 (Ohio 1994) (The wrongful death action is an independent cause of action.) *Sullivan v. Carlisle*, 851 S.W.2d 510, 516 (Mo. 1993) (a claim for wrongful death "is neither a transmitted right nor a survival right, but is created and vests in the survivors at the moment of death."); *Switzer v. Reynolds*, 606 P.2d 244, 247 (Utah 1980) (holding that the Utah wrongful death statute creates a new cause of action which runs directly to the heirs to compensate each for the individual loss suffered by the death.)

#### D. Arbitration Clauses Contained Within Nursing Home Admission Agreements Are Prohibited by Statute, and Therefore Null, Void, And Unenforceable

A novel argument is that federal and state Medicare and Medicaid regulations prohibit the inclusion of an arbitration clause in an admission agreement. Because most residents in nursing facilities are eligible for Medicare or Medicaid, this argument is applicable to most residents. All licensed nursing facilities in the United States may participate in the Medical Assistance Program, established under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, if the facility meets certain requirements relating to the provision of healthcare services. The Medical Assistance Program provides payments to States for medical assistance furnished by nursing facilities to residents in the facility. Nursing facilities participate in the program by entering into a "Provider Agreement" between the nursing facility and the respective State. The provider agreement generally obligates the nursing facility to comply with all relevant federal and state laws and regulations. Thus, as a participant in the Medical Assistance Program, a nursing facility is subject to the regulations governing the provision of resident services in 42 U.S.C. § 1396r(b).

Within the Social Security Act, resident admission is specifically governed by 42 U.S.C. § 1396r(c)(5). In pertinent part, that section states:

"(5) Admissions policy "

(A) Admission "With respect to admissions practices, a nursing facility must –  
"

"(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift,

money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.”

Thus, federal law may prohibit a nursing facility from accepting any additional consideration from a Medicare/Medicaid resident, aside from the standard rate paid by Medicare/Medicaid, as a precondition of admission to a nursing facility.

An arbitration agreement, like any other agreement, must have consideration to be enforceable. Generally mutuality of promises can be sufficient consideration for an arbitration agreement. In this respect, the argument goes that if mutual promises to submit to arbitration are consideration for the agreement, then the facility has accepted additional consideration aside from the payment by Medicare or Medicaid, making the arbitration agreement invalid because it violates federal law. This argument was raised in *Howell v. NHC Healthcare-Fort Sanders, Inc.*, *supra* and pretermitted because the arbitration agreement in that case was found invalid on other grounds. At least one administrative agency has released an opinion concluding that federal regulations prohibit any flow of consideration between Medicare/Medicaid program recipients and a nursing home upon admission to the facility for services covered by the Medicare/Medicaid programs, and that potential residents gain nothing in addition to admission for offering the additional consideration of forfeiture of their rights. *See In the matter of Northport Health Services, Inc. Arkansas Department of Human Services.* (no cite).

#### CMS Administrative Ruling Regarding Arbitration Clauses in Nursing Home Admission Agreements

On January 9, 2003, the Center for Medicare & Medicaid Services (CMS) released an administrative ruling regarding binding arbitration between nursing homes and prospective or current residents. *Binding Arbitration in Nursing Homes*, Center for Medicare & Medicaid Services, Ref: S&C-03-10, January 9, 2003.

The CMS memorandum stated that under Medicare, the issue whether to have a binding arbitration agreement is an issue between the resident and the nursing home. However, under Medicaid, CMS stated that it would defer to State law regarding whether such binding arbitration agreements are permitted, subject to its concerns when Federal regulations may be implicated. According to the memorandum, under both programs, there may be consequences for the nursing facility where facilities attempt to enforce arbitration agreements in a way that violates Federal requirements.

CMS further opined that a nursing home's discharge or retaliation against an existing resident for failing to sign or comply with a binding arbitration agreement could result in enforcement action based on a violation of the rules governing resident discharge and transfer. Federal regulations limit the circumstances under which a facility may discharge or transfer a resident 42 C.F.R. § 483.12(a)(2). Because none of the conditions specified in the regulation permit a facility to discharge or transfer a resident based on his or her failure to comply with the terms of a binding arbitration agreement,

CMS concluded that a current resident is not obligated to sign a new admission agreement that contains binding arbitration.

### **ENFORCEABILITY VARIES WIDELY**

Both federal and state law governs the enforceability of arbitration clauses in nursing home admission contracts. Since the U.S. Supreme Court's decision in *Allied-Bruce Terminix*, state courts have become more likely to uphold arbitration agreements.

In order to invalidate an arbitration agreement, nursing home residents must show that there exists some ground for the revocation of the arbitration agreement based upon contract law principles. Enforceability is still largely dependent upon the state in which one brings suit. Some states, such as Tennessee, may be largely open to invalidating an arbitration agreement upon grounds of unconscionability, while other states, like Alabama, very rarely find an arbitration agreement unconscionable. Moreover, the question of whether the arbitration agreement will be enforced is a fact intensive inquiry, and may be dependent upon the moment-to-moment factual circumstances surrounding the signing of the agreement.