

**THE PLAINTIFF'S PERSPECTIVE ON IDENTIFYING AND INVESTIGATING  
SPECIFIC CASES**

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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***

Approximately twenty-five thousand people in Alabama wake up everyday 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 the baby boomers begin entering retirement. This oncoming 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 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. The nursing personnel of the facility should be 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 they are not committed to these duties, inevitably, nursing standards of care are 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 very 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 regulations that apply. Finally, the attorney

must be intimately familiar with the law of these cases, much of which seems to be 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). Georgia nursing home regulations, which are patterned to some extent after the Federal regulations, are located in the Rules of Department of Human Resources Public Health chapter 290-5-8, entitled “Nursing Homes.” These state and federal regulations created standards which have heightened 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 **These regulations, in part, require:**

- Adequate numbers of nursing personnel to provide for the needs of the resident;
- 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 insure 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 the regulations 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.

### Gathering the Information

Most families frequently visit their loved ones in a nursing home. Some family members may visit every day. The first thing you must do 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 may be 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)
- Lack of staff to respond to residents' needs

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. When the care at the home became poor, anger, desperation, and a feeling of helplessness 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, it is not unusual for family members to continue to trust the staff of the nursing home and place credence in the staff's representations that the care will get better. If the care does not get better, at some point the frustration becomes too great and that is when they seek an attorney's advice.

The family will have vast knowledge of specific information 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 specific questions in order to build a strong foundation for the injuries and damages.

Specific knowledge may be:

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 even years. The complaint is usually not based on one incident or occurrence, but on numerous incidents of neglect that transpired over an extended period of time.

You should also listen for clues that could indicate problems with the case. The cost of obtaining records and the time commitment in reviewing them is significant and you need to be aware of the potential pitfalls.

Some negatives to watch out for are:

- Many years in the home
- Single incident
- Statute of limitation problems
- Bickering family members
- Multiple nursing homes

- Treatment worse at other facilities
- Family reluctant to move resident from defendant nursing home
- Home with excellent reputation and small damages
- Small town, single owner home

Even if some of these factors exist in a case, it may still be worth pursuing. It is possible to overcome a bickering family with significant damages, but you must find out their motivation. You should use your judgement 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? Most of the time, money is not an issue; they simply do not want other nursing home residents to be subjected to the same bad conditions and poor care.

## **B. INVESTIGATION**

### The Records

The interview process should provide enough information to determine whether medical records should be ordered. Strong consideration should be given to ordering the records if the interview indicated any of the following:

- Pressure sores
- Malnutrition/weight loss
- Dehydration
- Contractures
- Falls
- Drops

- Improper restraints
- Significant general neglect/abuse

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. See Attachment "A". 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 years from the date of discharge when there is no other requirement 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. 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 in Georgia 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 Office of Regulatory Services, Georgia Department of Human Resources, 2 Peachtree Street, Northwest, 21<sup>st</sup> Floor, Suite 21-325, Atlanta, Georgia 30303-3167. 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, identify a sample of residents in the facility, tour the facility, observe and interview residents and staff, and review the sample 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.

### **C. CASE ANALYSIS**

#### **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 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 in cases like these,

the LNC's review can never replace an attorney's judgement. 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. When I first began handling nursing home cases, I did my own chart reviews. It was not uncommon for me to spend sixty plus hours reviewing the nursing home chart for a case involving a two or three year residency.

#### Expert Witnesses

Even though you may have retained the services of an LNC to assist you in review of 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 or not 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.

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

#### Defendant:

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. You can contact the Office of Regulatory Services and request a copy of the licensing documents for the facility. These documents will 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 for doing this is Dunn and Bradstreet. You can obtain software from Dunn and Bradstreet that allows you to find out the corporate information of any business on-line. If the licensee and the corporate owner of the facility are two different entities, I would suggest naming 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:

Find out if a management company was involved in running the nursing home during the time at issue in your case. If there was, they are most likely 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. Even if the physician is the medical director of the facility, they typically are independent contractors. You should discuss this issue carefully with the family. They may not want to sue the doctor. On the other hand, they may have very bad feelings concerning the doctor and the fact that he or she only saw the resident once every thirty days at most, and on those occasions never got beyond the doorway of the resident's room. If you do not name a physician in the lawsuit, you need to be prepared to rebut the "empty chair" defense that will be asserted by the defendant.

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. Resident's Rights Claims
- F. Miscellaneous causes of action

It is important to remember that a contract claim is always available in a nursing home case based on the resident admission agreement. In a bedsore case my firm recently tried in Arkansas, the jury did not award the plaintiff a verdict on the negligence claim, but did on the contract claim in the amount of approximately 3 million dollars.

In Alabama a contract claim survives the death of the decedent. Ala. Code § 6-5-462. A successful claim for breach of that contract should allow for the recovery of some pre-death damages such as mental anguish and suffering. *See Wellcraft Marine v. Zarzour*, 577 So. 2d 414 (Ala. 1990); *Walker Builders, Inc. v. Lykens*, 628 So. 2d 923 (Ala. Civ. App. 1993). In a nursing home case pre-death damages are often significant when it can be proven that neglect occurred over an extended period of time. In essence, this allows the plaintiff to retain some of the injury claim that otherwise would not survive the death of the decedent.

## **F. COMMON TYPES OF LONG TERM CARE CLAIMS**

### **1. Decubitus Ulcers And Other Progressive Failures And Omissions of Care**

#### **a. 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 is receiving excess pressure. However, in those with spinal cord 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).

#### **b. 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 least the 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).

### **c. 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.

**d. 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 pus 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.

**G. OTHER PROGRESSIVE FAILURES AND OMISSION OF CARE**

**a. 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's 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.

### **b. 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.

### **c. 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).

### **d. 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).

**e. 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).

**f. 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).

**g. 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.

#### **h. 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.

## **H. 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.