

TOP TEN THINGS TO DO TO PREPARE A NURSING HOME CASE

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1.

Know the Regulations

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.

A. 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.

B. 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.

C. 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.

D. 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.

E. 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.

A. 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).

G. 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).

H. 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):

- (1) **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).
- (2) **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).
- (3) **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).

I. 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:

- (b) sufficient information to identify the resident;
- (c) a record of the resident’s assessments;
- (d) the plan of care and services provided;
- (e) 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.

J. 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).

2.

Know the Cases

You need to be able to make a decision as early as possible as to whether the story you are hearing from the client might actually be a case worth pursuing. The ability to make such a decision will save you time and money.

Clinical Outcomes Frequently Linked with Neglect

- F. 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

- G. Injuries precipitated by medication prescription and administration failures

- H. 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

3.

Do the Probate

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. It may be 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 any "after the fact" litigation.

4. Get the Records

Request a copy of the resident's entire nursing home chart and intervening hospital admissions from the appropriate providers. 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.

5. Read 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.

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.

6. Hire a Nurse

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. 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. The nurse consultant can also help you identify experts that will need to be retained.

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.

7. Get the 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

Survey information is 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. Look to see if your resident is in the survey and whether the facility was cited for providing them with substandard care.

8. Identify the Parties

A. Plaintiff

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, Alabama allows for the filing of the complaint by an individual as "next friend", of the incompetent nursing home resident. This is important in Alabama where injury claims are extinguished concurrently with the death of the resident.

B. Defendants

The following are potential defendants in a nursing home case:

Licensee/Owner/Parent

In determining the appropriate defendant to sue in a nursing home case, you should begin with the entity that is licensed to operate the facility. 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, conduct discovery to show that the parent actually controls the operation of the home.

Management Company

If a management company was involved in the day-to-day operation of 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 administrator. The administrator is responsible for ensuring the quality of each resident's care in the facility.

9. Arbitrate the Claim?

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.

Recent Alabama Nursing Home Arbitration Cases:

Briarcliff Nursing Home, Inc. v. Turcotte, 2004 WL 1418698 (Ala.)

Owens v Coosa Valley Health Care, 2004 WL 260969 (Ala.)

Springhill Nursing Homes v McCurdy, 2004 WL 2134652 (Ala.)

Community Care Of America Of Alabama, Inc. v. Davis, 850 So.2d 283

McGuffey Health & Rehabilitation Center v. Gibson, 864 So.2d 1061

10. Litigate the Case!

In general, the requirements of burden of proof, proximate cause, and expert medical testimony apply to all nursing home cases. Most nursing home cases are governed by the Alabama Medical Liability Act, *Ala. Code* § 6-5-480 et. seq. (1975) and the Alabama Medical Liability Act of 1987, *Ala. Code* § 6-5-540 et. seq. (1975 and 2000 sup.) Since expert testimony is generally required to prove negligence in nursing home cases, see *Rosemont, Inc. v. Marshall*, 481 So.2d. 1126 (Ala. 1985), the following are some helpful strategies in dealing with medical expert testimony.

A. Burden of Proof

Pursuant to *Ala. Code* § 6-5-481(7)(1975), a nursing home is considered a hospital, thus claims such as breach of contract, negligence and wrongful death brought against a nursing home are considered medical malpractice claims governed by AMLA. *Ex parte Northport Health Service, Inc.*, 682 So.2d 52, 55 (Ala. 1996).

Moreover, the focus in an action under AMLA is on the individual practitioner whose specific action is alleged to have fallen below the standard of care. *Husby v. South Alabama Nursing Home, Inc.*, 712 So.2d 750, 753 (Ala.1998).

In order to prevail on a negligence claim governed by AMLA, a plaintiff must produce evidence that establishes: (1) the appropriate standard of care, *Dobbs v. Smith*, 514 So.2d 871 (Ala.1987); (2) the nursing homes deviation from that standard, *Dobbs*, supra; and (3) a proximate causal connection between the act or omission constituting the breach and the injury sustained by the plaintiff. *Ensor v. Wilson*, 519 So.2d 1244 (Ala.1987). See also, *Crowne Investments, Inc. v. Reid*, 740 So.2d 400, 404 (Ala. 1999).

(1) *Standard of Care*

The standard of care applicable to a nursing home is "... that level of such reasonable care, skill and diligence as other similarly situated health care providers in the

same general line of practice, ordinarily have and exercise in like cases." *Ala. Code* § 65-548(a)(1975). See *Parker v. Collins*, 605 So.2d 824 (Ala.1992)(discussing the burden of proof, standard of care, and breach of standards under AMLA).

Therefore, a plaintiff in a nursing home case must show that the actions of the nursing home and/or its employees was not in accordance with those of similarly situated nursing homes in the nursing home community at the time of the challenged actions, notwithstanding any contention that such standard was insufficient where reasonable prudence dictated that a stricter standard of care should be met. *Barton v. American Red Cross*, 829 F.Supp. 1290, 1297-98 (M.D.Ala.1993). See also, *Brooks v. Goldhammer*, 608 So.2d 394, 395 (Ala.1992)(citing *Bates v. Meyer*, 565 So.2d 134, 136 (Ala. 1990)).

(2) *Breach of the standard of care*

The plaintiff has the burden of proving by substantial evidence that the nursing home failed to maintain a standard of care as set out in § 6-5-548(a), and the jury must be so charged. *Ala. Code* § 6-5-549 (1975). It is not necessary to establish that prompt care could have prevented the injury or death of the resident; rather, the plaintiff must produce evidence to show that his or her condition was adversely affected by the alleged negligence. *Parker v. Collins*, 605 So.2d 824 (Ala.1992). Further, a nursing home may be held liable for the negligent conduct of independent physicians, even though they are neither employees nor agents of the nursing home, on a theory of corporate liability. To do so, however, the plaintiff must show that some underlying negligent act of the physician caused the injury. *Id.* at 824.

The plaintiff ordinarily must offer expert medical testimony as to what is or what is not the proper practice, treatment, and procedure in the particular case of the resident. *McAfee v. Baptist Medical Ctr.*, 641 So.2d 265, 267 (Ala.1994). A lack of expert medical testimony will usually result in a lack of proof of the essential elements to establish the plaintiff's case. *Rosemont, Inc. v. Marshall*, 481 So.2d 1126, 1129 (Ala. 1985)(citing *Parrish v. Spink*, 284 Ala. 263, 224 So.2d 621 (1969)); see also, *Tuscaloosa Orthopedic Appliance Co. v. Wyatt*, 460 So.2d 156 (Ala.1984)(expert testimony was required to determine whether performance of orthotist fell below acceptable standard of care since laymen do not have background and knowledge without expert testimony to understand whether a fracture brace had been properly applied). Moreover, once the defendant offers expert testimony establishing a lack of negligence, the defendant is entitled to summary judgment unless the plaintiff counters the defendant's evidence with expert testimony in support of plaintiff's claim. *Swendsen v. Gross*, 530 So.2d 764 (Ala.1988).

Nevertheless, there are several exceptions. A plaintiff is not required to offer expert medical testimony as to proper practice, treatment, and procedure where want of skill or lack of it is so apparent as to be within the comprehension of the average layman, and thus requires only common knowledge and experience to be understood. In addition, a plaintiff is not required to offer expert medical testimony as to proper practice, treatment, and procedure where a recognized standard or authoritative medical text or treatise is introduced to prove what is or is not proper practice. *Rosemont*, 481 So.2d at 1130.

B. Proximate Cause

A plaintiff establishes proximate cause by demonstrating that an injury or death was probably caused by the defendant's conduct. *Crowne Investments, Inc. v. Reid*, 740 So.2d 400, 404 (Ala. 1999). In wrongful death cases, the probability of survival test has been rejected and is not required. *Brackett v. Coleman*, 525 So.2d 1372 (Ala. 1988). In addition, testimony that earlier treatment could possibly have made a difference is insufficient as a matter of law. *Williams v. Springhill Memorial Hospital*, 646 So.2d 1373 (Ala. 1994).

C. Expert Medical Testimony

In *Medlin v. Crosby*, 583 So.2d 1290 (Ala.1991), the Alabama Supreme Court developed a test for determining whether an expert qualifies to testify in an AMLA case. The court said it is necessary to determine (1) the standard of care the plaintiff says the defendant breached; (2) whether the defendant who is alleged to have breached the standard of care is a specialist in the area of care in which the breach is alleged to have occurred; and (3) whether the expert qualifies under the criteria set out in the AMLA statute. *Id.* at 1293.

The question whether a witness is qualified to give an expert opinion is customarily left to the discretion of the trial court, and the trial court's determination will not be disturbed on appeal absent a finding of abuse of discretion. *Bell v. Hart*, 516 So.2d 562, 569 (Ala.1987).

D. Nursing Home Litigation After Tort Reform

The last several years have seen several changes in the scope of discovery allowed in nursing home abuse cases, caps on punitive damages, and the availability of causes of actions other than medical malpractice under AMLA.

(1) Scope of discovery under the Alabama Medical Liability Act, § 6-5-551

The Supreme Court of Alabama has made it clear that in an action against a health-care provider, based on acts or omissions in the hiring, training, supervision, retention, or termination of the health-care provider's employees, a plaintiff is entitled to discovery concerning only those acts or omissions specifically detailed and factually described in the complaint and alleged by the plaintiff to render the health care provider liable to the plaintiff. *Ex parte Coosa Valley Health Care Inc.*, 789 So.2d 208 (Ala. 2000) (citing *Ex parte Ridgeview Health Care Center Inc.*, 786 So. 2d 1112, 1116-17 (Ala. 2000)).

However, the court has also held that since negligence claims based on "systemic failure" of a nursing home will not all solely involve care by medical personnel, and, thus, it is likely that the employees to which some of those claims relate would not be named in plaintiff's medical records, requesting a list of employees to identify all individuals who either witnessed or had the opportunity to witness the circumstances, events or occurrences

that were relevant to the facts and issues in the plaintiff's case is permissible. *Ex parte Coosa Valley Health Care Inc.*, 789 So.2d at 219.

a. *Ex Parte Ridgeview Healthcare*

The Supreme Court of Alabama, following an amendment to the statute prohibiting any party in a malpractice action against a health care provider from conducting discovery with regard to any other act or omission, vacated a prior ruling allowing broad discovery in nursing home actions and held that AMLA governs claims of negligent or reckless hiring against nursing homes, thereby strictly limiting the discovery available to plaintiffs in elder abuse actions. *Ex parte Ridgeview Health Care Center Inc.*, 786 So. 2d 1112, 1116-17 (Ala. 2000).

b. *Ex parte Coosa Valley Health Care*

The Alabama Supreme Court subsequently reaffirmed its ruling in *Ex parte Ridgeview* that plaintiffs who assert negligent hiring or systemic failure claims against nursing homes cannot get around the prohibition contained in AMLA against discovery of other acts or omissions evidence. *Ex parte Coosa Valley Health Care Inc.*, 789 So.2d 208 (Ala. 2000).

Citing its recent decision in *Ridgeview*, the court said that *Ala. Code* § 6-5-551 (1975), as amended, limits discovery of acts or omissions to those detailed in the complaint and related to the care rendered to the plaintiff. However, plaintiff is entitled to discovery of a nursing home's list of employees who worked at the nursing facility during the resident's stay when the plaintiff asserts systemic failure in the complaint.

E. Discovery

The following is a list of discovery requests that may be generally applicable in nursing home injury or death cases.

1. Requests for production

- Documents reflecting ownership or management of the facility
- Articles of incorporation or partnership agreements
- Minutes of the governing board
- Organizational chart reflecting all officers, directors, departments, committees, and employees
- All state or other licenses

- Insurance agreements
- List of names and last known addresses and telephone numbers of present and former nursing personnel (e.g., nurses and nurse aides/nursing assistants)
- All guidelines of any local, state or federal governmental entity relating to facility's resident care policies and procedures
- All documents reflecting facility's resident care policies and procedures
- All documents reflecting facility's personnel policies and procedures
- All documents pertaining to complaints of alleged abuse, neglect or mistreatment of any resident, or to the health, safety and/or welfare of any' resident
- All clinical records, charts, documents, photos and other tangible things relating \ in any way to plaintiff/resident (including but not limited to assessments; care plans; medical, hospital, and autopsy records; nursing notes; medication records; incident reports relating to plaintiff/resident; notes charted by nursing assistants, such as activities of daily living records; physician orders; records of notifications of plaintiff/resident's attending physician)
- All documents and other evidence pertaining to investigation of alleged abuse, neglect or mistreatment of plaintiff/resident
- Legal notices provided to residents (e.g., notices of resident rights)
- Documents pertaining to advertisements or other representations to the public concerning the quality, characteristic, type and standard of care provided to residents at the facility
- Documents reflecting resident occupancy and characteristics of those residents (e.g., daily resident census)
- Documents reflecting level of staffing (e.g., work schedules and time sheets showing the identity, number and classification of staff) as to area in which plaintiff/resident was housed
- Employee work schedules
- Clocked time cards
- Personnel records of persons involved in providing care to plaintiff/residen

- Personnel records of facility administrator
- Documents pertaining to disciplinary action or investigation of persons involved in providing care to plaintiff/resident
- Evaluations of persons involved in providing care to plaintiff/resident
- Employment application form and all other forms used in screening applicants for employment
- Floor plans or other documents reflecting layout and number of rooms in facility
- All documents pertaining to in-service training of employees (e.g., syllabi or other documents reflecting content of training sessions, materials distributed, attendance records, results of any tests)
- All documents relating to inspections, adverse findings, proposed sanctions, or responses
- Witness statements
 1. Interrogatories
 - All persons with knowledge of discoverable facts
 - Experts
 - Persons from whom statements have been taken
 - List of names and last known addresses and telephone numbers of present and former nursing personnel (e.g., nurses and nurse aides/nursing assistants)
 - List of names and last known addresses and telephone numbers of former nursing Personnel
 - List of names and last known addresses and telephone numbers of persons who provided care to plaintiff/resident
 - Other lawsuits
 - Any other potential parties
 - Other previous and subsequent incidents occurring in substantially the same or similar way as incident made the basis of suit

A. Non-party subpoenas duces tecum

- Documents relating to licensure and certification surveys or inspections, adverse or deficiency findings, sanctions, and facility response -- State Health Department, Division of Licensure and Certification
- Documents related to any investigations of alleged abuse, neglect or mistreatment at facility-- State Health Department, Division of Licensure and Certification
- Licensing status (including initial licensing and any renewals) of licensed nurses – Alabama Board of Nursing
- Documents relating to alleged violations by licensed nurses of Board rules and regulations, or to any investigations of alleged abuse, fraud, neglect or exploitation by licensed nurses, or to any disciplinary proceedings -- Alabama Board of Nursing
- Licensing status of nursing home administrator-- Board of Examiners of Nursing Home Administrators
- Documents relating to alleged violations by nursing home administrator of Board Rules and regulations, or to any investigations of alleged abuse, fraud, neglect or exploitation by nursing home administrator, or to any disciplinary proceedings – Board of Examiners of Nursing Home Administrators
- Medicare and Medicaid reimbursement documents
- Acute care hospital records
- Treating physician records
- Police reports