

TRYING A NURSING CARE CASE

I. PROJECTED NEEDS FOR LONG TERM CARE

- **Long Term Care:** a variety of services that help people with their medical and non-medical needs over a period of time.
- Most long term care is **custodial care** that involves help with bathing, dressing, eating, toileting transferring, housekeeping, etc.
- **70% of 65-year-olds will need some form of long-term support and services:**
 - 42% will have a need that lasts less than a year at home.
 - 37% will have a need that lasts less than a year in a facility.
 - Average duration is 3 years (3.7 years women, 2.2 years men).
 - 20% will need some sort of help for 5 years.

Source: US Dept of Health and Human Services 2020

<https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html>

1. Facility Care

- **Independent Senior Living**
 - Apartments, homes in large facility or complex
 - Residents do not need hands-on care.
 - Meals, housekeeping available; social and physical activities.
- **Assistant Living Facility (AL)**
 - Private apartments; monthly rental.
 - Need some assistance with daily tasks, but not 24/7 skilled nursing care.
 - Assistance with activities of daily living and medication management.
 - Meals; housekeeping; activities.

- **Memory Care Units**
 - Often part of assistant living; secure.
 - 24-hour supervision by specially trained staff.
 - Private or semi-private rooms.
 - Meals, housekeeping; activities.
- **Residential Care Homes (Board and Care)**
 - Supervised care, meals, activities and health management.
 - Private or semi-private room in a house.
 - Usually about 4-6 residents.
- **Skilled Nursing Facility – SNF (Nursing Home)**
 - Requires physician orders.
 - 24-hour monitoring and medical care.
 - Bed-ridden and/or wheelchair bound.
 - Dining rooms for those who are able.
 - Individual and group activities.

2. Continuing Care Retirement Communities (CCRC)

- **AKA** Life Care Facilities
- Many levels of care in one community:
 - Independent apartments.
 - Assistant Living/Memory Care
 - Skilled Nursing Facility – SNF

- If needs change, can move smoothly to the next level of care w/o having to completely change environment.
- Most require buy-in fees and monthly payments.

II. PRESSURE WOUND: THE LAW AND MEDICINE

a. STANDARD OF CARE

Regulation Section 483.25(c) Pressure Sores.

F-Tag F314 provides the following definitions:

“Pressure Ulcer”—A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to underlying tissue(s). Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers.

“Avoidable”—means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with the resident’s needs, resident’s goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

“Unavoidable”—means that that the resident developed a pressure ulcer even though the facility had evaluated the resident’s clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with the resident’s needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

The Centers for Medicare and Medicaid Services (CMS) Guidance to Surveyors for Long Term Care Facilities, “F-Tag” designated requirements of participation: F-Tag F314 provides:

Based on the comprehensive Assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores should not develop pressure sores unless the individual's clinical condition demonstrates that they were unpreventable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The National Pressure Ulcer Advisor Panel (NPUAP) recognizes six categories of pressure wounds:

- Stage I: Non-blanchable area of red skin
- Stage II: Partial thickness skin loss or blister
- Stage III: Full thickness skin loss (fat visible)
- Stage IV: full thickness skin loss (muscle/bone visible)
- Unstageable: Full thickness skin or tissue loss-depth unknown due to surface eschar
- SDTI: Suspected deep tissue injury, intact surface skin with damage of underlying tissue to unknown depth

b. DEFENSES

- i. Not facility acquired: Whether the pressure wound was community acquired or facility acquired? When the wound progressed from partial to full-thickness (from Stage II to Stages III, IV, or Unstageable)? If the patient or resident is transferred from one facility to another, explore discrepancies that may exist in the wound assessments at each facility, which casts doubt as to where the harm occurred. Suspected deep tissue injuries (SDTI) are often mistaken for Stage I wounds, but may indicate that underlying tissue damage has already occurred and will inevitably evolve.
- ii. Not caused by Unrelieved Pressure: not all wounds are caused by pressure, but may be traumatic, vascular or dermatological. Heel pressure wounds often have a vascular component which, if not causative, contributes to the resident's inability to heal.
- iii. Patient Non-Compliance: Whether non-compliance provides an effective defense depends on the patient or resident's mental status,

the degree to which patient resistance prevented offloading, the documentation of frequency of refusals to turn, and whether alternative measures were employed by nursing.

- iv. Two hour turning not required: Defense experts are relying on studies that question the need for two hour turning and repositioning. See Turning for Ulcer Reduction: Nancy Bergstrom, et al., *A Multisite Randomized Clinical Trial in Nursing Homes*, J. Amer. Geriatric Society, 61:170S-1713 (2013) (finding no difference in incidences of pressure ulcer for patients on 2, 3 and 4 hour turning schedules). Two hour turning is a NPUAC “guideline” and not a rule, but is a universally adopted standard in virtually all hospital and nursing home nursing policies and procedures.
- v. Unavoidable or Unpreventable
 - 1. Center for Medicare Services (CMS): In 2007, CMS classified full-thickness pressure ulcers (Stage III and IV) as “never events,” meaning that pressure ulcers should never occur or are reasonably preventable.
 - 2. National Pressure Ulcer Advisory Panel Consensus Conference: In 2010, the NPUAP convened a multidisciplinary conference on whether there are individuals in whom pressure ulcer development may be unavoidable. See Joyce Back, et al., *Pressure Ulcers: Avoidable or Unavoidable? Results of the NPUAP consensus Conference*, Wound Ostomy Management, 57(2):24-37 (2011). The conference reached consensus on the following: most pressure ulcer are avoidable; not all pressure ulcers are avoidable; there are situations that render pressure ulcer development unavoidable, including hemodynamic instability that is worsened by physical movement and inability to maintain nutrition and hydration status and advanced directives prohibiting artificial nutrition and hydration.
 - 3. Wound Ostomy and Continence Nurses Society Position Statement: Avoidable v. Unavoidable Pressure Ulcers: While recognizing unavoidable pressure ulcer can occur, the Society supports the use of evidence based clinical practice guidelines to reducing prevalence and incidence of pressure ulcers.

4. In 2014, the NPUAP Consensus Conference concluded that “in the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer formation.” However, consensus was reached that the following conditions increase the risk for unavoidable pressure ulcers:
 - a. significantly altered cardiopulmonary status;
 - b. when sustained head of the bed over 30 degrees is medically necessary;
 - c. hemodynamic instability requiring pressor support;
 - d. sepsis;
 - e. extensive body edema;
 - f. severe burn injuries;
 - g. medical devices or pelvic or spinal cord injuries that preclude turning and repositioning;
 - h. immobility;
 - i. terminal illness;
 - j. severe malnutrition in combination with multiple comorbidities; and
 - k. Cachexia.

See Laura Edsberg, et al. *Unavoidable Pressure Injury, State of the Science and Consensus Outcomes*, J WOCN, 41(4)313-334 (2014).

III. CORPORATE NEGLIGENCE LAW UPDATE

- A. Theory of Direct/Corporate Negligence articulated in *Thompson v. Nason Hosp.*, 591 A.2d 703 (Pa. 1991)
- B. Expand the reach of *Thompson’s* definition of “health care entities”
 - i. HMOs if the HMO provides healthcare services, “the same or similar functions as a hospital” *Shannon v. McNulty*, 718 A.2d 828, 836 (Pa. Super. Ct. 1998)
 - ii. Professional medical corporations See *Hycza v. W. Penn Allegheny Health Sys., Inc.*, 978 A.2d 961 (Pa. Super. Ct. 2009) *appeal denied*, 987 A.2d 161 (2009).
- C. Does not include physicians’ outpatient offices See *Sutherland v. Monongahela Valley Hosp.*, 856 A.2d 55 (Pa. Super. Ct. 2004).

D. Finally, skilled nursing facilities

iii. *See Scampone v. Highland Park Care Ctr., LLC*, 57 A.3d 582 (Pa. 2012)

1. Nursing home management company and nursing home facility's grant of nonsuit reversed and denial of nonsuit affirmed, respectively and remanded for examination of duty in tort.

IV. CASE SELECTION AND PRETRIAL PROCESS

a. SCREENING PROCESS

i. Client Meeting:

1. Identify the appropriate plaintiff: Power of Attorney, Executor, Estate Administrator, Next-of-Kin, heirs and beneficiaries
2. Obtain medical history: Obtain a chronology of facility admissions and list of outpatient treatment locations
3. Documentations: Death certificate, Will, Living Will, DNR, photographs of injuries, documents provided by the nursing home (admission agreement, pamphlets, advertising, arbitration agreement), health insurance information, short certificate, correspondence from the nursing home, Department of Health or federal agency.

ii. Raising an Estate:

Via probated Last Will and Testament or administration. Identify Executor, Administrator, beneficiaries and heirs. Obtain original Death Certificate and notarized renunciations. Meet client at Register of Wills and instruct to bring identification, and marriage/birth certificates.

iii. Medical Charts

1. Medical records

- a. Facility
- b. ER, hospital or subsequent facility
- c. Nursing records

- i. Assessments
 - ii. Care plans
 - iii. Notes
 - iv. Flowsheets
 - v. CNA ADL sheets or caretracker
 - vi. Wound tracker and consults
- d. Minimum Data Sets (MDS)

iv. Medicare and Department of Health Websites

1. Survey reports: was the facility cited by Department of Health? Have the client report the nursing home to the Pennsylvania Department of Health:

Nursing home and long term care facilities: 1 800 254 5164
 Assisted living and personal care home: 1 877 401 8835

The complaint process is described at:

http://www.portal.health.state.pa.us/portal/server.pt/community/complaint_form/20164

2. Key staff: Identify the Nursing Home Administrator, Director of Nursing, managing employee
3. Ownership information: The Medicare website identifies the entities having an ownership interest in the facility. It also identifies the facility operator and any management company. The Medicare compare site is at

www.medicare.gov/nursinghomecompare/search.html#

4. County v. Private: County owned facilities and staff have governmental immunity under state law. Consider federal civil rights claim. *See Grammar v. Kane Regional Centers*, 570 F.3d 520 (3d Cir. 2009) *cert denied*, 130 S. Ct. 1524 (2010) (recognizing federal civil rights claim under Section 1983 for violation of rights granted by FNHRA). However, a plaintiff has a high burden to establish a civil rights violation. Also consider whether the facility has a private management

company by reviewing Medicare Website or Pennsylvania Department of Health Nursing Home Locator at

<http://app2.health.state.pa.us/commonpoc/nhlocatorie.asp>

v. Certificate of Merit: The certificate must be signed by an expert who would be qualified at trial to provide opinion testimony on the standard of care and medical causation. The standard is whether a “reasonable probability” exists that the skill or knowledge exercised or exhibited in the treatment, practice or work provided by the defendant fell outside acceptable standards and was a cause in bringing about harm to the patient/resident.

vi. Liens:

1. Medical-Medicare, DPW and private insurance
2. Estate lien-DPW

vii. Identify the Defendant:

1. Department of Health Facility locator locator page:

<http://app2.health.state.pa.us/commonpoc/nhlocatorie.asp>

2. Medicare Website contains lists of the owners and operators of all nursing homes at

www.medicare.gov/nursinghomecompare/search.html#

3. Licensure file from Department of Health from

Director William Bordner
Division of Nursing Care Facilities
Pa. Department of Health
Health and Welfare Building, Room 528
7th & Foster Streets
Harrisburg, PA 17120

4. Identify if the facility is operated by a management company, especially if County owned

- viii. Venue: Nursing home claims are subject to Pa. R.C.P. 1006 (a.1) and (c)(2) and must be brought in a county in which the cause of action arose. Some nursing facilities are not separately incorporated and owned by parent company outside of Pennsylvania, giving rise to diversity jurisdiction. A Plaintiff may consider joining non-diverse parties, such as the NHA, DON or individual tortfeasor, to prevent federal court removal.

V. DISCOVERY

- i. Documents from defense

- 1. Incident reports and staff statements
- 2. Missing chart records
- 3. Reports to Department of Health
- 4. Facility Policies and Procedures

- ii. Third Party records

- 1. Department of Aging and Department of Health records
- 2. Subsequent treaters and providers (may have wound photographs)
- 3. Medicare Quality Improvement Organization: Livanta
- 4. Police report

- iii. Identify key staff:

- 1. Nursing Home Administrator
- 2. Director of Nursing
- 3. Assistant Director of Nursing
- 4. Charge nurse, Registered Nursing Assessment Coordinator (RNAC)

5. Dietician, physical therapist, pre-admission assessor
6. Staff involved with care, including RNs, LPNS, CNAs
7. Contact providers

iv. Staff depositions

1. Goals: identify the goal for the deposition. Does the witness have an independent recollection? What did the witness author in the chart and what does it mean? Have the witness explain nursing practices and procedures and record keeping practices, identify the authors of records and supervising staff, describe staff turnover and describe any internal investigation efforts, findings, and conclusions. Identify any opinions the witness intends to provide at trial. Obtain opinions from the witness on standards, practices and expectations that may contradict the defendant's expert.
2. Doctors and third party contractor staff: Consider whether to avoid as possibly counter-productive.

v. Expert reports:

1. Physician and nurse.
2. Violation of Omnibus Budget Reconciliation Act ("OBRA"), also known as the Nursing Home Reform Act of 1987, and Pennsylvania Department of Health regulations:
 - a. Federal regulations: 42 CFR ch. IV, Subpart B, Sections 483.1-483.75. See Addendum 1.
 - b. Pa State regulations: 28 Pa. Code Sections 201-215

VI. TRIAL

a. Six week Pretrial check list:

- i. Schedule experts
- ii. Notice defense witnesses
- iii. Obtain updated lien information and stipulation on medical costs
- iv. Motions in Limine: Unproduced records, prejudicial comments, unqualified or cumulative expert testimony, testimony concerning undocumented care.
- v. Retain a trial technology presentation service
- vi. Research defense experts writings, cited authorities and prior testimony

b. Direct Witnesses

- i. Hospital wound Nurse on direct: certified wound nurses will provide useful testimony, that may conflict with the defense expert, concerning the importance of assessments, documented offloading and timely consults, and when a wound may be considered unavoidable. At deposition, confirm the wound consult has no opinion as to why the wound developed.
- ii. Hospital nutritionist on direct: The nutritionist will testify that the patient was not at risk for nutrition, which undercuts a claim the wound was unavoidable, or will testify that all necessary nutritional support was provided. This witness will not help if the patient refused nutritional support or failed to thrive despite all nutritional interventions
- iii. Nursing staff as of cross: independent recollections, confirm knowledge, experience and skill if made useful assessments, documentation practices, experiences with wounds.
- iv. Patient's Family: observations during visits concerning wounds and offloading, what and when they were told, complaints of care. Did they bring the wound to the staff's attention?

- v. Former CNA employees for direct testimony on under-staffing conditions and impact of understaffing on resident care.

c. Defense witness cross-examination materials:

- i. Documentation gaps and omissions: With electronic records explore documentation practices and options. Electronic records identify the specific time information is entered. Identify when during a shift charting was being performed (are the nurses pre-documenting turning?). Where check boxes used: Did the staff document the use of devices such as a clip or pressure pad alarm, or more frequent checks? Were the Braden Pressure wound risk assessments consistent? Was a full-thickness pressure wound documented after within normal assessments during prior shift?
- ii. Surveillance: Does the facility have hallway cameras that may show how long the resident was unsupervised? If the video recording was not preserved, is there a spoliation claim or argument?
- iii. Incident reports: Was the incident report to the Department of Health in an Event Report? Were witness statements obtained? What new interventions were added to the Care Plan after the accident and were they feasible before it happened?
- iv. Literature: National Pressure Ulcer Advisory Panel (NPUAP) and Wound and Ostomy Nurses Society Publications: These organizations publish policy and consensus papers on unavoidable wounds and whether most wounds are avoidable. The consensus is that a pressure wound cannot be deemed unavoidable unless every reasonable intervention was tried.
- v. Turning studies: Use the documentation forms from studies that question the efficacy of two hour turning and repositioning for pressure wound prevention to show strict enforcement of documentation practices skewed results. In these studies, pressure wound prevalence rates were very low for both two and four hour turning schedules because strict documentation acted as reminders to staff and enforcement tool for supervisors.
- vi. Defense expert witnesses:

1. Obtain prior reports and testimony from Association of Justice List Serve members, or Trialsmith, Westlaw or Lexus.
2. Obtain publications listed on expert's CV.
3. Search online for prior statements, experts' marketing and advertising.
4. Search dockets for prior lawsuits involving expert, contact former adverse counsel.