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Why Institutions Lose Lawsuits (And Why They Might Deserve To)

Memorial Herman Hospital System
"Pressure Ulcers and the Law" Seminar

By

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Introduction

There is no doubt that litigation over the negligent occurrence of pressure sores has become very prevalent. Some of these cases can be categorized as frivolous, some are justly categorized as disputed, and others can be classified as clear liability cases. Obviously, the institution fights the frivolous claims and tries to settle those claims where there is undisputed evidence of liability. This leaves the category of disputed claims. In a disputed claim, the institution believes that they have abided by the appropriate standards of care or have an adequate defense, which frequently involves the "unavoidable" pressure sore and the "presumption of care." The question then becomes: How does a disputed claim evolve into the monster that ate the nursing home? This article answers this question, providing a unique glimpse into the reasons why nursing homes not only lose pressure sore cases, but also how denials of neglect by the facility and refusal to accept responsibility for the occurrence and progression of a pressure sore can, under certain circumstances, significantly aggravate legal exposure.

The Evolution of Nursing Home Litigation

In days gone by, malpractice cases involving long-term care residents generated little interest on the part of the legal profession. The occurrence of a negative outcome in a nursing home was simply viewed as the "will of God." Seldom was the conduct of a facility or its staff questioned. Complaints of nursing home neglect or abuse were rarely entertained by attorneys and it was an even rarer occasion that allegations of this nature materialized into a successful lawsuit.[1] Perceived by practicing lawyers as economically nonviable cases due to the absence of provable lost income and the presence of complex medical histories, making it difficult to distinguish the sequelae of neglect from the natural progression of the underlying disease, geriatric residents had virtually no recourse against a nursing home or its employees for mistreatment.

In the late 1970s as the public's intolerance for widespread nursing home neglect and as abysmally poor care in America's long-term care institutions grew, the legal community began to reassess its earlier position. Undoubtedly fueling this evolutionary process was the continual flood of profoundly disturbing exposés, studies, and investigations dealing with the hazardous and life-threatening conditions that many nursing home residents encountered.

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[1] Marks, David T. "Legal Implications of Increased Autonomy." *Journal of Gerontological Nursing* 19.3 (March 1987).

Typical of the voluminous findings are those made public in 1974 by the Senate Special Committee on Aging, 93rd Cong., 2nd Sess. Following a fifteen year study, the Committee concluded that at least half of the nation's nursing homes had one or more serious, life threatening conditions, and that residents frequently encountered abuse and physical mistreatment, including negligent and intentional actions by nursing staff which led to injury or death."[2] A succession of state and federal studies in the 1980s confirmed that the evidence of abuse and neglect identified in the past, continued to persist. The seminal report by the Institute of Medicine in 1986 reiterated the ongoing problems of grossly inadequate nursing home care with its finding that:

> Today, nursing homes can be found in every state that provide seriously inadequate quality of care. In many government certified nursing homes, individuals who are admitted receive very inadequate – sometimes shockingly deficient – care that is likely to hasten the deterioration of their physical, mental and emotional health.[3]

Unfortunately, public and congressional concern about the prevalence of nursing home neglect has not abated since the IOM report. Recent congressional reports and findings by the U.S. General Accounting Office of the Inspector General have identified a range of serious problems including pressure sores, malnutrition, dehydration and widespread neglect attributable to inadequate staffing.[4]

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[2] Subcommittee on Long-Term Care of the Aged. Senate Special Committee on Aging, Nursing Home Care in the United States: Failure in Public Policy No. 93-1420, 93rd Cong., 2nd Sess. (1974). Over thirty years after the Senate's findings, the issue of elder abuse has become such a major concern that two bills have been introduced into the legislature, the "Elder Justice Act" and the "Patient Safety and Abuse Prevention Act," to protect the most vulnerable Americans who need long-term care. *Abuse of our Elders: How We Can Stop It: Hearing before the Special Committee on Aging*, U.S. Senate, 110th Cong., 1st Sess. (2007).

[3] Institute of Medicine (U.S.). Committee on Nursing Home Regulation. *Improving the Quality of Care in Nursing Homes*. Washington, D.C.: National Academy Press, 1986.

[4]U.S. General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999); U.S. General Accounting Office, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).
[4] *Abuse of Residents Is a Major Problem in U.S. Nursing Homes*, U.S. House of Representatives, Committee on Government Reform, Special Investigations Division, Minority Staff, July 2001, at 4-5; *Nursing Home Conditions in Texas, Many Nursing Homes Fail to Meet Federal Standards for Adequate Care*, U.S. House of Representatives, Committee on Government Reform, Special Investigations Division, Minority Office, October 2002; see Report following page 187. "Of the 1,148 nursing homes in Texas, only 161 facilities (14%) were found to be in full or substantial compliance with the federal standards. In contrast, 987 nursing homes (86%) had at least one violation with the potential to cause more than minimal harm to residents or worse" *Id. See also*, GAO, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, GAO-08-517 (Washington, D.C.: May 9, 2008); GAO, *Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations*, GAO-07-373 (Washington, D.C.: May 29, 2007).

Such reports have caused long-term care facilities to become symbols of abandonment, isolation and neglect; galvanized public concern for the quality of care provided the aged; led to the 1987 Omnibus Budget Reconciliation Act (OBRA)[5] which established federal standards for Medicare-certified nursing homes; and, have increased the likelihood that consumers in cases where elder malfeasance is suspected, will seek legal counsel.

Awakened to the effects of iatrogenic and nursigenic[6] behavior by years of publicity, both public and private attorneys began to pay careful attention to allegations of substandard care and to slowly explore the legal dimensions of nursing home liability. By 1990, following a flurry of highly publicized scandals including the prosecution of a nursing home corporation for the murder of many residents,[7] a growing number of plaintiff and defense firms realized that nursing home litigation represented a new legal frontier. Bolstered by the universal standards of care imbedded within state and federal regulations as well as the Institute of Medicine's list of potential indicators of neglect, Plaintiffs firms began to devote substantial resources to this new area of law, with some limiting their practices exclusively to the area of nursing home litigation. In response to the rising number of lawsuits, prominent defense firms entered into this practice area, creating litigation sections to handle a new client base made up of nursing homes and their insurers.

In the wake of this changed climate, a plethora of legal precedent has evolved holding that nursing homes can be liable for not only actual and punitive damages, but also for crimes ranging from fraud, tampering with a governmental record, theft by deception, criminal abuse, and even homicide. In the past 15 years perhaps no subject in the field of nursing home litigation has received more attention than the pressure ulcer case. Identified as being a symbol of the same kind of scandalous and repugnant neglect found by Congress to exist in America's nursing homes, the pressure sore has been at the forefront of this relatively new and growing area of litigation.

Why Lawyers Lose Pressure Ulcer Cases (And Why They Might Deserve To)

The most important decision made on a recurrent basis by a lawyer who has a nursing home practice is the decision to accept a case and invest time and money towards

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[5] 42 U.S.C. §§ 1320a *et seq.* and 42 U.S.C. §§ 1396 *et seq*., as amended.

[6] For a proposed definition see: Miller, M. "Iatrogenic and Nursigenic Effects of Prolonged Immobilization of the III Aged." 23 J. AM. GERIAC SOC. 360-369 (1975). "…In a variety of dictionary and word sources, terminology identifying a nurse-induced abnormal state in a patient by inadvertent or erroneous treatment is singularly lacking. In the absence of a suitable word, we propose the term 'nursigenic,' derived from the French 'nourrice' for nurse." *Id*.

[7] *State of Texas v. Autumn Hills Convalescent Center, Inc.*, No. 85-CR-2625 (Dist.Ct. of Bexar Co., 187th Judicial Dist. of Texas, March 25, 1986).

its resolution. The lawyer prone to accept a number of speculative or marginal cases is destined to drain his or her office of the substantial energy and resources needed to pursue meritorious claims. Perhaps nowhere is this more true than in the evaluation of cases arising out of the occurrence of a pressure sore.

The most common pitfall in evaluating a pressure sore case grows out of the flawed belief that the occurrence, in and of itself, of a pressure sore in a nursing home is prima facie evidence of negligence. Many lawyers inexperienced in the prosecution of pressure sore cases operate under the mistaken premise that when it comes to the question of nursing home liability, all pressure sores are created equal. They are wrong. Attorneys who blindly accept a pressure sore case without carefully considering the patient centered medical and nursing diagnosis as well as relevant environmental factors impacting the care in the nursing facility are likely to find themselves in a losing lawsuit or a case where the cost of litigation exceeds recovery.

For example, a claim solely based on a pressure ulcer located on an extremity carries significant risk growing out of the incidence and likelihood of peripheral vascular disease (PVD). Certainly, the presence of advanced PVD in a heel pressure ulcer case diminishes the exposure, presenting the nursing home with a compelling argument as to the unavoidability of the wound. Recognizing this potential defense, a knowledgeable litigator will carefully consider and weigh the degree of underlying disease process before accepting the prosecution of such a cause of action. The unseasoned lawyer, on the other hand, will unwittingly assume that liability is effectively determined by the mere existence of the pressure sore. As a consequence, the exposure analysis by the latter is contaminated by the false presumption of liability.

Pre-suit evaluation of a pressure sore case also requires a basic understanding of the evolution, severity and duration of the wound. Failure to appreciate the ulcer's chronological progression, distinguishing the in-house tissue damage from that which occurred outside the facility, can prove fatal to a lawyer's financial health. Likewise, an attorney who pursues a case based primarily upon the occurrence of a superficial pressure sore places both his pocketbook and pride at risk. Ignorance or willful disregard of the forgoing principals of case screening is a root cause of frivolous lawsuits and legal misadventure.

Notwithstanding the importance of the above principles, the strongest predictor of the outcome of a pressure ulcer case is the presence of devastating evidence of care deprivation caused by a facility in meltdown and multi-system failure. In a properly vetted pressure sore case, the lawyer who fails to consider or comprehend the impact of systemic neglect which has metastasized throughout the operational body of the nursing home proceeds at this own financial peril. Given the endemic care problems that have plagued nursing homes for over three decades and the pronouncements from no less an

authority than the IOM[8], the Agency for Health Care Policy and Research,[9] and leading Geriatric practitioners,[10] that pressure sores are not only preventable but also a potential indicator of neglect, the consideration that a decubitus ulcer was possibly caused by the ongoing failure to comply with physicians' orders and standard care measures should, at a minimum, be a part of the attorney's differential reasoning process.

The myopic view that avoidability or unavoidability of a pressure sore should be determined in a vacuum, considering only the medical diagnoses and functional disability of the resident, ignores the environmental influences and is no more valid than the belief that a pressure sore is always a *res ipsa* indicator of neglect. Accordingly, in examining the occurrence of a pressure sore, the evaluator must not be blind to either: 1) the underlying medical condition and functional decline of the resident; or 2) the environmental causes that limit or destroy the delivery of essential care to the resident.

Telltale Signs of Malignant Neglect Which Are Often Ignored

It has long been clear that staffing shortages and inadequate staff expertise are major factors in poor quality, resulting in extremely low levels of incontinent care; turning, repositioning; low rates of ADL care; sporadic assistance with feeding; and negative patient outcomes.[11] Moreover, it has long been known that the single most important factor related to poor nursing home quality is the inadequate numbers and training of nurses and nurse aides.[12] The link between low staffing levels and quality problems is intuitively obvious. If all of the nursing staff in a facility were removed, the resident population would be in severe jeopardy.[13] Clearly, there is a minimum threshold ratio of nurses and nurse aides to residents, below which nursing home residents are at

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[8] IOM, *Improving the Quality of Care in Nursing Homes*, Appendix E: 378-388.

[9] Panel for the Prediction and Prevention of Pressure Ulcers in Adults. Clinical Practice Guideline Number 3: *Pressure Ulcers in Adults: Prediction and Prevention*. Rockville, Md: US Department of Health and Human Services. Public Health Service. Agency for Health Care Policy and Research; 1992. AHCPR Publication 92-0047.

[10] Kane, Robert L., Joseph C. Ouslander, and Itamar B. Abrass. *Essentials of Clinical Geriatrics*. 4th ed. New York: McGraw, 1999; Calkins, Evan, Amasa B. Ford, and Paul R. Katz, eds. *Practice of Geriatrics*. 2nd ed. Philadelphia: Harcourt Brace Jovanovich, Inc., 1992; Katz, Paul R. and Evan Calkins, eds. *Principles and Practice of Nursing Home Care*. New York: Springer Publishing Co., 1989.

[11] Kovner, Christine, Mathy Mezey, Jeanie Kavser-Jones, et al. "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States." *The Gerontologist* 40.1 (2000): 5-16.

[12] U.S. Senate Special Committee on Aging Forum, *Nursing Home Residents: Short-Changed by Staff Shortages*, November 1999. Chair, Senator Charles Grassley; Moderator, Charlene Harrington, Ph.D., R.N., Professor, Department of Social and Behavioral Sciences, University of California, San Francisco, California.

[13] Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final, December 2001: 1-5.

substantially increased risk of quality problems including the occurrence of pressure sores.

This minimum threshold was empirically established in late 2001. On December 24, 2001, the long awaited and comprehensive report mandated by Public Law 101-508 on the minimum nurse and nurse aide ratios was delivered to Congress. This seminal report presented strong and compelling empirical evidence validating the solid link between critical, threshold amounts of nursing staff time per resident and negative resident outcomes. Analyzing data from over 5,000 representative nursing homes from ten states, as well as time and motion studies and computer modeled care simulation, it was empirically determined that the critical staffing threshold for nurse aides in a long stay nursing home population was **2.8 hours per resident day to 3.0 hours per resident day**.[14]

The existence of this lower bound threshold of 2.8 hours per patient day has significant ramifications in a pressure ulcer case where the pivotal question often boils down to: was the basic care widely recognized as necessary for the prevention of pressure ulcers and/or existing decubitus provided? Obviously, evidence that during the course of the ulcer's development and progression the nurse aide to patient ratio in the facility was fifty percent (50%) below the minimum critical level has significant cause and effect implications and is, therefore, highly relevant to the above-posed question. In this example, the nursing home that desperately clings to the presumption that a pressure sore resident received routine and necessary preventive care, in the face of the strong causative relationship between grossly insufficient nurse aide ratios and extremely low rates of incontinent care, turning and ADL care, not only assumes an intellectually dishonest position but also enters into dangerous legal waters.

Furthermore, in a case where there are major deviations from the nurse aides critical staffing thresholds, the probability that a resident was intensely deprived of routine care necessary to prevent the development and progression of a pressure ulcer *significantly increases* when one or more of the following conditions are present:

1) **Financial Needs of the Corporation Take Priority Over the Needs of Residents**. The corporate parent strips the nursing home and clinical staff of its authority to make critical operational decisions at a local level including ratios of staff to residents, census levels and mix, census targets, and minimum revenues and expense ratios. Instead, at all relevant times such decisions are made and tightly controlled at a corporate level due to *revolving credit and loan agreements* requiring said corporation to comply with *minimum threshold levels* of census revenues, and revenue to expense

[14] *Id*. at 1-8.

ratios which are required to be reported to the bank on at least a monthly basis**.**

2) **Census and Acuity Increases, Staffing Does Not**. The nursing home dangerously drives its census and acuity levels up through a relentless and aggressive marketing campaign, while at the same time refusing to allocate sufficient funds to increase staffing levels to meet the rising patient population needs.

3) **No Moratorium in Patient Admissions**. The nursing home/corporate parent dangerously decides to increase revenues in the facility by increasing census and/or resident acuity levels when; (a) the nursing home's staffing levels (which are available at www.medicare.gov) are well below the critical threshold ratios identified by the government; and/or, (b) the facility has been cited in regulatory findings for a litany of violations, causing actual harm to residents due to insufficient staff and widespread failure to provide for basic ADL care needs.

4) **Significant Percentage of Direct Care Provided by Repeat Criminal Offenders**. Still another practice which should raise a red flag about the reliability of the care giver staff and their provision of care is evidence that a significant portion of the routine care required to prevent the occurrence and progress of pressure sores was assigned to and documented by employees having been convicted of crimes of moral turpitude.

5) **Insufficient Numbers of Licensed Staff, Uncertified and Incompetent Nurse Aides, and Exceptionally High Turnover**. The likelihood of persistent failure to provide basic care further escalates in the presence of: a) major deviations by the facility from empirically established RN and licensed staff critical thresholds;[15] b) the prevalence of uncertified and unqualified nurse aides in the subgroup of caregivers who were responsible for providing nursing and nursing related care to the resident; and, c) excessive rates of turnover in not only direct care givers but also facility management.

6) **Adverse Regulatory Findings** (Available at www.medicare.gov). Further potentiating the likelihood of care deprivation is evidence at relevant times that the nursing home was cited by state regulators for: a) the practice of failing to provide adequate turning, repositioning, incontinent care, ADL

[15] The minimum threshold for RNs was determined to be .75 hours per patient day in a long stay nursing home. Additionally, the threshold for licensed staff in such a facility was determined to be 1.3 hours. *Id*. at 2-17.

care, treatment of pressure sores or notify the physician of significant changes in the condition of a pressure sore; and/or, b) actual harm by causing avoidable pressure sores. For example:

- State investigator, by marking the sheets and observing a resident over a four day survey, finds that the resident who had a Stage IV coccyx pressure sore was not repositioned off of his back for 6 straight hours on each of the survey dates, despite doctor's orders to turn every two hours and documentation by the nursing home that such care was provided;

- State investigator observes that physician's orders for treatments are not performed for three straight days and coccyx pressure sore deteriorates; and

- Later, state investigator finds that these treatments were initialed as performed in the treatment records, when in fact, they were not.

7) **Strikingly Discrepant Findings**: **Nursing Home Discharge Picture v. Hospital Admit Picture**. Still another relevant indicator of ongoing indifference for the resident is found when a resident, upon admission to a hospital, is discovered in the Emergency Room to have a large, deep, Stage III or IV pressure ulcer surrounded by erythema which the nursing home was oblivious to. This is particularly true where the nursing home routinely charted on each shift during the four days prior to discharge to the ER that the resident received incontinent care every two hours, calmoseptive ointment was applied to the buttocks after each incontinent episode, and no skin breakdown was present. Obviously, the stark absence in the nursing home records of any reference or mention of the significant wound should raise serious questions about the facilities care and concern for the resident.

8) **Huge Gaps in Care Services Found Throughout Medical Records**. In addition to the above predictors, a further sign and symptom of systemic neglect caused by dangerous staffing levels can be found in a medical record containing huge gaps in nurse notes, skin assessments, treatment records and other important care documents. Examples of these include:

- Routine violation of physician's orders for pressure sore treatments;

- Ongoing failure to notify physician of new pressure sores and significant changes in an existing sore;

- Ongoing failure to notify the physician of ineffective treatment measures;
- Persistent violation of physician's orders for nutritional supplements, diet, and/or fluids;
- Large gaps in skin/wound assessments and nursing observations;
- Routine violation of physician's orders for pain medication;
- Routine failures to assess the resident's pressure sore pain;
- Continuing violation of physician's orders for equipment, i.e., specialty bed, specialty mattress, leg flotation devices, boots, etc.;
- Violation of dietary assessment recommendations;
- Failure to notify dietary consultant of significant changes in condition;
- Failure to plan care for: (a) risk of developing pressure sores; and/ or (b) significant changes in a pressure sore which requires modification of the care approach;
- No pressure sore risk assessments;
- Routine violation of orders to turn, reposition and keep off resident's back; and
- Routine failure to provide basic hygiene care, incontinent care, bathing and cleaning.

9) **The Routine and Rampant Practice of Falsifying Medical Records**. Certainly another practice which should cause concern about the delivery of care to a resident is the routine practice of falsifying medical records to make it appear that basic care services were provided to a resident. Examples of this include:

- Documenting the delivery of care services in the nursing home when the resident is in the hospital;

- Documenting the delivery of care services when the resident is dead;

- Routinely initialing care services as having been provided on dates and shifts when the care giver was not on duty; and

- Blatantly charting in a single sitting three weeks of care on every shift, all of which was purportedly provided by one super human care giver.

10) **Testimony of Key Care Givers Who Have the Most Knowledge of Relevant Care Practices and Care Provided to Resident**. The sworn testimony of treatment nurses, charge nurses and nurse aides who were most frequently assigned to render care to the resident or most often charted in the medical record is certainly probative on the question of whether the required care was provided. The direct knowledge by this staff of the care that routinely could or couldn't be provided to a resident is obviously an important barometer.

Why Institutions Lose Lawsuits (And Why They Might Deserve To)

The short answer to this question is that nursing homes lose because the overwhelming evidence shows the facility failed to provide essential and necessary care to prevent the occurrence and progression of the pressure ulcer. And why are nursing homes sometimes exposed to catastrophic financial losses in such a case? Because they refuse to acknowledge the devastating and compounding impact caused by the events described above and their responsibility for the sore. In summary, the monster swallows the nursing home when the facility not only neglects the resident but also the truth.