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NEW ISSUES IN LITIGATING NURSING HOME CASES

§1.00 Scope

The purpose of this paper is twofold: 1) to define the issues which litigators are commonly required to address in the course of a nursing home maltreatment case; and 2) to discuss new and evolving developments in this area of practice. Significantly, in the past twelve months three important subjects have come to the forefront in the area of nursing home litigation: 1) punitive damages; 2) negligence per se; and 3) the discovery and admissibility of survey and investigative reports conducted by the Texas Department of Human Services. These new issues as well as those questions which have traditionally been a part of a nursing home case are addressed in this article.

§1.01 Common Case Evaluation Concerns

The most important decision made on a recurrent basis by the personal injury practitioner is the decision to accept a case and invest time, experience and money towards 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 cases. Perhaps nowhere is this more true than in the evaluation of cases arising out of the alleged negligent conduct of health care professionals and long term care institutions. The cost of development, in terms of time and money, is so demanding that the initial determination as to whether a case is meritorious is of primary importance.

Evaluation of the nursing home malpractice treatment case begins with the proposition that the criteria traditionally utilized to assess the potential and quantity of recovery in a personal injury case (and for that matter, in a medical malpractice case) are simply not applicable to litigation arising out of neglect and injury of a long term care resident. Characteristically, in a significant personal injury case, plaintiff's health status at the time of the injury (made the basis of the lawsuit) makes him or her eligible for the full spectrum of traditional tort damages. In such a case, plaintiff's capacity for life and earnings, measured from that point in time when the injury is sustained, is sufficient enough to allow recovery for: (1) lost earning potential; and (2) future health care expenses. From a quantitative value perspective, the huge discrepancy between plaintiff's "before injury picture" and "after injury picture" constitutes the lifeblood of the significant personal injury case.

In a lawsuit filed on behalf of a nursing home resident for injuries or death allegedly caused by the wrongful conduct of a health care facility, the gap separating plaintiff's "before injury picture" and "after injury picture" is substantially smaller and arguably indistinguishable in many cases. Typically, plaintiff in a nursing home case is 67 to 95 years of age; frail and dependent upon the nursing staff for assistance with such basic activities of daily living as toileting, bathing, and ambulation;[1] and a recipient of Medicaid assistance.[2]

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[1] See Butler, *Nursing Home Quality of Care Enforcement, Part I -- Litigation by Private Parties,* 14 CLEARINGHOUSE REV. 622, 641 (1980).

[2] Eighty-three percent of all single residents entering a nursing home are impoverished within 12 months of admission. Fifty-eight percent of the married residents are impoverished within 12 months of admission. Of those individuals who enter a convalescent facility as private pay patients, 92% of the single residents and 80% of the married residents will "spend down" their income and resources to a poverty level within 104 weeks. Such spend down suggests that private patients are inevitably transformed into Medicaid recipients. BARRON'S MAG., June 2,1986, and U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES *Technical Work Group on Private Financing at Long-Term Care for the Elderly,* pp. 2-21.

Furthermore, plaintiff in such a case characteristically suffers from a cluster of maladies and diseases; commonly resembles a living chemistry set due to the large number of medications required to control preexisting conditions; and universally has a very limited life expectancy. As a consequence, plaintiff is not a candidate for damages based upon lost earning potential. The potential to earn wage or salary in most instances was impaired long before the resident entered the nursing home in question. In all likelihood, plaintiff's only source of income is a monthly Social Security check, the majority of which is paid to the nursing home.[3] Moreover, the ability of a nursing home victim to recover residual damages based upon continuing health care expenses; future pain, suffering and mental anguish; and diminished capacity to enjoy life in the future is severely limited by reason of the reduced and questionable length of plaintiff's life expectancy.

The foregoing case realities translate into the following significant liability and damage hurdles:

- How can plaintiff unravel the effect of neglect from the sequelae of underlying disease processes?

- As a practical matter, given the deteriorated health status and limited life expectancy of the resident upon admission to the nursing home, how has the conduct of the facility altered the resident's future?

- What is the likelihood of establishing a residual injury which will support a substantial award for future medical expense?

- Can a causal link between the alleged nursing home neglect and the destruction of capacity to earn wage or enjoy life be established?

- Have the statutory beneficiaries of the resident suffered any (1) pecuniary loss, (2) mental anguish, (3) impairment of familial interests, or (4) loss of inheritance as a result of said resident's wrongful death?

In the past, the inability of attorneys to overcome these obstacles has caused the plaintiff's bar to be unenthusiastic about nursing home maltreatment cases. However, since 1984, a growing number of litigators have consistently obtained six and seven figure verdicts and settlements ranging up to $90 million for personal injury, wrongful death, and survival actions arising out of the neglect of nursing home residents. Their efforts not only have established the principle that the quantitative value of a nursing home case cannot be accurately measured by traditional personal injury discriminators (such as those questions posed above) but also have given rise to clear fact patterns customarily associated with high verdict and settlement value. These patterns, as well as the legal and factual issues occasioned by such litigation, are explored throughout the remainder of this article.

§1.02 Causation: The Determinant Variable

[3]Such maintenance deductions can result in a net income of $25-$30 per month for the resident.

Before accepting a case founded upon allegations of nursing home neglect, the attorney for the injured resident must be satisfied that the omissions or acts of the defendant can be causally linked to the injury of the plaintiff. The injury suffered by the resident must be a natural and continuous product of the defendant's conduct, without which such injuries would not have occurred.[4]

It is a fundamental principle of the law of torts that a person who suffers injury is entitled to recover damages only if a connection between such damages and the wrongful conduct of the defendant can be established. There can be no recovery of damages if: (1) plaintiff's injury merely coincides with the proscribed activities of the defendant but is not causally related to plaintiff's condition in question; (2) plaintiff's injury was the result of existing disease processes not caused by defendant's conduct; or (3) the expense, pain, suffering and mental anguish suffered by plaintiff would have occurred even in the absence of the injury which serves as the basis for the cause of action.

Under the traditional standard of sufficiency of evidence for submitting a medical malpractice case to the jury, plaintiffs are required to adduce evidence of a "reasonable medical probability" or "reasonable probability" that their injuries were caused by the negligence of one or more defendants[5], meaning simply that it is "more likely than not" that the ultimate harm or condition resulted from such negligence.[6] As is true in other types of negligence cases, the ultimate standard of proof on the causation issue is whether, by a preponderance of the evidence, the negligent act or omission is shown to be substantial factor in bringing about the harm and without which the harm would not have occurred.[7] The effect of these standards is to bar recovery where the defendant's negligence deprived the tort victim of only a 50% or less chance of avoiding the ultimate harm. Stated another way, plaintiff must establish that the victim chance of avoiding the specific fatal injuries which caused death was greater than 50% prior to the occurrence of defendant's negligence. Hence, where preexisting illnesses or injuries have made improbable a patient's chance of avoiding the specific fatal injuries which produced death, the application of current causation principles will totally bar recovery for wrongful death.

[A] Pre-Existing Condition

It is well settled that an injured person is entitled to recover full compensation for all damage proximately resulting from the defendant's acts, even though his injuries may have been aggravated by reason of his preexisting physical or mental condition, rendered more difficult to cure by reason of his state of health, or more

[4] *Missouri Pacific Railroad Co. v. American Statesmen*, 552 S.W.2d 99 (Tex.1977*); Kramer v. Lewisville Memorial Hospital v. Lewisville Memorial Hospital*, 888 S.W.2d 397 (Tex.1993). The traditional test of causation is the "but for" or "sine qua non" test. Under this test, causation exists when the injury would not have occurred "but for" the defendant's tortious conduct. In recent years, the "substantial factor" test has been advocated as a replacement for the "but for" test. A force or condition is deemed a cause of a victim's harm when it was a "substantial factor" in bringing about that result. King, *Causation, Valuation, and Chance in Personal Injury Torts Involving Pre-existing Conditions and Future Consequences*, 90 YALE L. J. 1353, 1356 (1981)

[5] See, e.g., *Duff v. Yelin*, 751 s.w.2d 175, 176 (Tex.1988); *Lenger v. Physicians' Gen. Hosp., Inc.*, 455 S.W.2d 703, 706-07 (Tex.1970); Darrell L. Keith, *Loss of Chance: A Modern Poportional Approach to Damages in Texas*, 44 BAYLOR L.REV.759, 761-62 (1992)

[6] See *Lenger*, 455 S.W.2d at 707 Keith, 44 BAYLOR L.REV. at 761.

[7] See, e.g., *Havner v. E-Z Mart*, 825 S.W.2d 456, 459 (Tex.1992); *McClure v. Allied Stores of Texas, Inc.*, 608 S.W.2d 901, 903 (Tex.1981).

serious because of a disease,[8] than they would have been had he been in robust health. Preexisting weakness which results in the plaintiff suffering a worse injury than a normal person would suffer from the defendant's negligence is not in itself a grounds for defeating causation.[9] Thus, one who violates the duty imposed by law of exercising due care not to injure others may be compelled to respond in damages for all the injuries which he inflicts by reason of the violation of such duty, even if a particular injury may have been aggravated by or might not have happened at all except for the peculiar physical condition of the injured person. This is the maxim that "the defendant takes the plaintiff as he finds him," or the "thin skull" or "eggshell skull" rule.[10] Phrases such as “predispositions,” “latent illnesses,” “dominant conditions” and "the defendant takes the plaintiff as he finds him," all illustrate the attempt of the rules to deal with the fact that most people are not perfect specimens. A defendant may not avoid a

[8]*Valdez v. Lyman Roberts Hosp., Inc.* 638 S.W.2d 111 (Tex. App.--Corpus Christi, 1982, writ ref’d. n.r.e.); Stoleson v. United States 708 F.2d 1217 (7th Cir. 1983) (fact that the plaintiff’s vulnerability because of a pre-existing condition is psychological (predisposition to hypochondria) rather than physical is irrelevant); Maurer v. United States 668 F.2d 98;(2d Cir 1981); Henderson v. United States 328 F.2d 5O2 (5th Cir. 1964) (action under Federal Tort Claims Act; stating law of Alabama); Bowles v. Zimmer Mfg. Co. 277 F.2d 868 (7th Cir. 1960); Central Dispensary & Emergency Hospital, Inc. v. Harbaugh, 174 F.2d 507 (D.C. Cir 1949); Oliver v. Yellow Cab Co. 98 F.2d 192 (7th Cir. 1938); Underwood v. Smith, 261 Ala 181, 73 So.2d 717 (1954) (prior injury); Intermill v. Heumesser, 154 Colo 496, 391 P.2d 684 (1964); Turner v. Scanlon, 146 Conn 149, 148 A.2d 334 (1959); Flood v. Smith, 126 Conn 644, 13 A.2d 677 (1940); C.F. Hamblen, Inc. v. Owens, 127 Fla 91, 172 So 694 (1937); Wise v. Carter (Fla App Dl) 119 So.2d 40 (1960); Dzurik v. Tamura, 44 Hawaii 327, 359 P.2d 164 (1960); Reed v. Harvey, 253 Iowa 10, 110 N.W.2d 442 (1961); Knoblock v. Morris, 169 Kan 540, 220 P.2d 171 (1950); Louisville Taxicab & Transfer Co. v. Hill, 304 Ky 565, 201 S.W.2d 731 (1947); LaPleine v. Morgan’s L. & T. R. & S. S. Co., 40 La Ann 661, 4 So 875 (1888); Walters v. Smith, 222 Md 62, 158 A.2d 619, (1960); Coca Cola Bottling Works, Inc. v. Catron, 186 Md 156, 46 A.2d 303 (1946); Royer v. Eskovitz, 358 Mich 279, 100 N.W.2d 306 (1960); Nelson v. Twin City Motor Bus Co., 239 Minn 276, 58 N.W.2d 561 (1953); Smart v. Kansas City, 208 Mo 162, 105 S.W. 709 (1907); Rawson v. Bradshaw, 125 NH 94, 480 A.2d 37 (1984) (instruction that plaintiff was entitled to damages even though some of the injuries may have been rendered more difficult to cure by reason of plaintiff’s existing state of health conveyed idea that his injuries might have been aggravated or precipitated by reason of his pre-existing condition); Hebenstreit v. Atchison, T. & S. F. R. CO., 65 NM 301, 336 P.2d 1057 (1959); Reeg v. Hodgson (Scioto Co) 1 Ohio App 2d 272, 30 Ohio Ops 2d 293, 95 Ohio L Abs 148, 202 N.E.2d 310 (1964) (aggravated or accelerated); Maynard v. Oregon R. & N. Co., 46 Or 15, 78 P 983 (1904) (ovrld on other grounds) Fehely v. Senders, 170 Or 457, 135 P.2d 283 (1943); Watson v. Wilkinson Trucking Co., 244 SC 217, 136 S.E.2d 286 (1964); Cobb v. Waddell, 51 Tenn App 458, 369 S.W.2d 743, (1963); Watford v. Morse, 202 Va 605, 118 S.E.2d 681 (1961); Gregory v. Shannon, 59 Wash 2d 201, 367 P.2d 152, (1961); French v. Chase, 48 Wash 2d 825, 297 P.2d 235 (1956).

Complaint, petition, or declaration -- Allegations of aggravation of pre-existing physical condition, 8 AM. JUR. PL. & PR. FORMS (Rev), DAMAGES, Forms 16, 17 (1982).

Instructions to jury -- Liability for aggravation of pre-existing condition, 8 AM. JUR. PL. & PR. FORMS (Rev), DAMAGES, Form 225 (1982).

Instructions to jury -- Effect of Plaintiff’s susceptibility to injury because of previous infirm condition. 8 AM. JUR. PL. & PR. FORMS (Rev), DAMAGES, Form 257 (1982).

Proof, by testimony of plaintiff, of good health or disability prior to injury. 3 AM. JUR. POF 491, DAMAGES, Proofs 24, 25 (1959).

Holeman v. T. I. M. E. Freight, Inc. (WD Ark) 236 F Supp 462 (1964); Owen v. Dix, 210 Ark 562, 196 S.W.2d 913 (1946); Bruneau v. Quick, 187 Conn 617, 447 A.2d 742 (1982); Pozzie v. Mike Smith, Inc. (1st Dist) 33 Ill App3d 343, 337 N.E.2d 450 (1975); Gallardo v. New Orleans S.B. CO. (4th Cir (1984) 459 So.2d 1215; Owens v. Kansas C., S. J. & C. B. R. CO., 95 Mo 169, 8 S.W. 350 (1888) (disapproved on other grounds Moore v. Ready Mixed Concrete Co. (Mo) 329 S.W.2d 14); Sterrett v. East Texas Motor Freight Lines, 150 Tex 12, 236 S.W.2d 776 (1951); Reeder v. Sears, Roebuck & Co., 41 Wash 2d 550, 250 P.2d 518 (1952).

[9]22 AM. JUR. 2d, *DAMAGES*, §281 (1988).

[10]A person injured by the negligence of another is entitled to recover to the full extent of the injury so caused without regard to whether, owing to his previous condition of health, he is more or less liable to injury. Purcell v. St. Paul C. R. Co., 48 Minn 134, 50 N.W. 1034 (1892).

Recovery for frostbite was allowed even though plaintiff’s poor blood circulation rendered her more susceptible to frostbite than a person in normal health. Owen v. Rochester-Penfield Bus Co., 304 NY 457, 108 N.E.2d 606, 33 (1952).

Underwood v. Smith, 261 Ala 181, 73 So.2d 717 (1954); Mourison v. Hensen, 128 Conn 62, 20 A.2d 84, (1941); Squires v. Reynolds, 125 Conn 366, f A.2d 877 (1939); Sansonni v. Jefferson Parish School Bd. (4th Cir 1977) 344 So.2d 42, cert den (La) 346 So.2d 209 (plaintiff who suffered from congenital defect rendering his bones unusually brittle and susceptible to fracture with a minimum of force was entitled to substantial damages even though a normal child would have sustained only a bruise from the type of slip and fall accident that occurred); Owen v. Rochester-Penfield Bus Co., 304 NY 457, 108 N.E.2d 606, (1952); Lockwood v. McCaskill, 262 NC 663, 138 S.E.2d 541 (1964); Florig v. Sears, Roebuck & Co., 388 Pa 419, 130 A.2d 445 (1957).

Bahr and Graham, *Thick Skull Plaintiff Concept: Evasive or Persuasive*, 15 LOY. L.A.L. REV. (Los Angeles) 409 (1982).

claim of damages by pointing out this self-evident circumstance.[11]

The foregoing rules are of particular importance in a nursing home maltreatment case, given the susceptibility and vulnerability of residents to injury. Rare indeed is the case where the pre-existing condition, weakness, and frailty of the victim does not form the nucleus of the nursing home's defense, with the thrust of the facility's argument being that the injury sustained by the nursing home resident was the inevitable product of his or her compromised health status/physical weakness (which was present at time of admission to the facility in question) rather than the result of any neglect by defendant.[12] The argument advanced by the defense revolves around the question of "cause in fact" as opposed to "foreseeability," obligating plaintiff to show that the injury was more probably the result of external forces for which defendant is responsible rather than the internal preexisting weaknesses of plaintiff.

The relationship between any injury and a preexisting condition depends principally upon: (1) the status of any underlying disease process present at the time of infliction of the alleged neglect; and (2) the severity and extent of the alleged neglect. In most nursing home maltreatment cases, the pre-existing conditions of the plaintiff have been known and treated for many years prior to admission into defendant's facility. Accordingly, the key question relating to the status of plaintiff's preexisting condition necessarily focuses upon the stability or rate of deterioration of any relevant disease processes affecting plaintiff's health. The importance of distinguishing relevant disease processes from non-relevant is crucial to the causation determination in these cases, as discussed below.

[B] Application of Current Causation Principles to the Pre-existing Condition Case

Given the leanings of the Supreme Court as enunciated in *Kramer v. Lewisville Memorial Hospital*[13] and *Park Place v. Milo*[14], plaintiff in a nursing home wrongful death case must be prepared to establish through a qualified expert that "but for" the negligent conduct of defendant, the nursing home resident would not have suffered the specific injuries which in continuous sequence produced death. Moreover, given the language in *Park Place*, plaintiff's expert must, based on a reasonable degree of medical probability, be prepared to counter defense expert testimony to the effect that, "the nursing home resident's pre-exiting conditions made the resultant injuries and death probable by a likelihood of 50% or more, prior to the occurrence of any alleged negligence on the part of defendant".

Accordingly, plaintiff's expert must controvert any claim by defendant that the victim had less than a 50% chance of avoiding the specific injuries and death. In such case, if plaintiff is to meet the standard of proof required to establish causation under *Kramer* and *Park Place*, he must offer expert testimony of a qualified witness that:

[11] STEIN, DAMAGES AND RECOVERY, §123.

[12] See e.g., *Convalescent Services, Inc. v. Schultz*, 921 S.W.2d 731 (Tex.App--Houston [14th Dist.], Mar. 14, 1996) (No. 14-94-01198-CV), rehearing overruled (May 16, 1996), error denied (Dec. 13, 1996), petition for rehearing of application for writ of error 130 (d) filed (Jan. 30, 1997)

[13] *Kramer v. Lewisville Memorial Hospital*, 858 S.W.2d 397 (Tex.1993)

[14] *Park Place Hospital v. Estate of Milo*, 909 S.W.2d 508 (Tex. 1995)

1) there was a 51% or greater chance, that the nursing home resident would not have suffered the injuries and death due to the residents pre-existing conditions and , 2) there was a 51% or greater likelihood that negligent conduct of defendant produced a continuous sequence of injuries that caused the residents death. The bottom line is that plaintiff's expert must be prepared to address the resident's chances of survival and avoidance of the fatal injuries in question, given said residents' prior condition.

It should be noted that neither *Kramer* nor *Park Place* addressed the question of: 1) hastening or acceleration of death; or 2) death caused some manner unrelated to the diagnosis or attempt to cure the underlying terminal condition. Rather these cases dealt with the question of how negligent diagnosis and treatment of the underlying terminal disease altered the victim's chance of survival. For example, in this author's opinion, it would be illogical to extend the principles of causation enunciated in *Park Place* and *Kramer* to a nursing home case wherein a resident afflicted with terminal cancer whose life expectancy was less than a year, was beaten to death by a nursing home employee. Clearly, in such case, the conduct of the employee was: 1) unrelated to the diagnosis and attempt to cure the resident's terminal disease; and 2) a more immediate cause and "substantial factor" in the resultant death. By the same token, the deliberate starvation of this same resident by the nursing home is also: 1) unrelated to the diagnosis or attempt to cure the terminal disease; and 2) a more immediate cause of death. Therefore, simply because a nursing home resident is diagnosed with a terminal condition does not automatically trigger the causation principles established in *Kramer* and *Park Place*.

[C] Red Flag Injuries -- Clinical Outcomes Frequently Linked

In screening a potential nursing home maltreatment case, one of the threshold questions the lawyer must address is whether the resident's injury is generally regarded as being linked to deficient care and nursing home neglect. In other words, is the outcome in question commonly recognized as being an indicator of poor care? Such determination is primarily derived from a review of the resident's clinical record, coupled with interviews of witnesses who observed the resident's condition. Secondarily, review the teachings, literature, and experience of two distinct professional communities: (1) the health care community, which includes medical, nursing, pharmaceutical, and nursing home professionals, and, (2) the legal community. As to the former, the pertinent inquiry is: What injuries are generally recognized by the health care community as being caused by a failure to render adequate care? As to the latter, the relevant question is: What types of injuries have been identified by the United States Congress, state regulators, courts, juries, and/or insurance carriers as being associated with a valid claim of nursing home neglect? Answers to these questions are compiled in the illustrative list below.

[D] Injuries Precipitated by Progressive Failures and Omissions of Care

The injuries listed in this category generally result from a prolonged form of neglect, as contrasted with an event which immediately produces an injury, such as a scalding. At the outset, it is important that plaintiff's counsel understand whether the injury in question was caused by recurrent neglect over an extended period of time or

was simply the result of a single event which effectively produced injury to the nursing home resident. The injuries listed below have been recognized by the medical and nursing communities as preventable in nearly all nursing home residents through implementation of ordinary nursing care. They have also been the subject of successful litigation.

- Decubitus ulcers -- Stage III or IV;
- Infected decubitus ulcers;
- Gram negative septicemia, secondary to decubitus ulcer or wound sepsis;
- Severe dehydration;
- Severe protein-calorie malnutrition;
- Septic shock;
- Gangrene;
- Osteomyelitis secondary to Stage IV decubitus ulcer;
- Gram negative septicemia, secondary to long term failures regarding urinary catheter (e.g., failure to appropriately monitor and change urinary catheter);
- Gram negative septicemia, secondary to urinary tract infection or other localized sepsis;
- Aspiration/pneumonia;
- Gram negative or positive septicemia, secondary to pneumonia;
- Emotional trauma and distress arising out of inhumane conditions and care of a persistent and long-standing nature.[15]
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[E] Injuries Precipitated by Medication Errors

Approximately 95 percent of all nursing home patients receive medication on a regular basis. The typical nursing home patient takes five to six medications daily. The over-use or under-use of certain medications can result in serious injury or death.

Drug-related injuries in a nursing home case are usually the result of: (1) inappropriate prescribing by the physician; (2) failure of the nursing home staff to follow physician's instructions by properly monitoring a specific aspect of the patients condition prior to administering the medication in question; (3) administering medications to the resident despite the presence of adverse symptoms which require immediate physician notification; (4) over or under medicating the resident by the nursing home staff; or (5) administering Patient A's medication to Patient B. The following list consists of drug-related injuries that commonly occur in a nursing home setting and are the subject of litigation.[16]

- Mental or physical deterioration secondary to inappropriate; psychotropic medication administration;[17]

[15] The list of progressive-failure injuries set forth above is not intended to be all-inclusive. There are surely other injuries that might qualify for inclusion herein. This listing is intended only to identify the most common types of progressive injuries.

[16] This listing is intended only to identify the most common types of drug-related injuries and is not intended to be all inclusive.

[17] Examples of drugs which are sometimes inappropriately prescribed and administered include Thorazine, Haldol, Valium, Librium, Lithium, Stelazine, Sinequan, Mellaril, Miltown and Serentil.

- Digoxin toxicity;
- Untreated congestive heart failure (such condition may be recognized by the following symptomology: edema, difficulty in breathing--especially in a prone position--chronic cough, swollen ankles, and/or bloated abdomen);
- Dilantin toxicity;
- Insulin shock/coma resulting from inappropriate administration of insulin;
- Improper antibiotic therapy resulting from: (1) the inappropriate prescription and continuation of a broad spectrum antibiotic coupled with the failure to obtain culture and sensitivity or the failure to track the effectiveness of the antibiotic; or (2) the failure to adjust the antibiotic therapy in response to the sensitivity report;
- Severe fall resulting from the failure to monitor the effects of any hypertensives and anti-arrhythmia drugs or from negligent use of psychotropic drugs;
- Hyperkalemia resulting from dehydration coupled with the use of any hypertensives, diuretics and/or potassium supplements;
- Any adverse drug reaction identified in the *Physician's Desk Reference* or product literature of the drug manufacturer.

[F] Injuries Precipitated by Singular Event

A third category of injuries exists for the purposes of nursing home litigation. This category consists of injuries which can be causally linked to a singular event. In such cases, an efficient cause is said to exist. For example, in a case where a resident has drowned in a whirlpool bath, the cause of death is clearly connected to a singular occurrence at a specific time. The time between the negligent behavior and the appearance of the full-blown injury is minimal. In contrast, in the case of a progressive injury such as a decubitus ulcer, the wound gradually evolves and cannot be pinned down to a specific time.

For injuries resulting from an unwanted incident, the defense often asserts that the resident was psychologically dysfunctional to the point of being impossible to monitor and control. For example:

> "Patient John Doe was out of sight of nursing personnel for a mere fifteen minutes, and was subsequently discovered floating face-down in the whirlpool bath. Defendant contends that it cannot assign a staff member to monitor each and every resident every second of the day. Consequently, the injury was not the fault of the nursing home staff but rather resulted from the resident's unfortunate mental condition. John Doe was simply a time bomb waiting to go off. "

In the progressive injury case (§1.02D), the defense often asserts that the complex medical history of the elderly resident, coupled with his/her age and deteriorating health status, was the true cause of the injury in question. The defense

seizes upon the frail physical condition of the resident (as opposed to the mental condition), arguing that such condition preordained the occurrence, e.g. the Stage IV sore(s).

Thus, the distinction between the injuries identified below and the progressive failure injuries stems not only from the amount of time between the negligent behavior and the presence of the full-blown injury, but also the excuse typically offered by the defense to explain away liability.

Nursing home injuries precipitated by untoward incidents which are frequently the subject of litigation are as follows:

- Strangulation (e.g., strangulation resulting from the failure to either monitor restraints or the improper use or application of restraints such as posey restraints);
- Drowning;
- Scalding;
- "Wander-off" cases, wherein death or serious injury occurs after the resident has wandered away from the facility;
- Falls and fractures resulting from the failure of nursing home staff to follow accepted protocols and implement necessary preventive measures[18];
- Rape and/or sexual assault;
- Physical abuse and assault resulting in wounds, bruising or disfigurement.[19]

§1.03 Key Damage Elements and Appraisal Questions

To restate the obvious, the damage elements which in large degree make up the bulk of the verdict in a significant personal injury case seldom contribute to the award for damages in a nursing home maltreatment case. Rare indeed, is the nursing home case where damages of a meaningful nature are recovered on the basis of future harm and pecuniary detriments occurring over the remainder of the resident's life.[20] Even more rare is the case where plaintiff resident has the capacity to generate earnings subsequent to admission to defendant facility. And of course, the most unusual case of all is one factually capable of supporting claims for both future medicals and lost income.

Less than one-half of the twenty-nine damage elements presently recognized in most jurisdictions as being applicable to either a personal injury case, survival action or wrongful death action are realistically available to the nursing home resident injured as a result of the wrongful conduct of a long term care institution. See Appendix A.

Those items checked in Appendix A represent the relatively small subset of damages which are *commonly* recoverable in

[18]The occurrence of a fracture and subsequent failure to timely assess and recognize it may give rise to a *progressive failure injury* such as the case where patient Doe falls, sustains a fracture, but is not x-rayed nor treated for the fracture, despite the presence of classic symptoms for eight days suggesting the occurrence of the same.

[19]It should be noted that the occurrence of one or more of the injuries contained in the above checklist does not absolutely guarantee the existence of a solid causal link. Counsel must not fail to factor into the evaluation the preexisting condition defenses discussed supra in §1.04(C).

[20]The disease process and other debilitating factors underlying the condition of the nursing home residents, coupled with documentation in the patients nursing home chart stating "provide comfort as she prepares for death" or "unable to rehabilitate," severely weakens the probative value of any life expectancy estimate necessary to compute future damages.

an action arising out of personal injury or death of a nursing home resident. [21] As a practical matter, however, only five of the twelve designated elements consistently form the basis for a large recovery: (1) claims for punitive damages; (2) claims for past mental anguish; (3) claims for past pain and suffering; (4) claims for past loss of love, affection, solace and companionship on the part of statutory beneficiary of decedent resident; [22] and (5) past medical expenses.

Because the relationship between the deceased resident and the statutory beneficiaries is often at best tenuous, claims by the relatives of a nursing home victim for mental anguish and loss of society are frequently rendered suspect and inconsequential. Predictably, juries look with disdain on the claims of relatives who, for whatever reason, rarely visit the deceased.[23] Although there are exceptions to this general rule, such as the devoted wife or daughter who regularly attended to needs of a loved one in the convalescent facility,[24] attorney for plaintiff must be extremely cautious in projecting the damages that realistically are recoverable by reason of the emotional trauma inflicted upon beneficiaries of the deceased resident.

Furthermore, litigators must be cognizant of the fact that medical expenses subsequently occasioned by the wrongful conduct of the nursing home are often limited in scope. The failure of the nursing home to transfer an injured resident in need of medical attention to a hospital, coupled with the relatively short life expectancy of said resident frequently restrict the quantum of medical expenses.

Due to of these limitations, potential nursing home litigators should approach the issue of damage appraisal with the general view that claims for punitive damages, [25] mental anguish,[26] and pain and suffering represent the center of gravity of the case. Although other specific damages may be available to plaintiff,[27] in most cases, the final award will hinge upon this small core of elements. Accordingly, it follows that the key questions confronting one who seeks to determine the quantitative value of a nursing home maltreatment case are:

1. Based on the underlying facts, what is the probability that a jury will award punitive damages?

[21]Certain other damage elements may be available, depending on the facts of the case. This subset is intended to represent only those elements most frequently associated with substantial recovery by plaintiff against the long-term care facility.

[22]In a case where the life expectancy of the nursing home victim prior to the injury made the basis of the lawsuit is more than a few years, the damage elements consistently bearing economic fruit are expanded to include compensation for future losses and emotional and economic detriments.

[23]McMath, *The Nursing Home Maltreatment Case*, 21 TRIAL 52 (Sept. 1985).

[24]*See* F. Campbell v. Payton Health Care Facilities, Polk County Circuit Court, Florida, No. GCG84, 1170, (jury awarded $500,000 for mental anguish suffered by wife of decedent in wrongful death action); and DSF, Inc., v. Mary Sue Sager, Los Angeles County Superior Court, California, Dept. No. 31, No. C449288, (January 27, 1988) (jury in a wrongful death action awarded daughter of decedent $185,000 for loss of her father's love, comfort, companionship, society and moral support and $5,800 for emotional distress resulting from her contemporaneous observations of defendant's negligent conduct).

[25]For reasons discussed above, claims brought by the injured resident or on behalf of said resident's estate are sometimes favored over wrongftil death actions where statutory beneficiaries of decedent rarely visited the decedent at the convalescent facility. *See* McMath, *The Nursing Home Maltreatment Case*, 21 TRIAL 52 (Sept. 1985).

However, in appraising the potential damages, counsel should be mindful that a close relationship between the decedent and the beneficiary may give rise to substantial damages for mental anguish and loss of familial relationship suffered by said beneficiary. *See supra* note 17.

[26]Claims for mental anguish and pain and suffering by the resident are generally better received than those claims by relatives or beneficiaries for mental anguish.

[27]The elements of damages available to plaintiff are always a function of the underlying facts.

2. What sum of money is a jury likely to award to plaintiff resident against defendant nursing home as punitive damages?

3. Based on the underlying facts, what is the probability that a jury will award damages for the:

   (a) Physical pain and suffering of the resident?

   (b) Mental anguish of the resident?

   (c) Medical expenses?

4. What sum of money is a jury likely to award to plaintiff resident as fair and reasonable compensation for:

   (a) Pain and suffering of the resident?

   (b) Mental anguish of the resident?

   (c) Medical expenses?

5 . Based on the underlying facts, what is the probability that a jury will award damages arising out of the wrongful death of the resident for the:

   (a) Loss of love, companionship, comfort, society and moral support suffered by statutory beneficiary?

   (b) Mental anguish suffered by statutory beneficiary?

6. What sum of money is a jury likely to award to the statutory beneficiary as fair and reasonable compensation for his/her:

   (a) Loss of love, companionship, comfort, society and moral support suffered by statutory beneficiary?

   (b) Mental anguish suffered by statutory beneficiary?

§1.04 Causes of Action

[A] Negligence

The most common basis for imposing liability on a nursing home for the injury of its resident is the common law concept of negligence. Although a facility may be held liable under a variety of other theories,[28] negligence serves as the primary cause of action for plaintiffs in the majority of cases yielding large damage awards or settlements. To recover under this theory, plaintiff must establish: (1) that the nursing home and its employees were legally obligated to conform to a certain standard of conduct in caring for residents; (2) the applicable standard of conduct and its breach; (3) actual injury to the plaintiff; and, (4) a causal connection between the breached standard of care and the complained-of harm.

1. Basic Fact Issues

Under a theory of common law negligence, the critical liability issues for case appraisal purposes include:

[28] *See* JOHNSON, TENY AND WOLFF, NURSING HOMES AND THE LAW: STATE REGULATION AND PRIVATE LITIGATION, §3-4, (Breach of Contract), and §3-9, (Assault and Battery); Neemore and Horvadi, *Nursing Home Abuses as Unfair Trade Practices*, 20 CLEARINGHOUSE REV. 801, (1986); Neemore, *Applying Racketeering Laws to Nursing Homes*, 19 CLEARINGHOUSE REV. 1306 (1986);

a. Did the nursing home fail to use ordinary care in providing for the needs of plaintiff/resident: Did it fail to do that which a nursing home of ordinary prudence would have done under the same or similar circumstances, or did it do that which a nursing home of ordinary prudence would not have done under the same or similar circumstances?

b. Was such negligence the proximate cause of the occurrence in question?

More specifically, the attorney must determine if: (1) the negligent conduct of the nursing home produced the complained-of event in a natural and continuous sequence, such that without such conduct, the event would not have occurred; and (2) the act or omission complained of must be such that a nursing home exercising ordinary care would have foreseen that the event or some similar event might reasonably result. As is true in any case founded in negligence, the pivotal issue in a nursing home neglect case is the applicable standard of care by which the facility's conduct is to be measured. The law requires a nursing home to exercise that degree of skill and care which is expected of a reasonably competent nursing home in the same or similar circumstances.[29] In other words, a nursing home must provide reasonably competent health care to its patients.

2. Duty of Care in a Nursing Home Case: *Golden Villa v. Smith*

What duty is owed by a nursing home to its patients? The seminal case in Texas on nursing home duty of care is *Golden Villa Nursing Home, Inc. v. Smith*,[30] which holds:

> "[A] nursing home in Texas is under a duty to exercise such reasonable care for a patient's safety as his **known mental and physical condition may require.** This standard requires that a determination of what constitutes "reasonable care" be made in **each individual case, taking into consideration the individual patient's known mental and physical condition."**[31]

Amelia Oliver was a 68 year old patient in the Golden Villa nursing home. She had a known proclivity for wandering and considerable evidence established that she needed to be supervised closely. On the day in question, she wandered away from the home, onto Highway 35 in Brazoria where she was struck by Minnie Smith who was riding a motorcycle. Both Smith and Oliver sued Golden Villa to recover for their injuries.

Golden Villa contended that as a matter of law, it owed no duty to either Smith or Oliver; and it did not breach a duty of care. In rejecting this argument the court indicated that the concept of duty with regard to a patient in a hospital or nursing home was not to be measured by objective, across-the-board standards. Rather, the duty of care is and must be **particularized and individualized to each patient in light of their known physical and mental conditions.**

Accordingly, the jury in a nursing home case involving a resident, who is vulnerable and susceptible to injury based on his known condition, should not be given a general and objectively worded definition of negligence and ordinary care. Rather, the definition of negligence and ordinary care should be individualized so as to take into account the known physical and mental condition of the resident in question.

> "[T]his standard requires that a determination of what constitutes 'reasonable care' be made in each individual case, taking into consideration the individual patient's known mental and physical condition."[32]

[29] ALEXANDER'S JURY INSTRUCTIONS ON MEDICAL ISSUES (2nd ed.) INST8-1, 8-2, and 8-3; May v. Triple C Convalescent Centers, 19 Wash. App. 794, 578 P.2d 541 (1978).

[30] Golden Villa Nursing Home v. Smith, 674 S.W.2d 343 (Tex.Civ.App.--Houston [14th Dist.], 1984, writ ref'd n.r.e.)

[31] *Id.* at 348 (emphasis added).

[32] *Id.*

3. Jury Instruction of Negligence in a Nursing Home Case

Under *Golden Villa* and the *Texas Pattern Jury Charge*, the term negligence and ordinary care should be defined as follows:

> "Negligence," when used with respect to the conduct of Defendants and their agents and employees means failure to use ordinary care to safeguard [resident's name], that is, failing to do that which a person of ordinary prudence would have done under the same or similar circumstances, or doing that which a person of ordinary prudence would not have done under the same or similar circumstances.
>
> "Ordinary Care," when used with respect to the conduct of Defendants, their agents or employees, means that degree of care that a nursing home of ordinary prudence would use under the same or similar circumstances, as [resident's name] **condition, as it is known to be, may require**, including safeguarding and protecting [resident's name] from any **known dangers that may arise from his/her known physical and mental incapacity.**

Such definitions are legally correct. They are also sufficiently similar to the boilerplate definitions from the *Texas Pattern Jury Charge*, so as to not constitute a comment on the evidence.

4. Vicarious and Direct Corporate Liability for Negligence

Generally speaking, the responsibility for a residents injury or death arising out of the negligent conduct of an agent may be ascribed to the corporate nursing home owner or operator by way of two distinct but overlapping theories: (1) direct corporate liability; and (2) vicarious liability. Direct corporate nursing home liability is predicated on the idea that the long term care facility, as a separate entity, owes a direct non-delegable duty of care to its residents. If a breach of this duty proximately causes a patient's injury, the facility will be held directly liable, even though an employee within the facility's purview caused the actual injury.[33] At its most fundamental level, imposition of direct corporate nursing home liability depends upon two interrelated prerequisites: (1) definition of the duty owed by the facility to the patient; and (2) determination of the forms of evidence acceptable to define that duty.[34] Vicarious liability, on the other hand, does not presuppose that the nursing home owes its resident any independent duty of care. Under this theory, the facility may be held liable for injuries that others cause if a certain relationship is established between the institution and the person whose negligence proximately caused the injury. The threshold question under this theory revolves around the duty owed by the person whose substandard conduct caused the injury; and such person's relationship to the facility.[35]

As a practical matter, the distinction between these two theories becomes blurred when plaintiff, as a part of his cause of action, draws a connection between the resultant harm and the failures of administrative personnel of the corporate entity and the high managerial agents to adequately discharge their supervisory responsibility (e.g., the failure of the Director of Nurses to adequately monitor nurses and nurse assistants, enforce patient care policies,

[33]Hacker, *Expansion of Health Care Provider's Liability: An Application of Darling to Long-Term Care Facilities*, 9 CONN. L. REV., 462 (1977); JOHNSON, TERRY AND WOLFF, NURSING HOMES AND THE LAW, §§3-18 (Corporate Liability); Stogsdill v. Manor Convalescent Home, Inc., 35 I.V. App.3d 634, 343 N.E.2d 589 (1976); Capital City Manor, Inc. v. Culberson, 613 S.W.2d 835 (Ark. Ct. App 1981).

[34]Purdue, *The Law of Texas Medical Malpractice.* 22 HOUS. L. REV. 1, 280 (1985).

[35]*Id.* at 154.

and assure that sufficient nursing care was provided in quantity and amount to meet the needs of patients).

5. Nursing Home Negligence Based on Ministerial Failures

Commonly, nursing cases with explosive verdict potential involve extensive proof of ministerial failures on the part of defendant. The care each resident receives in a nursing home hinges upon the simultaneous presence of: (1) adequate numbers of nursing personnel (including aides and orderlies); (2) adequate amounts of food, supplies, equipment, and medication; (3) competent nursing staff (including aides and orderlies) who have been screened at the time of hiring and monitored throughout employment in order to eliminate unfit personnel; (4) adequately trained personnel who are assigned duties consistent with their demonstrated level of competency; (5) adequate care planning to assure that each resident has an individualized care plan which: (a) addresses each problem of the resident, (b) is updated when said resident's condition changes, and (c) is communicated and available to direct care staff; (6) adequate policies and procedures to assure that personal care is provided on a uniform and uninterrupted basis to each resident; (7) adequate supervision and monitoring of nursing personnel to assure that the health care plan, physician's orders and policies/procedures have been implemented/complied with; and, (8) adequate assessment and evaluation of each resident on a frequent basis to assure that changes in condition are addressed on a timely basis. It is the responsibility of management for the nursing home to provide the above ingredients of care. The failure to provide these essential components are known as ministerial failures.

It should be noted that several courts have held that expert testimony is not necessary to support a negligence finding based on ministerial failures and omissions of routine care in a nursing home.[36] The standard for non-medical, administrative, ministerial, or routine care at a nursing home need not be established by expert testimony because the jury is competent from its own experience to determine and apply such a reasonable care standard.[37]

The Checklist of Ministerial Omissions (Appendix B) may serve as the basis for imposing liability on the corporate nursing home for negligence, regardless of whether the concept of direct corporate liability or the more prevalent theory of vicarious responsibility is employed.

[B] Negligence Per Se

1. Overview

The unexcused violation of a legislative enactment or an administrative regulation, which is designed to prevent injury to a class of persons to which the injured party belongs, is negligence per se.[38]

Under the doctrine of negligence per se, courts use a statute, ordinance or regulation as a legislatively-mandated standard of conduct as a definition of what a reasonably prudent person would do in a particular situation. If a legislative pronouncement covers the fact situation of a case, the trier of fact is not asked to judge

[36] Golden Villa Nursing Home, Inc. v. Smith, 674 S.W.2d 343 (Tex.Civ.App.--Houston [14th Dist.] 1984, writ ref'd n.r.e.).

[37] *See e.g., Id.* at 349 (holding that an expert was not necessary to establish negligence in leaving a patient unsupervised for 57 minutes*);* Cramer v. Theda Clark Memorial Hospital, 172 N.W.2d 427 (1964) holding that negligence based on leaving a patient unattended did not require expert testimony).

[38] El Chico Corporation v. Poole, 732 S.W.2d; and Dusine v. Golden Shores Convalescent Center, Inc., 249 So.2d 40 (Fla. App. 1971).

whether the defendant acted as a reasonable and prudent person would have acted under the same or similar circumstances. Instead, the legislature is deemed to have prescribed, as a matter of law, what a reasonably prudent person would have done. Unless the defendant proves some legally recognizable excuse, the only inquiry for the trier of fact is whether the defendant violated the statute, ordinance, or regulation and whether this violation was the proximate cause of the accident.[39]

In the wake of persistent quality of care problems over the last three decades in Americas long term care facilities, federal and state governments have created a myriad of regulations and statutory duties governing the care provided to residents in long term care facilities.[40] These regulations are designed to assure that patients receive safe and adequate care. Failure on the part of the nursing home to conform to such legislative and administrative standards subjects the non-compliant facility to a variety of regulatory sanctions, including: (1) loss of license to operate; (2) loss of federal and state Medicaid revenues; (3) loss of right to participate as a provider in the Medicaid program; and (4) fines for violation of regulations. Without question, these statutes and regulations are designed to protect a class of persons, of which the resident is a member, from the type of injury or hazard created by the violation of such statute or regulation. Accordingly, liability in a nursing home case may be predicated upon a finding, by the trier of fact, that defendant nursing home violated a state or federal long term care regulation or statute.[41] Rather than quibbling over the appropriate standard of care by which to judge defendants conduct, plaintiff is entitled to frame the charge submitted to the trier of fact in terms of whether the defendant nursing home failed to comply with the applicable rules and regulations.

Two additional points should be noted. First, although violation of a standard of care borrowed from a legislative enactment is negligence per se, the converse is not necessarily true. The fact that a statute was complied with is not an absolute defense to an ordinary negligence action.[42] Compliance with a statute does not prove a lack of negligence.

A statutory provision or regulation is usually considered a minimum standard, and tort law may impose a higher standard under some circumstances. For example, a nursing home was sued for allowing an elderly patient to wander onto the highway and cause an accident in which both the patient and a motorist were injured. The nursing home attempted to argue that its conduct was not negligent because it complied with the Texas Department of Health's minimum licensing standards for nursing homes. The court ruled that compliance with such regulations was irrelevant, and that excluding the regulations from evidence would be, at most, a harmless error. Compliance with such regulations would not have precluded a finding of negligence.[43]

Secondly, long before plaintiff's attorney first interviews his or her client in a nursing home case, substantial evidence of statutory and regulatory violations may have

[39]EDGAR AND SALES, TORTS AND REMEDIES, §1.05 (Negligence Per Se) (Supp. 1988).

[40]*Laws Governing Nursing Home Care. See supra* subsection [B]2.

[41]El Chico Corporation v. Poole, 732 S.W.2d; and Dusine v. Golden Shores Convalescent Center, Inc., 249 So.2d 40 (Fla. App. 1971).

[42]*See* Golden Villa Nursing Home, Inc. v. Smith, 674 S.W.2d 343, 348-349 (Tex. App.--Houston [14th Dist] 1984, writ ref'd. n.r.e.)

[43]*See Id.*

already been documented in the form of investigative and surveillance reports by state and/or federal nursing home inspectors. Often such findings provide key evidence of neglect in a major nursing maltreatment case.

2. Laws Governing Nursing Home Care

The following laws govern the requirements for the long-term care nursing facility requirements for licensure and Medicaid certification:

- Official Texas Administrative Code, Title 40, Social Services and Assistance, Chapter 19, *Nursing Facility Requirements for Licensure and Medicaid Certification.*
- V.T.C.A. Health & Safety Code, Chapter 242, *Convalescent and Nursing Home Related Institutions*.
- V.T.C.A. Human Resources Code Chapter 102, *Rights of the Elderly*
- §§1102, 1819(a)-(d), 1861(j) and (*l*), 1863, 1871, 1902(a)(28), 1905(a), (c), and (d) 1919(a)-(f) of the Social Security Act (42 U.S.C. §§1302, 1395i-3(a)-(f), 1395x(j) and (*l*), 1395z, 1395hh, 1396a(a)(28), and 1396d (a), (c), and (d), and 1396r(a)-(f)).
- 42 C.F.R. 483, *Requirements for States and Long Term Care Facilities*

The long-term care nursing facility requirements for licensure and Medicaid certification specify requirements of federal and state laws and regulations governing the Title XIX Nursing Facilities Vendor program administered by the TDHS in cooperation with other federal and state agencies.[44] **The purpose of these regulations is "to promote the public health, safety and welfare and provide for the development, establishment and enforcement of standards for the care of the individuals in facilities."**[45] Insomuch as the express purpose of the aforementioned regulations is to promote the health and safety of nursing home residents, **it is clear that such regulations were designed to protect a class of persons of which the nursing home resident is a member**. See §1.06[d] and brief attached as Appendix C. It should be noted, that amendments to V.T.C.A. Health & Safety Code Chapter 242 (SB190 effective September 1, 1997) further establishes the legislative purpose and intent to protect the special class of persons made up of nursing home residents. No longer must attorneys rely principally upon the medical licensure regulations in order to construct a negligence per se argument. As of September 1, 1997, ample support for a negligence per se theory can be found in the statutory provisions of Chapter 242.

The long-term care nursing facility requirements for licensure and Medicaid certification contain the requirements that an institution must meet in order to qualify to participate as a licensed facility in the Medicaid program. They serve as a basis for survey activities for licensure and certification. These requirements provide the nursing facility with information necessary to fulfill its vendor contract for participation with the TDHS. Each facility is

[44] *See* 40 T.A.C. §19.1, et seq.; 42 C.F.R. §483, et. seq.

[45] 40 T.A.C. §19.1(c).

required to keep these requirements current. The requirements are the basis for surveys by federal and state surveyors, are part of the vendor contract, and are necessary for the facility to remain in compliance with federal and state laws.

3. Mandatory Judicial Notice of Nursing Home Laws

Rule 204 of the Texas Rules of Evidence provides that "a court upon the motion of a party **shall take judicial notice...of the codified rules of agencies published in the Administrative Code."**[46] Moreover, the contents of the Texas Register are to be judicially noticed and constitute prima facie evidence of the text of documents published in the Register and of the fact they are in effect on and after the date of notation.[47] See also wherein it was held that a failure to admit photocopy of federal regulations concerning standard of care which hospitals receiving Medicare and Medicaid funds must have complied was reversible error.

4. Legal Status of Nursing Home Resident and Defendant

In the past, the applicability of negligence per se as a theory of recovery in a nursing home case hinged upon three determinations: (1) the source of payment for the nursing home care rendered the resident in question, (i.e. was the alleged victim a "private pay patient" versus a "Medicaid recipient?"); (2) whether the nursing home participated in the medical assistance program as a certified provider, (i.e. Did the nursing home accept Medicaid patients in its facility?"); and (3) where the nursing home in question operated both a "certified Medicaid wing" and a "private pay wing," on which wing did the resident in question reside?

Under prior regulatory provisions, it was questionable as to whether a private pay patient was able to invoke negligence per se as a theory of recovery based solely upon violations of Medicaid regulations (except in a case where the private pay resident occupied a bed on a wing certified for Medicaid program participation.[48]) Prior to August 31, 1993, a non-certified nursing home (i.e. a "private pay" facility) was however, required to comply with the licensure regulations found in the Official Texas Administrative Code, Title 25, Health Services, Chapter 145, *Nursing Facilities and Related Institutions.* Therefore, a claim for negligence per se by a private pay patient who resided in a non-certified facility could be asserted for violations of 25 T.A.C., Chapter 145. A nursing home which did not participate in the Medicaid program was under no obligation to comply with the Medicaid regulations found in 40 T.A.C., Chapter 19.[49]

[46] TEX. R. CIV. EVID. 204.

[47] Mullinax, Wells, Baab & Cloutman, P.C. v. Sage, 692 S.W.2d 533 (Tex.App.--Dallas 1985, writ ref'd n.r.e.). *See also* Kish v. Van Note, 692 S.W.2d 463 (Tex. 1985) for judicial notice of public statutes; and Hickson v. Martinez, 707 S.W.2d 919 (Tex.App.--Dallas 1985).

[48] 40 T.A.C. §19.1(b)(3), 15 Tex.Reg. 5220 (effective Oct. 1, 1990).

[49] Prior to October 1, 1990, each wing or distinct part in a nursing home which participated in the Medicaid program was certified as either a skilled or intermediate wing. With respect to cases occurring prior to October 1, 1990, this distinction was significant in that there were specific regulations which governed the care provided to residents who occupied a bed on the skilled wing as opposed to the intermediate wing. The Social Security Act §1919(a)-(d), effective October 1, 1990, created the term "nursing facility" in the Medicaid program to replace the terms "skilled" and/or "intermediate" certified wing. It should be noted, however, that the term "skilled care certification" has survived and is currently utilized in nursing homes which have been certified to provide care to Medicare recipients and receive reimbursement from the Medicare program. These Medicare standards can also serve as a basis for a negligence per se claim in a case where the resident was Medicare eligible and the nursing home was a certified Medicare provider.

Today these questions are rendered moot for all practical purposes by 40 TAC §19.1(a) and (b) 20 Tex.Reg. 2393 which provides:

> "(a) Basis in legislation. The Nursing Facility Requirements for Licensure and Medicaid Certification specify requirements of federal and state laws and regulations **governing licensed nursing facilities and the Title XIX Nursing Facilities** vendor program administered by the Texas Department of Human Services (DHS) in cooperation with other federal and state agencies. If there is a conflict between material in these requirements and the laws or regulations governing the program, the latter are controlling."
>
> "(b)Scope. The Nursing Facility Requirements for Licensure and Medicaid Certification **contain the requirements that an institution must meet in order to be licensed as a nursing facility and also to quality to participate in the Medicaid program**. The requirements serve as a basis for survey activities for licensure and certification."
>
> > "(1) Certain requirements are specific to Medicaid-certified facilities are so designated. **The Medicaid-specific requirements apply to all residents, including, but not limited to private pay, Medicaid applicants and recipients, VA patients, and Medicare recipients,** who are admitted to and reside in a Medicaid-certified facility or a Medicaid-certified distinct part of a facility."
> >
> > "(2)Additional Requirements for facilities or distinct parts of facilities that are certified for Medicare-only participation are in Chapter 42, Code of Federal Regulations, §§483.5-483.75"
> >
> > "(3)These requirements do not apply to skilled nursing facilities (SNFs) licensed under the Health and Safety Code, Chapter 241, participating only in the Medicare program."

§1.05 Discovery: What Basic Information is Needed?

It is beyond the scope of this article to set out detailed discovery currently propounded by plaintiff in a nursing home case. Appendix D illustrates the basic information which this author believes is necessary to prosecute a case involving a progressive injury such as the development of a serious pressure sore. Discovery in a progressive injury case is generally more extensive than singular event occurrences and thus the former serves as the basis for the discovery attached as Appendix D. Specifically set out are key requests for production which are frequently served upon a nursing home defendant as part of the initial discovery in a case [Plaintiff's First Request for Production]. With respect to the requests for production, twelve categories of documents are sought as part of plaintiff's initial discovery efforts in Appendix D.

In addition to the below requests for production, plaintiff should also consider serving interrogatories which inquire as to the following topics: (1) the specific employees, including aides and orderlies, who cared for plaintiff; (2) the specific measures undertaken to prevent plaintiff's injuries; (3) the evolution, extent and severity of each injury from admission to discharge;

(4) each date the attending physician for plaintiff was notified about plaintiff's condition at the nursing home; (5) all of the care and treatment provided to plaintiff's injury by defendant's staff; (6) all individuals having knowledge of facts relevant to the lawsuit; and (7) any in-house investigation conducted by defendant in the normal course of business.

§1.06 Recent Evidentiary and Discovery Issues: 1995 - 1997

[A] Introduction

Texas Human Resources Code §32.021(j) (Vernon 1996) was enacted on September 1, 1995 during the 75th Legislative Session raising three issues dealing with the discovery and admissibility of: 1) Texas Department of Human Services' (TDHS) written survey findings; and 2) oral testimony deriving from TDHS' investigation and inspection of a Texas nursing home. More specifically, nursing home defendants across the state argued that:

1) State survey and investigative reports were exempt from discovery under § 242.049 Tex. Health and Safety Code;

2) §32.021(j) Tex. Human Res. Code (Vernon 1996) prohibited for any purpose discovery and admissibility of not only reports but also the live testimony of TDHS surveyors;

3) The rules and regulations which TDHS surveyors applied in their investigation were not designed for the purpose of protecting nursing home residents thereby rendering any live testimony by the nurse surveyors who observed a given resident's condition and care relevant and inadmissible.

Each of the foregoing arguments is discussed in the remainder of this section.

[B] § 242.049 of the Health & Safety Code Does Not Prohibit the Discovery of Texas Department of Human Services Survey/ Investigative reports

Nursing home defendants have repeatedly raised the issue as to whether §242.049 of the Texas Health and Safety Code make nursing home survey reports exempt from discovery? The answer to the question lies in §242.049(i) and brief attached hereto as Appendix E.

In relying upon the provisions of §242.049 as a basis for blocking discovery, nursing home defendants have ignored §242.049(i) which states:

> "Any information, reports, and other documents produced which are subject to any means of legal compulsion or which are **considered to be public information** under Subchapter E and the rules adopted under the subchapter **shall continue to be subject to legal compulsion and be treated as public information** under Subchapter E after the effective date of this Act, even though such information, reports, and other documents may be used in the collection, compilation, and analysis described in Subsections (b) and (d)."[50]

It is clear from the above-language that any information, reports or other documents which are considered to be public information, "including but not limited to, individual survey reports and investigative

[50] §242.049(I) Tex. Health and Safety Code (Vernon 1996)

reports"[51] are exempted from the discovery bar set forth in § 242.093(d) and (e). A reading of the entire statute reveals that the survey, and complaint investigative reports are specifically exempted from the meaning of "information and reports, compilations, and analysis developed by the department for quality improvement."

The test for whether the survey and investigative reports are excluded from the meaning of § 242.093(d) and (e) is whether the documents are regarded as "public information." § 242.043 Tex. Health and Safety Code (Vernon 1996) provides:

"(a) The department or the department's representative may make any inspection, survey or investigation that it considers necessary and may enter the premises of an institution as reasonable times to make an inspection, survey, or investigation in accordance with board rules..."

"(d) The department shall establish procedures to preserve all relevant evidence of conditions found during an inspection, survey or investigation that the department reasonably believes threatens the health and safety of a resident . . ."

"(h) The department shall establish proper procedures to ensure that copies of all forms and reports under the section are **made available to consumers, service recipients and relatives of service recipients as the department considers proper**." (Emphasis added).[52]

Moreover, official rules and regulations adopted under the Health and Safety Code establish the public nature of these reports. 40 TAC § 90.216 (effective August 31, 1993 TexReg 2557) which provides:

> "Completed written investigation reports are **open to the public** provided the report is de-identified. The process of de-identification means removing all names and other personally identifiable data, including any information from witnesses and others furnished to the department as part of the investigation."[53]

Another persuasive argument derives from the Texas Department of Human Services' treatment of survey and investigative reports. It is clear that the Texas Department of Human Services has not modified its' position as to the public nature of survey and investigative reports. Today, as in the past, the Unit Manager of the Information System Support Section for the Texas Department of Human Services regularly forwards survey and investigative reports to the public at large and attorneys certifying the same as authentic governmental records. Certainly, if the Department regarded the survey and investigative reports at issue nondiscoverable, it would not as a matter of practice produce such documents as part of the business records of TDHS.[54] Therefore, for reasons set forth above, the survey and investigative reports are discoverable pursuant to § 242.049(i).[55]

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[51] §242.093(b) Tex. Health and Safety Code clearly designates "individual survey reports and investigative reports" as public information

[52] §242.043 Tex. Health and Safety Code (Vernon 1996)

[53] 40 TAC §90.216

[54] The public nature of survey and investigative reports at issue can further be confirmed by contacting the current manager of TDHS' Information and Disclosure for Long Term Care, Nora Fernandez, at 1-800-458-9858 or (512) 834-6774.

[55] Moreover, the Texas legislature has specifically provided that in proceedings involving abuse and neglect of a nursing home resident,

[C] §32.021(j) of the Human Resources Code Does Not Bar the Testimony of a TDHS Surveyor Nor Bar the Admissibility of Surveyor Reports For Purposes of Establishing Nursing Home Defendant's Knowledge

Arguing that the clear legislative mandate of §32.021(j) Tex. Human Res. Code (Vernon 1996) is to prohibit the discovery and admissibility of a TDHS' surveyors testimony, nursing home defendants have routinely attempted to prevent plaintiffs from introducing not only surveyor reports but also the live testimony of TDHS surveyors. §32.021(j) provides that:

> "A finding by the department that an institution has violated a standard of participation in the Medicaid program or the assessment or payment of a monetary penalty under this section, is not admissible as evidence in a civil action **to prove that the institution has committed a violation**." (Emphasis added)

It is readily apparent from a review of the above-language that the word "finding" is subject to many interpretations. Nursing home defendants have argued that the term "finding" should be broadly interpreted to include written documentation and oral testimony. Such an argument ignores §311.011(b) Tex. Gov't. Code Ann. (Vernon 1988) which provides:

"If a word is connected with and used with reference to a particular trade or subject matter or is used as a word of art, the word shall have the meaning given by experts in the particular trade, subject matter, or art."

A "finding" is a word which is connected with and used with reference to nursing home inspection and deficiency reports issued by the Texas Department of Human Services. It is clear that the word "finding" is a term of art used in the context of the department's inspection of nursing homes. The broad and ambiguous nature of this word requires an examination of the legislative intent of this provision. The only legislative intent that can be found with respect to the enactment of § 32.021(j) are the explanatory comments of its author, Representative Harvey Hilderbran. Representative Hilderbran, who was Chairman of the House Committee on Human Services during the 1995 legislative session, drafted and introduced the bill (House Bill 2644) which was subsequently enacted into law of September 1, 1995 as § 32.021(j) of the Texas Human Resource Code. It has long been held that comments by those who participated in the drafting of legislation and who explained it to the legislature, constitute persuasive authority on the subject of legislative intent.[56]. In clarifying the specific intent of § 32.021(j), Representative Hilderbran stated in his commentary that:

> "This law (§ 32.021(j)) was not intended to place blinders on a jury, thereby preventing the introduction of evidence which would establish the track record of a nursing home, particularly one which habitually places residents in situations where their health and safety are at risk. . . . § 32.021(j) was intended to promote **accurate testimony**, and not serve as a shield to hide the track record of a bad nursing home. . . . "

"evidence may not be excluded on the ground of privileged communication" § 242.129 Tex. Health and Safety Code (Vernon 1996).

[56] *Houston Bank & Trust Co. v. Lee* (Civ. App. - Houston 1961) and, 50 Amer. Jur., Statutes, § 336, p. 328

> **"This section was not intended to prohibit or limit the testimony of any surveyor in a civil action**. In fact, exactly the opposite is true. The law should be interpreted to encourage the testimony of surveyors in a civil action. Accordingly, under this section, surveyors may testify as to their observations, factual findings and conclusions as to whether a standard of participation or licensure regulation was violated. If the surveyor is cross-examined, then obviously, the written document would be admissible also. . . "
>
> "This section was not intended to prohibit the introduction into evidence of a nursing home's track record. **For example, a nursing home which continually places residents in situations where their health and safety are at risk, and are given notice and warning by state regulators, should not escape introduction of this evidence under this section**. Thus, § 32.021(j) would not preclude the introduction of evidentiary items, written or otherwise, for this purpose."

Accordingly, the argument that §32.021(j) (as effective between September 1, 1995 and August 31, 1997) prohibits the discovery and the admissibility of written findings and oral testimony by nursing home surveyors is untenable. Not only did the legislature intend that such evidence be discoverable, it is also clearly admissible, under the guidelines articulated above.

[D] Testimony by Surveyors that Laws Designed to Protect Nursing Home Residents were Violated is Not Only Discoverable But Admissible

The third argument lodged by nursing home defendants concerning the probative value of TDHS survey reports and testimony is considered herein. Nursing home defendants have consistently attempted to persuade the court that the Health and Safety Code and the regulations promulgated thereunder, were not for the purpose of protecting a class of persons to which nursing home residents belong. As such defendants argue that these laws should not be used as the basis for a negligence per se claim. This misconstrued interpretation of the law is further compounded by defendant nursing home's argument that surveyor testimony is not only irrelevant, but should be judicially branded as untrustworthy and unduly prejudicial.

In advancing such arguments, nursing home defendants ignore not only the express provisions of the Health and Safety Code, and the Texas Administration Code, but also the clear and precise rulings of the Texas Supreme Court. It is well-established that state health regulations, national standards and organizational bylaws are admissible to define the standard of care customarily offered.[57] The unexcused violation of a statute or an ordinance constitutes negligence as a matter of law if such statute or ordinance was designed to prevent injury to a class of persons to which the injured party belonged. [58] It is clear from the expressed language in the Health and Safety Code and Texas Administrative Code that such laws were designed to prevent injury

[57] *Hernandez v. Nueces County Medical Society*, 779 S.W.2d 867 (Tex. App. - Corpus Christi 1989).

[58] *Nixon v. Mr. Property Management*, 690 S.W.2d 546 (Tex. 1985)

to a class of persons to which a nursing home resident, belongs.

Primarily, three state laws govern the operation of nursing homes in Texas: 1) Health and Safety Code[59]; 2) Chapter 19, Nursing Facility Requirements for Licensure and Medicaid Certification[60]; and 3) Chapter 96, Certification of Long-Term Facilities.[61]

§ 242.001 Tex. Health and Safety Code provides:

> "The purpose of this chapter is to promote the public health, safety, and welfare by providing for the development, establishment, and enforcement of standards for the treatment of residents of institutions that, in the light of advancing knowledge, will promote safe and adequate treatment of residents."

The character of the obligations imposed upon nursing homes under the aforementioned laws clearly imposes a special duty of care to protect a specific class of persons. For example:

40 TAC § 19.701 (adopted to be effective May 1, 1995 20 TexReg 2393) states:

> "A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.. . . The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his individuality."

40 TAC § 19.801 (adopted to be effective May 1, 1995, 20 TexReg 2393) states:

> "A facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity."

40 TAC § 19.901 (adopted to be effective May 1, 1995, 20 TexReg 2393) states:

> "Based on the comprehensive assessment of the resident, the facility must ensure that: (A) a resident enters the facility without pressure sores does not develop pressure sores unless his clinical condition demonstrates that they are unavoidable; and (B) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing."

40 TAC § 19.1001 (adopted to be effective May 1, 1995, 20 TexReg 2393) states:

> "The facility must have sufficient 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."

40 TAC § 19.1002 (adopted to be effective May 1, 1995, 20 TexReg 2393) states:

> "(a) The ratio of licensed nurses to residents must be sufficient to meet the needs of the residents.

[59] Chapter 242 Tex. Health and Safety Code (Vernon 1996)

[60] 40 TAC § 19.1 *et seq.*

[61] 40 TAC § 96.1 *et seq.*

> (b) The facility must have sufficient total direct care staff to meet the needs of the residents."

It is patently obvious from a review of the above-regulations that the specific duties are not inconsequential or irrelevant. *Golden Villa Nursing Home v. Smith,*, 674 S.W.2d 343 (Tex. App- Houston [14th Dist.] 1984), clearly stated the relevance and significance of Texas nursing home regulations by enunciating the following:

> "The title of the Texas regulations alone makes it clear that the Texas Department of Health considers compliance with such standards to be merely the **minimum duty owed by a nursing home to its patients** rather than the full duty owed."[62]

Similarly, in *Hickson v. Martinez*, 707 S.W.2d 919 (Tex. App. - Dallas 1985), it was held that federal regulations governing hospital operation and care for Medicare and Medicaid recipients were relevant to establish the hospitals standard of care. The exclusion of these regulations was held to be reversible error by the Dallas Court of Appeals. Likewise, in *Dusine v. Golden Shore Convalescent Center, Inc.*, 249 So.2d 40 (2nd District - 1971) it was held to be reversible error to exclude from evidence nursing home rules and regulations, since a **violation of rules which specify a minimum standard of care, can provide a plaintiff with a prima facia case of negligence against a nursing home.**

§1.07 Legislative Update: September 1, 1997 to present:

Senate Bill 190 effective September 1, 1997 was enacted by the Legislature with the intended purpose of amending §32.021(j) of the Texas Human Resources Code. Specifically, subsection (j) delineated the use of the surveyor reports as follows:

"(j) Subsection (i) <u>does not</u>:

(1) apply in an enforcement action or related proceeding in which the state or an agency or political subdivision of the sate is a party;
(2) prohibit or limit the testimony of a department surveyor investigator in a civil action; or
(3) bar the admission into evidence in a civil action of a written finding, survey report, complaint investigation, incident investigation, or inspection report of the department that is offered:
(A) to establish warning or notice to an institution of a relevant finding;
(B) **under any rule or evidentiary predicate of the Texas Rules of Civil Evidence."**

As a result of S.B. 190, the current version of §32.021 of the Texas Human Resources Code, no longer prevents the admissibility of the Texas Department of Human Services' surveys, reports and complaint investigations as evidence of a nursing home's track record. [See brief attached as Appendix C]

§1.08 Recent Punitive Damage Standard Applied to Nursing Homes

The Fourteenth Court of Appeals and ostensibly the Supreme Court of Texas recently upheld a verdict for punitive damages applying the *Moriel* [63]definition of gross negligence to a

[62] *Golden Villa* at 349.

[63] *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10 (Tex.1994)

nursing home in the case of *Convalescent Services Inc. v. Schultz*[64].

This appeal arose out of unanimous jury findings that Defendant Convalescent Services, Inc. d/b/a Bayou Glen Nursing Home was negligent and grossly negligent. The jury awarded actual damages of $380,000 and assessed punitive damages in a separate proceeding in the amount of $850,000.

Defendant Convalescent Services, Inc. appealed the punitive damage portion of the verdict complaining that the evidence was legally insufficient to support jury findings of gross negligence and punitive damages. On March 14, 1996, the Fourteenth Court of Appeals Chief Justice Murphy, Justice Amidei, and Justice Anderson affirmed unanimously the verdict of the jury and the judgment of the trial court applying both a no evidence and insufficient evidence standard of review. On December 13, 1996, the Supreme Court of Texas found no reversible error and denied writ of certiorari.

The salient facts are as follows:

After hospitalization for pneumonia, Jacob Schultz was transferred from Seven Acres Nursing Home to Defendant Bayou Glen Nursing Home on July 5, 1991. At that time Schultz was 77 years old and suffering from end-stage Alzheimer's dementia. He was bedridden, incontinent, and his limbs were contracted. On admission, Bayou Glen's nursing staff noted that Schultz had a large, very dark red area on his coccyx and buttock, classified as a Stage I or II "decubitus ulcer". The ulcer worsened to at least Stage III when the skin surface broke open eleven days later on July 16, 1991. On August 25, 1991, Schultz was hospitalized for aggressive treatment of the steadily deteriorating ulcer, which had increased in size and progressed to Stage IV, exposing the bone. Schultz underwent several surgical procedures, including debridement of dead tissue and placement of a surgical skin flap to cover the exposed bone. After hospitalization of over three months, prolonged by infections after surgery, Schultz was released from Cy-Fair Hospital and re-admitted to Seven Acres Nursing Home.[65]

The thrust of Convalescent Services, Inc. d/b/a Bayou Glen Nursing Home's appeal was that there was no evidence that Bayou Glen had actual, subjective awareness of a serious risk to Schultz, that any of its acts or omissions caused the decubitus ulcer to progress to Stage IV, or that it acted in conscious disregard of this risk. Bayou Glen contended that the Schultz family only provided evidence of ordinary negligence based on the failure to document care. [66]

[A] No Evidence Standard of Review

In applying a traditional no evidence standard of review according to *Moriel*, the Appellate Court considered only evidence and reasonable inferences that supported the jury's verdict of gross negligence and did give not consideration to any evidence or inference that was to the contrary, *Havner v. E-Z Mart Stores, Inc.*, 825 S.W.2d 456 (Tex.1992).

The Court, reviewed the record in the light most favorable to Schultz to determine whether there was more than a scintilla of evidence to support both elements of Bayou

[64] 921 S.W.2d 731 (Tex.App--Houston [14th Dist.], 1996, writ denied)

[65] Adopted from the Appellate Court's Opinion rendered March 14, 1996

[66] Id

Glen's gross negligence[67]: (1) the extreme degree of risk of Bayou Glen's conduct that it created the likelihood of serious injury or harm to Schultz, *Universal Servs. Co. v. Ung*, 904 S.W.2d 638; and (2) that despite Bayou Glen's actual subjective awareness of the risk of harm involved, Bayou Glen was consciously indifferent to the risk.[68].

The Court found that there was more than a scintilla of evidence that Bayou Glen created the likelihood of serious injury to Schultz by failing to give sufficient care that created an extreme risk of causing Schultz's condition to worsen and ultimately caused his death. The Court considered the testimony of Plaintiff's expert, Dr. Taffett, who testified that: (1) Bayou Glen created an extreme risk of harm through its lack of care by not providing Schultz with the necessary treatments and preventive care measures; and (2) Schultz's high risk for the development of decubitus ulcers increased the probability that serious harm would result if Bayou Glen's nursing staff failed to provide regular monitoring and care.[69]

The Court then examined the second prong of the gross negligence test enunciated in *Moriel* under the no evidence standard of review to determine whether there was a scintilla of evidence that Bayou Glen had actual subjective knowledge of the harm. The Court analyzed the testimony of Bayou Glen's Director of Nursing, Nurse Theeck, who testified that the staff was familiar with the treatment necessary for patients like Schultz to prevent the formation of decubitus ulcers and the worsening of such ulcers. This testimony constituted evidence that Bayou Glen had actual subjective awareness.[70]

The Court concluded that Bayou Glen's knowing violation of its own policies, its failure to comply with the Nurse Practice Act, its apparent falsification of records, and disregard for doctor's orders constituted more than a scintilla of evidence of Bayou Glen's conscious disregard for the risk of serious harm to Schultz.[71]

[B] Review of the Factual Sufficiency of the Evidence

The Court noted that Bayou Glen's appeal focused on the legal sufficiency of the evidence supporting the jury's determination of punitive damages. Nonetheless, the Court conducted a factual sufficiency review of the evidence as to the amount of the punitive damages awarded by the jury.

Using the factors distinguished in *Alamo National Bank v. Kraus*, 606 S.W.2d 908, (Tex.1981), the Court held that the nature of the Bayou Glen's conduct compelled a finding of punitive damages. Schultz was totally dependent on Bayou Glen for all activities of daily life. He was helpless to even complain about any severe pain he was suffering. Schultz's vulnerability enhanced the seriousness of the risk to which Glen's conduct exposed him. Bayou Glen was responsible for caring for Schultz's needs and protecting him from injury. Through it's omissions, Bayou Glen permitted Schultz's condition to deteriorate and develop into a life-threatening situation by consistently violating its own policies and nursing procedures. Bayou Glen permitted Schultz to rapidly deteriorate without even informing his family of the existence of a

[67]The Appellate Court used the standard enunciated in *Transportation Ins. Co. v. Moriel*, 879 S.W.2d 10 (Tex.1994) to determine the applicability of gross negligence

[68]Id

[69]Adopted from the Appellate Court's Opinion rendered March 14, 1996

[70]Id

[71]Id

decubitus ulcer and the seriousness of the risk it posed. Such actions offended a public sense of justice and propriety and warranted an imposition of punitive damages both as a punishment and as a deterrent in an effort to ensure quality care for the elderly.[72]

[C] Extreme Risk of Harm

The Court's review of the record addressed the specific evidence of Bayou Glen's conduct that led to deterioration of Schultz's ulcer. The Court found the following evidence of Bayou Glen's failures probative and significant: (1) failure to turn Schultz every two hours and prevent the ulcer from developing into a life threatening condition; (2) failure to notify Schultz's physician, Dr. Wall, about the decubitus ulcer until July 16 when it had progressed to Stage III; (3) failure to follow doctor's orders by providing daily whirlpool baths on July 16-17 and 23-25, and 27; (4) failure to ensure that Schultz received sufficient nutrition to permit healing; (5) failure to provide a "Spenco" mattress to relieve pressure on the ulcer; and (6) failure to timely document Schultz's progress on a "skin assessment flow chart".[73]

The Court relied on the testimony of plaintiff's expert, Dr. Taffett, in determining the magnitude of the risk involved and its' probability. Dr. Taffett testified that: (1) without proper treatment the probability of the pressure ulcer worsening was very high, but with timely intervention there was a 95% probability of preventing the ulcer from worsening; (2) the nursing staff at Bayou Glen created an extreme risk to Schultz through it lack of care, in that there was no documentation in Schultz's medical record that the nursing staff had turned Schultz every two hours; (3) if a patient with a Stage I ulcer is not turned every two hours, the ulcer will become a Stage III or IV; and (4) the incontinent care provided to Schultz by Bayou Glen was insufficient to provide the degree of repositioning required for treating decubitus ulcers. Dr. Taffett also testified that Schultz was at a high risk for the development of pressure sore based on his need for assistance in all activities of daily living and that if Schultz was not turned every two hours his condition would deteriorate.[74]

The Court went on to discuss the testimony of Nurse Theeck, Bayou Glen's Director of Nursing. Nurse Theeck testified that to prevent the worsening of a decubitus ulcer, the nurses should have followed a protocol of: (1) bathing, turning and repositioning Schultz; (2)using a "Spenco" mattress to alleviate pressure; and (3) and ensuring that Schultz's nutritional needs were met.

The Court noted the testimony of the state inspector, Ms. Burdine, that proper care to prevent worsening of an ulcer of the type Schultz had required turning from left to right hip to alleviate pressure on the sacral area. Ms. Burdine concurred with Nurse Theeck that the medical records were the best evidence of the care that was delivered to Schultz[75]

The Court rejected Bayou Glen's arguments that: (1) care was provided despite not being noted on Schultz's chart; (2) Schultz's condition deteriorated even though proper care was provided; (3) Schultz's inability to heal more readily contributed to the deterioration of the sore; (4) Schultz was in general poor health by being bedridden, suffering from incontinence, being

[72]Id
[73]Id
[74]Id
[75]Id

malnourished on admittance, unable to turn himself, and needing assistance with all activities of daily life that contributed to his failure to heal; and (5) Bayou Glen did not have sufficient control over the progress of Schultz's condition to warrant a conclusion that its conduct alone created an extreme risk.[76]

[D] Actual, Subjective Knowledge

The testimony of Bayou Glen's Director of Nurses provided the Court with direct evidence that Bayou Glen had actual subjective awareness of the risk. Nurse Theeck, Bayou Glen's Director of Nursing, acknowledged that when Schultz was admitted to Bayou Glen with a large red area on his buttock and coccyx that "bells and whistles" should have gone off for the nursing staff. She further acknowledged that it was incumbent on nursing staff to take preventive measures to ensure that the decubitus ulcers did not worsen without which the ulcers got worsened most of the time. Nurse Theeck testified that the nursing staff was familiar with the treatment necessary for someone in Schultz's condition.

The Court, having thoroughly examined the record, found circumstantial evidence demonstrating Bayou Glen's conscious disregard of the risk of serious harm to Schultz. The Court discussed Bayou Glen's nursing staffs' unprofessional conduct wherein the nursing staff knowingly and consistently failed to comply with proper nursing standards by: (1) failing to document nursing notes in Schultz's records for July 9, 10, 11, 13, 14 or 15; (2) falsifying Schultz's records to reflect on a state-required reporting sheet dated July 16 that Schultz did not have any pressure sores when in fact Schultz's ulcer had progressed to a Stage III; (3) falsely documenting meals provided to Schultz on August 25 even though Schultz had already been discharged from the facility; and (4) falsely documenting on Schultz's nutritional records that Schultz's height was 5'4" instead of 5'10" or 5'11" to cover up the fact that Schultz was not provided adequate nutrition.[77]

Schultz's son, Mark, testified that neither he nor any other family member were ever informed of Schultz's decubitus ulcer until the sore had progressed to a Stage IV. [78]

The Court refused to entertain any of Bayou Glen's evidence under the no evidence standard of review that care was provided as demonstrated by evidence that the staff laboriously spoon-fed Schultz and that its efforts were commended by Dr. Taffett. [79]

After an exhaustive examination of the record, the Fourteenth Court of Appeals upheld the jury's finding of $850,000 in punitive damages assessed against Bayou Glen Nursing Home and overruled Bayou Glen's points of error attacking the legal sufficiency of the evidence for punitive damages.

§1.09 Conclusion

It is this author's sincere hope that the materials contained herein will provide the reader with an informative survey of traditional and emerging issues encountered in litigating a nursing home case that will prove beneficial to the reader.

[76]Id

[77]Id

[78]Id

[79]Id