Challenges of the Nursing Home Case

By Ellen B. Flynn

Sylvie had steel-blue eyes that sparkled when she cracked a dirty joke. She proudly did most of the *New York Times* crossword puzzle every day. There wasn't an Agatha Christie novel she hadn't read, or a politician she couldn't criticize. She was smart, funny and could tell a true story like only a matriarch with a good imagination and no one to check her facts could tell. But when she temporarily moved into a nursing home for rehab following a short hospitalization, she fell and broke her hip. This was the beginning of a long, miserable and preventable decline that included a stage IV decubitus ulcer, and which was no doubt the most humiliating experience of Sylvie's life. When her granddaughter unexpectedly arrived at the nursing home for a visit, she walked into the room to see Sylvie lying on a chucks pad with her backside exposed, her hands clenching the side rail of her bed and hoarse screams of pain filling the room as a nurse ripped a bandage from Sylvie's tailbone and told her not to wake up her roommate. The smell made her grab her nose to keep from retching, and her eyes filled with tears when she saw the size of the deep hole that was now oozing from her grandmother's backside. This should not have happened. What followed was a ping pong match of transfers from hospital to nursing home and back again, until Sylvie couldn't fight the infection that had spread from her wound to her heart.

Unfortunately, experiences like Sylvie's are more common that we would like to think. Respect, comfort, dignity, and quality care all things you would want for any elderly relative if nursing home care is required. But, looking at the inspection results of the Maryland Department of Health and Mental Hygiene, Office of Health Care Quality (OHCQ), Maryland nursing homes frequently fall short on some of the most fundamental categories of care.

Under the Maryland regulations applicable to nursing home facilities,[i] facilities must be open at all times for inspection by the Secretary of Health or any agency designated by the Secretary. OHCQ inspects each licensed nursing home at least every 15 months, or more frequently when the office receives a complaint that merits investigation. During OHCQ visits, inspectors observe whether a nursing home is in compliance with State and Federal regulations. Inspections are done to ensure that the nursing home residents receive quality care and services in accordance with rules established by Centers for Medicare and Medicaid Services (CMS). Nursing homes must comply with the federal regulations in order to participate in the Medicare or Medicaid program. When inspectors find that their care falls seriously short, nursing homes can lose payments under the program and/or be fined.

Despite these incentives to comply with the guidelines, examples of deficiencies recently found in Maryland might surprise you. They include:

- Failing to store, cook and serve food in a safe and clean way;
- Failing to give residents enough fluids to keep them healthy and prevent dehydration;
- Failing to immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline, etc.) that affect the resident;

i COMAR 10.07.02.05

- Failing to hire people without a legal history of abusing neglecting or mistreating residents and/or report and investigate any acts or reports of abuse, neglect or mistreatment of residents;
- Failing to keep accurate, complete and organized clinical records on each resident that meet professional standards;
- Failing to make sure that there is a pest control program to prevent and deal with mice, insects or other pests;
- Failing to develop a care plan that meets the resident's needs, with timetables and actions that can be measured;
- Failing to have enough health care providers (nurses and CNA's) to care for residents.

This is just a smattering of the reported deficiencies in recent Maryland inspections that are publicly available. When nursing homes are not run in accordance with established regulations, residents are needlessly injured.

Medical malpractice cases involving nursing home care are an unique breed of case not only because of the various regulations applicable to nursing homes that define how care should be provided, but also because the cases involve primarily pain and suffering claims that are tragically capped in Maryland. This makes fully capturing and presenting to a jury the pain associated with malpractice resulting in injury or death of our vulnerable elderly citizens even more important. Because these cases rarely involve large economic damages and most certainly involve Medicare liens, many firms avoid them entirely. But our elderly, vulnerable adults deserve our attention.

The most common nursing home cases involve injuries such as the development of bedsores due to lack of care, falls that could have been avoided if proper fall precautions were implemented in a resident's care plan, medication errors, and malnutrition. The standards of care in nursing home cases are drawn primarily from state and federal regulations that dictate how nursing home facilities are supposed to be run, and the nursing home's own policies and procedures concerning care that the nursing home facilities are required by regulation to establish and implement.

The Omnibus Budget Reconciliation Act of 1987, or OBRA, contains the Federal Nursing Home Reform

Act, which created a national set of expectations, or minimum standards of care, and rights for people living in certified nursing facilities. Essential to digesting the regulations for purposes of litigation or otherwise, is the "Watermelon" book, the so-called Bible for certified nursing homes. This book is the American Health Care Association's Long Term Care Health Survey and contains the minimum standards, classified by F-tags, used by inspectors to measure a facilities' compliance. This book frequently serves as a road map for experts in medical malpractice cases. If a resident's injury can be linked to a failure to comply with the regulations, a breach in the standard of care is easily proven. This leaves the nursing home reaching for causation defenses, that their residents are old, that the injury was unpreventable, and that their resident would have died (soon) anyway.

OBRA requires that each facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care for a patient. The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. According to the Institute of Healthcare Improvement (IHI), pressure ulcers are preventable in most cases. And yet, the prevalence of pressure ulcers in health care facilities is increasing and results in nearly 60,000 deaths each year.

Pressure ulcers are lesions caused by unrelieved pressure that results in damage to the underlying tissues. Nursing homes must evaluate whether a patient is at risk for developing pressure ulcers and implement the appropriate preventative measures to ensure that a patient doesn't develop an ulcer. Skin assessments are frequently required to ensure that ulcers are not developing and/or to identify developing ulcers before they progress to dangerous and life-threatening issues. Turning and repositioning every two hours for patients with limited mobility, and pressure relieving measures including special mattresses, heal protectors, protective barriers, appropriate hygiene for incontinence, and nutrition, are examples of measures that are proven to reduce the risk of ulcers.

When preventative measures are not implemented, the results can be devastating. Sacral wounds, for instance, on the tailbone of a largely immobile or incontinent patient are painful, very ugly (be sure to get pictures), and easily infected. Treatment of these largely preventable wounds is one of the most humiliating and miserable experiences imaginable. Wounds can progress all the way through the skin, muscles, fat and down into the bone. Treatment of these wounds often requires debridement where dead tissue is scraped away, either with a scalpel or by tearing it off using a wet-to-dry dressing to "mechanically remove" dead tissue, until fresh and healthy skin is reached and you will know when you get there because IT HURTS! Infections of these sores not only lead to painful debridement procedures, but can also lead to amputations, sepsis and death.

Another frequent and often preventable injury occurs from minor and major falls. According to a recent report in the Journal of Neurosurgery, subdural hematoma in the American population over 65 is on the rise.[ii] According to the Centers for Disease Control, about 1,800 older adults living in nursing homes die each year from fall-related injuries and those who survive a fall frequently sustain injuries that result in permanent disability and reduced quality of life.[iii] Even minor head trauma can cause significant injury because as people age, the brain shrinks, creating a space that makes veins

ii Balser, Farooq, Mehmood, Reyes, Samadani, Actual and Projected Incidence Rates for Chronic Subdural Hematomas in United States Veterans Administration and Civilian Populations, Journal of Neurosurgery (March 20, 2015).

iii http://www.cdc.gov/HomeandRecreationalSafety/Falls/nursing.html;

more susceptible to injury, and providing an area for blood to be trapped against the brain. Of the estimated 1.6 million residents in U.S. nursing facilities, approximately half fall annually. One in every 10 residents who fall has a serious related injury and about 65,000 patients suffer a hip fracture each year. Unfortunately, deaths resulting from falls in the American population over 65 are on the rise.[iv]

While not all falls and injuries can be prevented, Federal Regulation, 42 CFR §483.25(h), requires that facilities ensure the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Fall risk assessments should be performed on each resident so that measures can be put into place under the resident's care plan. Fall mats around beds, maintenance of beds in a low position, correctly sized and operational wheelchairs, bed and chair alarms, voiding schedules, and staff responsiveness to call buttons are all useful in preventing falls. Despite these available precautions, residents who are left unattended without fall mats in place, and residents who try to make it to the bathroom without assistance to avoid soiling themselves when call buttons remain unanswered, suffer catastrophic consequences.

In assessing nursing home cases such as the fall and wound cases, it is important to spend time evaluating what is, and what is not, in the medical records. Many nursing homes are just getting electronic medical record systems. Electronic medical records generate an audit trail log that documents when each entry was made. Thus, the end-of-shift, or better yet, beginning of shift, check marks across the page are now easily provable. Frequently charts that are supposed to document care that was actually given are rife with errors, including documented care on days the resident wasn't even at the facility. Medication logs can help to establish pain and suffering that is not otherwise documented in the medical chart. For cases where patients are sent to a hospital from a nursing home for acute care, pay attention to inconsistencies between the resident's documented condition at discharge or transfer and the admission assessment performed on the same day by the hospital accepting the patient, particularly in the pressure wound cases.

Pictures and witness testimony are also critical components of nursing home cases. A picture of a stage IV pressure wound will be burned into the minds of the jury in seconds. It will be nearly impossible to convince a jury that a resident with a stage IV pressure wound did not experience pain after they see the picture. Likewise, deposition testimony of CNA's and nursing staff can be very useful in establishing errors in the medical record, pain and suffering of the resident, and obtaining admissions about the standards of care. A good deposition of a CNA or nurse can frequently drive early settlement discussions. Family member testimony is also critical to describe conditions in the facility, observed pain and suffering, and of course to describe the meaning and value of their loved-one's life.

Nursing home residents have rights and protections under the law. These rights and protections have been legislated in an attempt to protect our elderly populations who are particularly vulnerable to malpractice and abuse. Use the fact that these persons have been legislatively recognized to merit our protection to build your case.

Navigating the nursing home case can be difficult and time consuming without resources at your fingertips.

iv Deaths From Unintentional Injury Among Adults Aged 65 and Over: United States, 2000-2013, NCHS Data Brief, No. 199 (May 2015)

The Maryland Association of Justice has a section that is dedicated to nursing home litigation. Roundtable discussions, CLE's and access to the list serve are valuable resources for litigators tackling cases like Sylvie's. For more information on how to participate in the Nursing Home Section of MAJ, please contact the main office, or eflynn@medicalneg.com. ■

Biography

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