

# **NURSING HOME NEGLIGENCE IN NEW YORK**

## **Nursing Home Neglect And The Regulations In New York**

### **The Duty To Assess And Plan Continued Care**

*Presented 5/19/05 and 5/24/05*

- The Statutes and Regulations Related to Nursing Homes
- The Duty To Assess, the Assessment Process and the MDS
- The Duty to Plan the Care

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# **TABLE OF CONTENTS**

## **I. OVERVIEW OF NURSING HOME NEGLECT**

- A. LITIGATION TRENDS**
- B. CAUSES OF ACTION AND LEGAL DUTIES ON THE NURSING HOME**
- C. SURVEYS AND GUIDANCE TO SURVEYORS**

## **II. STATUTORY AND REGULATORY PROTECTIONS OF NURSING HOME RESIDENTS**

- A. FEDERAL**
  - 1. FEDERAL STATUTE**
  - 2. FEDERAL REGULATIONS**
    - a. Code of Federal Regulations**
    - b. Guidance to Surveyors**
- B. NEW YORK STATE**
  - 1. NEW YORK STATUTES**
    - a. PHL Article 28 - Hospitals**
  - 2. NEW YORK REGULATIONS**

## **III. GENERAL REGULATIONS TO PROTECT NURSING HOME RESIDENTS**

- A. THE FACILITY MUST BE SAFE**
- B. THE RESIDENTS MUST BE PROVIDED GOOD AND NECESSARY CARE**
- C. AS FOR *INCIDENTS* INVOLVING RESIDENTS**
- D. DUTY TO ASSESS AND PLAN THE CARE**
- E. GUIDANCE TO SURVEYORS**

## **IV. FALLS (FALL INJURIES) AND PRESSURE ULCERS**

### **IV.(A) INTRODUCTION TO FALLS CASES**

#### **IV.(A)(1) Regulations In The “Falls” Case**

**IV.(A)(1)(a) Intent of 42CFR§483.25 (h)(2), (10 NYCRR §415.12 (h)(2))**

**IV.(A)(1)(b) Procedures under 42 CFR§483.25 (h)(2), (10 NYCRR §415.12(h)(2))**

**(A)(1)(b)(1)**

**(A)(1)(b)(2)**

**(A)(1)(b)(3)**

**IV.(A)(1)© Probes under 42CFR§483.25(h)(2), (10 NYCRR §415.12(h)(2)**

**A(1)©(1)**

**A(1)©(2)**

**A(1)©(3)**

**IV.(A)(2) INVESTIGATING THE “FALLS” CASE:**

**IV.(A)(3) SPECIAL TOPICS INVOLVED IN “FALLS CASES” - OTHER FACTORS, SCENARIOS AND THEORIES OF LIABILITY IN NURSING HOME “FALLS” CASES**

**IV.(B) PRESSURE SORES/ULCERS**

**IV.(B)(1) Introduction to Pressure sores, pressure ulcers, bedsores and skin ulcers**

**IV.(B)(2) REGULATIONS IN THE “PRESSURE ULCER” CASE**

**IV.(B)(2)(a) Intent**

**IV.(B)(2)(b) Procedures**

**IV.(B)(2)© Probes**

**IV. (B)(2)©(1)**

**IV. (B)(2)©(2)**

**IV.(B)(3) SPECIAL TOPICS IN EVALUATING PRESSURE ULCER CASES**

- a. WAS THE RESIDENT AMBULATORY?**
- b. WHAT STAGE WERE THE BEDSORES?**
- c. WAS THE RESIDENT INCONTINENT?**
- d. THROUGH MDS ANALYSIS, THE FOLLOWING AREAS WILL TRIGGER A RAP FOR PRESSURE ULCERS**
- e. URINE SMELL**
- f. DEHYDRATION AND/OR MALNUTRITION**
- g. ADMISSION ASSESSMENT**
- h. TURNED AND REPOSITIONED**
- i. CIRCULATORY DISEASE (PVD)**
- j. COGNITIVE LOSS**
- k. MEDICATIONS**
- l. RESTRAINTS**
- m. PLAINTIFF’S FAMILY’S DEPOSITION**
- n. DEFENDANT’S DEPOSITION**
- o. ATLA ARTICLE**
- p. STASIS ULCER**

**V. VIOLATION OF PUBLIC HEALTH LAW SECTION 2801-d**

**V.(A) PHL §2801-d AS AN ADDITIONAL AND CUMULATIVE TORT REMEDY**

**V.(B) EXTENT OF LIABILITY IMPOSED BY VIOLATION OF PUBLIC HEALTH LAW 2801-d**

**V.(B)(1) Strict Liability?**

**V.(B)(2) Negligence Per Se?**

**V.(B)(3) Some evidence of negligence?**

**VI. STATUTE OF LIMITATIONS CONCERNS**

- A. Alternate Periods of limitation**
- B. Medical malpractice vs. Negligence**
- C. Extending the applicable statute of limitations**
- D. The saving statute (CPLR§205(a))**

**VII. DISCLOSURE AND ADMISSIBILITY OF DOCUMENTS**

- A. Discoverability of surveys, investigations, reports, and/or written determinations relating to a complaint report made pursuant to Public Health Law §2803-d**
- B. Admissibility of department of health surveys and/or investigative reports**

**VIII. THE INITIAL CLIENT INTAKE AND SCREENING**

- A. Initial conversation and client intake**

**IX. PRESUIT CONSIDERATIONS IN NURSING HOME CASES**

- A. Who is your client and how to get started**
- B. Who will be your client, likeable?**
- C. Types of records and how to secure records**
- D. Other Presuit investigations**

## **I. OVERVIEW OF NURSING HOME NEGLECT**

### **A. LITIGATION TRENDS**

We have been litigating nursing home claims and have lobbied for legislative changes in supporting the improvement of nursing home safety. We have observed that settlements and verdicts in these cases continue to rise. In southern states large verdicts can easily be found. Recently, in Kolbert and Popielski v Maplewood Health Care Center, Inc., July 21, 2004, Supreme Erie, Index # 7674/01, a jury awarded \$1,500,000 for pain and suffering after plaintiff suffered a fractured arm due to a fall and subsequently developed pressure ulcers, dehydration and malnutrition.

According to the National Law Journal (7/8/03), citing the American Health Care Association, "lawsuits per nursing home bed have been increasing at an annual rate of 14% since 1995, with 14.5 claims for every 1,000 occupied beds last year."

Compensation in nursing home cases is growing particularly in the area of pressure ulcer a/k/a pressure sore or decubitus ulcer cases. According to the February 2001 edition of the Medical Malpractice Law & Strategy journal in the period from 1987 to 1994, the average award in a nursing home negligence case increased from \$238,285 to \$525,853. According to the National Law Journal (7/8/03), in 2001 the average jury award was \$406,000 and 46% of verdicts were for plaintiff. In addition, while personal injury litigation produced punitive damages in only 5% of cases, the figure was 10% for nursing home lawsuits, according to the recent National Law Journal article. Furthermore, in 28 of 30 plaintiff verdicts/settlements in pressure sore cases, awards averaged \$973,340.

Through these verdicts, juries are sending a clear message to nursing home corporations that they will no longer tolerate them putting "profits before people". On the other hand, State legislatures and the US Senate are, at this moment, being heavily lobbied by the insurance industry and health care companies, to pass a medical malpractice and products liability "reform statute" which would limit nursing home liability to \$250,000.00 for *pain and suffering claims*, which in New York, is essentially all one may claim. The future is unknown, except that by the year 2020, the population of "the aged 85 and older will increase by almost 60%". (National Law Journal (7/8/03).

This article outlines many of the laws and regulations governing nursing home care. Where we could, we tried to convey practical advice concerning the realities of litigating in this area. In this regard, we have suggested and interposed "Practice Points" at various times within the paper.

The regulations governing nursing homes in New York State are Federal (now CMS)

and State (Department of Health). In 10 NYCRR §415.1(a)(1), the "statement and purpose" for regulating nursing homes in New York is succinctly stated as:

“New York's residential health care facilities are responsible for the health and well-being of more than 100,000 residents ranging from infants with multiple impairments to young adults suffering from the sequelae of traumatic brain injury to the frail elderly with chronic disabilities. For the vast majority of residents, the residential health care facility is their last home. A license to operate a nursing home carries with it a special obligation to the residents who depend upon the facility to meet every basic human need.”

The regulations began to be promulgated in the late 1970's. Today there are over 120,000

residents in some 690 nursing homes in New York State. According to the New York Times on December 5, 2004, there are over 1,500,000 residents in nursing homes in the United States today.

In our office, we join the National Citizen's Coalition for Nursing Home Reform (NCCNHR) for every family or victim that retains us. This organization is worthy of your support, whether you are a member of industry, an employee of an insurance company, or members of the defense or plaintiff's bar. NCCNHR lobbies and educates in favor of better nursing home care. An application to join is in our materials. (**Exhibit “A”** - NCCNHR Application)

## **B. CAUSES OF ACTION AND LEGAL DUTIES ON THE NURSING HOME**

This paper will outline and discuss the causes of action that may be made on behalf of an injured, neglected and abused resident of a *nursing home* in the State of New York. The common causes of action are ones for Negligence, Medical Malpractice and violation of Public Health Law §2801-d (based upon the violation of a regulation). Whether or not a nursing home has violated a regulation or has been negligent or committed medical malpractice, we will focus on a certain method of analysis of nursing home neglect. This method is derived from the method that Federal and State regulators (surveyors) use to evaluate whether a nursing home is in compliance with regulatory standards.

In general, the regulations and the way they are applied by the federal and state surveyors reveal a repetitive method of analysis. The standard of good nursing home care, and compliance with the regulations, always seems to involve the same analysis:

1. Did the nursing home fulfill its duty to properly assess the resident and the resident's risks for certain injuries? *Did the nursing home properly assess the resident/patient?*
2. After assessment, *was a proper plan of care (or care plan) designed?* Did the “care plan” call for the implementation of the appropriate *interventions to avoid or lessen* the risk of injury?
3. Was the “care plan” put into place, or implemented?

4. Was the “care plan” appropriately updated and kept current (after a passage of time, or due to intervening changes of condition, or due to incidents or injuries to the resident)?

We will analyze the federal and state system of surveying nursing homes for compliance with the regulatory scheme. Such evaluation of the survey process and following the process, is a convenient method of measuring nursing home compliance or violation of the applicable regulations.

While negligence and medical malpractice claims involve violations of standards of care and of the regulations in place to protect nursing home residents, this paper will focus on the third cause of action, that is, violation of the PHL §2801-d. Since such a violation involves the question of whether or not the defendant nursing home has conformed to the existing regulations concerning nursing home care, a consideration of some of the applicable regulations will be made.

This paper will examine PHL§2801-d, in light of violations of the regulations governing nursing homes. We will outline general regulations concerning patient safety in *all* types of cases. We will then focus on the regulatory scheme involved in analyzing the two most common types of cases: FALLS (and Fractures), and PRESSURE ULCERS (and dehydration and malnutrition). One may have a “FALLS” case without fractures and one may have a “PRESSURE ULCER” case without dehydration and malnutrition, but commonly falls involve fractures and pressure ulcer cases involve at least consideration of malnutrition and dehydration.

## C. **SURVEYS AND GUIDANCE TO SURVEYORS**

The federal government, specifically the Centers For Medicare and Medicaid Services

(CMS) is now charged with coordinating nursing home safety issues. CMS regulations are the federal standard. New York State, through its Department of Health surveys, examines nursing homes in New York and judges the quality of the homes by testing their compliance with the Federal and DOH regulations. The DOH regulations, Title 10 of NYCRR, Parts 410-415 “Residential Care Facilities”, are almost identical to the federal regulations. In the “pressure ulcer” regulations, the New York DOH regulations are significantly more stringent in favor of protecting residents, than its Federal counterpart.

The Department of Health surveyors have been trained to examine nursing home compliance with the regulations by utilizing the “guidance for surveyors”, composed by the Federal regulators. A publication of these guides for surveyors can be found at “Guidance To Surveyors-Long Term Care Facilities” in “The Long Term Care Survey” by American Health Care Association, May 2003. References to this book shall be used through out this paper.

Nursing homes must submit to *annual* surveys conducted by The New York State



## II. STATUTORY AND REGULATORY PROTECTIONS OF NURSING HOME RESIDENTS

Following is a list of some of the Federal and State Statutes and Regulations involved in regulating care and protecting residents in nursing homes in New York. Resident's rights and standards for resident's care are detailed in the regulations.

### A. **FEDERAL**

#### 1. FEDERAL STATUTE

Nursing Home Reform Act, Omnibus Reconciliation Act (OBRA) of 1987 (42 U.S.C. 1396r; 42 U.S.C. 1395I-3), is the comprehensive federal statute that imposed far reaching reform on the nursing home industry.

#### 2. FEDERAL REGULATIONS

##### a. **Code of Federal Regulations** (42 CFR Part 483)

Federal regulations under the above statute which create specific standards of care the nursing homes must follow in order to collect Medicare and Medicaid reimbursements.

##### b. **Guidance to Surveyors**

Interpretive guidelines which explain the regulations.

### B. **NEW YORK STATE**

#### 1. NEW YORK STATUTES

##### a. **PUBLIC HEALTH LAW ARTICLE 28 - HOSPITALS**

§2801 Definitions – Nursing Home is a hospital.

§2801-d. "Private actions by patients of residential health care facilities"

- New York statute which creates a private cause of action for nursing home neglect or abuse or violation of "any right or benefit....granted by contract..., regulation or statute".

- Special advantages conferred by PHL 2801-d: **(Exhibit “K”)**
  - creates a private statutory right of action
  - elements of claim: injury caused by deprivation of a right or benefit
  - establishes minimum amounts of damages (at least 25% of the daily rate the nursing home charges)
    - expressly authorizes punitive damages (if deprivations of any right or benefit was willful or in reckless disregard of the patient’s rights)(d)(2)
    - attorney fees can be awarded in discretion of court to victorious resident’s attorney (d)(6)
    - 3 year statute of limitations
    - damages recovered are not to be reduced by Medicaid liens and are exempt for purposes of determining continuing eligibility for Medicaid, if your injured client is still alive (d)(5)

§2803-c “Rights of patients in certain medical facilities”

§2803-d “Reporting abuses of persons receiving care or services in residential health care facilities”

§2803-e “Reporting incidents of possible professional misconduct”

§2805-d “Limitation of medical, dental or podiatric malpractice action based on lack of informed consent”

§2805-e “Reports of residential health care facilities”

§2805-l “Incident Reporting”

2. **NEW YORK REGULATIONS**

Title 10 – DOH – Nursing Homes – Part 415

### III. GENERAL REGULATIONS TO PROTECT NURSING HOME RESIDENTS

As described in section I.C. above, the New York State Department of Health surveys

every nursing home each year. In general 5% of all State surveys must be done by the federal government as oversight on the State's surveyor performance. The Federal regulators survey to see that the State surveyors are doing their jobs. Surveyors are supposed to interview staff, residents, resident's families and review charts (both "active" and "closed"). The purpose of these surveys is to monitor whether or not the nursing home is providing good care to maintain the health and welfare of the residents.

The Federal Regulations and New York State Regulations have specific requirements that nursing home operators must comply with. When alleged neglect or abuse has lead to claims or litigation, a jury may be asked to decide whether the defendant nursing home has complied with or violated these regulations. This section describes and discusses some of the general regulations which affect ALL CASES. In section IV. below, we discuss the regulations that specifically apply to the FALLS CASE and the PRESSURE ULCER CASE.

#### III. A. THE FACILITY MUST BE SAFE

In 42 CFR 483.70 and 10NYCRR§415.29 "the facility (the physical environment) must be designed and maintained to protect the health and safety of residents".

#### III. B. THE RESIDENTS MUST BE PROVIDED GOOD AND NECESSARY CARE Under 42CFR 483.25 and 10NYCRR§415.12 (Quality of Care):

"Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination."

In the federal regulation (42 CFR 483.25) and the New York State regulation (10NYCRR§415.12): there is a list of required necessary quality of care and treatments that the nursing home "ensures" will happen relating to:

- a. Activities of daily living (ADL)
- b. Vision and hearing
- c. Pressure sores
- d. Urinary incontinence
- e. Range of motion
- f. Mental and psychosocial functioning
- g. Enterol feeding tubes

- h. Accidents
- i. Nutrition
- j. Hydration
- k. Special needs
- l. Drug therapy
- m. Medication errors

This list of Quality of Care issues is actually not exclusive and complete. The opening paragraph to 10NYCRR§415.12 (and 42CFR§483.25) <sup>1</sup> is a general “catchall” to “ensure” all other safe care that is not included in the above list. In the “Guidance to Surveyors” (PP-83) the surveyors are instructed to “use Tag F309 to cite (the nursing home for) quality of care deficiencies that are not explicit in the quality of care regulations.” For instance, whether or not a nursing home has sufficiently treated the resident to avoid “pain” and avoid “fecal impaction” are covered by F309. A violation of F309 would be at least a “G” level- serious-violation. This writer cites “pain” and “fecal impaction” as to conditions which are unfortunately not uncommon in nursing home cases and may be the basis of a case.

Support for the concept that the nursing home “ensures good care” in avoiding “pain” and “fecal impaction”, although these two areas are not explicitly covered in 10 NYCRR §415.12, not only comes from an analysis of the survey process, but from the “Guidance To Surveyors”. When the Department of Health survey occurs, the nursing home must present a “Roster/Sample Matrix” listing every patient and all their “resident characteristics”.<sup>2</sup> Each patient’s data and problems are listed, including “pain”, “fecal impaction” and items listed in the above regulation, 10 NYCRR §415.12, such as “pressure sores” and “accidents” (falls).<sup>3</sup>

**PRACTICE POINT:** *In disclosure, get this form from defendant and from DOH with other patient’s names redacted - gives you full view of the patient on a particular day. It also gives characteristics of other patients (redacted names) so you can explore whether staffing levels were appropriate for these types of residents.*

The list of Quality of Care issues includes many items whose violation may cause an accident (falls) or other liability inducing changes in the plaintiff.

In this most generally applicable regulation, which covers “Quality of Care”, the Guidance To Surveyors teaches, that since the regulation requires the “highest practicable” levels of well-being in each quality of care category, a decline in functioning must be evaluated.

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<sup>1</sup> (F309)(PP-83)(citations hereinafter to “PP-page #” are to the pages of “Guidance To Surveyors-Long Term Care Facilities” in “The Long Term Care Survey” by American Health Care Association, May 2003)

<sup>2</sup> (**Exhibit “B”**) - form (Exhibit 90 - Roster Sample Matrix from AHCA “the Long Term Care Enforcement Procedures”)

<sup>3</sup> (form HCFA 802 and Exhibit 265 of “The Long Term Care Survey” by AHCA (May of 2003))

The nursing home cannot state a decline is “unavoidable” unless “all of the following are present”:

- “ •An accurate and complete assessment (42CFR§403.20);
- A care plan which is implemented consistently and based on information from the assessment;
- Evaluation of the results of the interventions and revising the interventions as necessary.”

The theme we will revisit again is apparent. The nursing home has the duty to assess, the duty to then formulate a care plan, the duty to implement the care plan and the duty to evaluate the results of the interventions from the care plan and the duty to revise the interventions as needed.

### III C. AS FOR *INCIDENTS* INVOLVING RESIDENTS

The regulations at 42 CFR §483.13 and 10NYCRR§415.4 (Resident Behavior and Facility Practices) state that:

- The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, are *reported* immediately to the administrator of the facility and to the (State Department of Health) 42CFR §483.13( c )(2); 10 NYCRR§415.4(b)(2) (pursuant also to PHL §2803-d); and
- All alleged violations including neglect must be thoroughly *investigated* 42CFR §483.13( c )(3); 10 NYCRR§415.4(b)(3); and
- Injuries of unknown source must be reported to the facility administrator and to the (State Department of Health) and must be thoroughly investigated. 42CFR§483.12( c )(2); 10NYCRR§415.4(b)(2); and finally
- The results of the investigations cited above must be “reported to the administrator and .... to the (Department of Health) within five (5) days of the incident”.

When the New York State Department of Health receives the report of an “alleged violation” it is to generate a survey (investigation). A survey can also be initiated from the complaint made by family, the attorney or an honest employee (whistle blower), *but the facility is required* to report all “alleged violations involving neglect, including injuries of unknown source, to the Department of Health”.

**PRACTICE POINT:** *If an incident or alleged violation was not reported to DOH, depose the nursing home. Why was it not reported? Who discussed it? Who made the decision not to report?*

**PRACTICE POINT:** *If your client's case was surveyed by the annual routine surveys or in response to a complaint, question the nursing home on the factual findings, did they agree or disagree with the surveyor's findings? Did they write in response? Did they submit "plan of correction"? (By not disputing the DOH findings and merely putting in a "plan of correction", weren't they admitting the finding?)*

### III. D. DUTY TO ASSESS AND PLAN THE CARE

The duty of a nursing home to properly assess risks to a resident comes directly from the applicable regulations. Pursuant to 10 NYCRR §415.11, the nursing home must assess the resident "upon admission and periodically thereafter". The regulation states:

*"Upon admission and periodically thereafter the facility shall conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Based on the results of these assessments, the facility shall develop and keep current an individualized comprehensive plan of care to meet each resident's needs."*

Also, under 10 NYCRR §415.11 and 42 CFR 483.20 (b)(2), the nursing home must conduct "comprehensive assessments", "no later than 14 days after the date of admission, (by utilizing the MDS form- **Exhibit "C"**) and again promptly after a significant improvement or decline in the resident's physical, mental or psychosocial status .... and again less often than once every 12 months for each resident." Further, "the results of the comprehensive assessment shall be used by the interdisciplinary team ... to develop, review, and revise the resident's comprehensive plan of care, ...(F273)(PP-72). The comprehensive care plan is to be done by day 21. (F280)(PP-82.2)

According to the "guidance to surveyors", (PP-72) §483.20, Resident Assessment, (b) (2), "requires comprehensive assessment of resident within 14 days of admission" but also the Guidance to Surveyors §483.20 (b) (PP-69) provides that "the facility is responsible for addressing the resident's needs from the moment of admission". Therefore an initial care plan is required.

Further, in the Guidance To Surveyors for 42CFR§483.25 (Quality of Care), the surveyors are to determine if the services noted in the plan of care, (which was to be) based on a comprehensive and accurate functional assessment of the resident", including "risk factors", "is continuously and aggressively implemented and updated by the facility staff".

This is a very stringent requirement: To seriously assess and plan care with interventions and to "aggressively implement" the care plan and update the care plan.

Finally, the same "Guidance to Surveyors" (§483.25) not only refers to the assessment after 14 days but also for "residents... in the facility for less than 14 days..." The resident is to be "assessed and

care planned and provided appropriate services”.

**In summary**, the regulations of the New York State Department of Health, and Federal Regulations require an assessment of real risks (i.e.: falls, ulcers) with **any** admission and daily and of course with the comprehensive MDS (14 days) assessment.

Once again, the regulations require:

- assessment from admission and comprehensive assessment by day 14 on the MDS form;
- initial plan of care from initial assessment;
- comprehensive plan of care from comprehensive assessment;
- aggressive implementation of the plans of care with interventions;
- new assessments;
- revising and updating of plans of care.

### **III. E. GUIDANCE TO SURVEYORS**

The “Guidance To Surveyors” is organized in that each regulation is stated and a violation of that regulation is assigned an “F-tag”. The writers state the “**intent**” of each regulation, what the regulation means. Listed next are “**procedures**” for the surveyor to use to test whether a nursing home is in compliance with the regulation or has violated the regulation. These “procedures” walk the surveyor through or guide the surveyor by asking specific questions that the surveyor is to secure answers to. Finally, the Guidance asks the surveyors to delve deeper using suggested “**probes**” or detailed additional questions regarding the care of the resident.

#### IV. REGULATIONS IN CASES CONCERNED WITH FALLS AND PRESSURE ULCERS

In section IV, we will focus on the Regulations and the regulatory process affecting the two most common types of nursing home liability cases - FALLS and PRESSURE ULCERS.

##### IV.(A) INTRODUCTION TO FALLS CASES

The elderly fall with alarming regularity. So much of the Federal regulations and State regulations deal with “falls” due to the proclivity of falls as well as the danger to the remaining health of the elderly that a severe fracture presents. Typical results include the permanent loss of mobility and permanent decrease in the quality of life as well as the dangers of a severe downturn in the health and quality of life, for the elderly and infirm. Undergoing anesthesia in surgery for fractures from falls, and the resultant decrease in mobility, present challenges that often are catastrophic. Cases involving “falls” center upon issues of poor quality of care and neglect.

Falls are extremely common in nursing homes. In surveys of nursing home resident the percentage of residents reported to fall each year ranges from 16-75% with a mean of 43%. See chapter 12, Medical Legal Aspects of Long-Term Care, compiled and edited by Dr. Jeffrey M. Levine, MD, Lawyers & Judges Publishing Company, Inc. citing a study.

A high percentage of nursing home complaints involve falls. The defense will typically be that falls are inevitable. The defense will argue that falls have occurred since nursing homes have been forced to move away from physical and chemical restraints. (Actually, a recent Texas study indicated that as restraint use has decreased, prevalence of falls did not increase and that the injuries, without using restraints, due to falls, were actually less severe. (i.e.: climbing over side rails instead of falling out of a lowered bed). In Texas the residents had been restrained in order to avoid falls or wandering. In the study it was determined that less restraints was better for preserving the resident’s function and to actually decrease injuries. The “myths” that restraints protect residents, decrease staff time, decrease the cost of care or that it allows for less medication use and decreased liability were proved false. In fact, “The Texas Department of Insurance recognizes restraint use as a key facility liability risk - management issue, because of liability claims arising from the use of restraints.” The study concluded that *nursing homes should evaluate and care for residents and seek restraint - free environments.* (**Exhibit “D”**- copy of the Texas study))

A fall in a nursing home should not be viewed as in anyway similar to a fall that occurs in any other setting. The “falls case” centers around the physical plant , the medical condition of the resident and how the resident was assessed or evaluated, what plan of care and interventions and safeguards of care were taken and how aware and committed the staff was in dealing with the individual care of the victim. Was the plan of care acted on? Was it updated in light of changes in circumstances, such as subsequent falls?

#### IV.(A)(1) REGULATIONS IN THE “FALLS” CASE

With respect to analyzing the ‘FALLS’ case, we begin with 42 CFR Section 483.25(h) (Quality of Care - Accidents) & its counterpart 10 NYCRR §415.12(h). The regulation states that “the facility must ensure that:

(h)(1) The resident environment remains as *free of accident* hazards as is possible; and

(h)(2) Each resident receives adequate supervision and assistance devices to *prevent accidents*.

In order to apply this Regulation, we turn to the “**Guidance To Surveyors**” which teaches us the meaning of this regulation and how nursing homes are to apply it. In the “Guidance To Surveyors” under 42 CFR §483.25(h) (PP-104-105), the federal administrators state what the regulation means and how to test that the home is complying with the regulation.

The Guidance defines an “Accident Hazard” (h)(1) as: physical features in the nursing home environment that can endanger a resident’s safety, including but not limited to:

- Physical restraints (see physical restraints §483.13);
- Equipment or devices that are defective, poorly maintained, or not used in accordance with manufacturer’s specifications (e.g., wheelchairs or geri-chairs with nonworking brakes, and loose nuts and bolts on walkers);
- Bathing facilities that do not have nonslip surfaces;
- Hazards (e.g., electrical appliances with frayed wires, cleaning supplies easily accessible to cognitively impaired residents, wet floors that are not obviously labeled and to which access is not blocked);
- Defective or improperly latched side rails or spaces withing side rails, between upper and lower rails, between rails and the mattress, between side rails and the bed frame, or spaces between side rails and the head or foot board of the bed that can entrap limbs, neck or thorax, and can cause injury or death;
- Handrails not securely fixed to the wall, difficult to grasp, and/or with sharp edges/splinters; and
- Water temperatures in hand sinks or bath tubs which can scald or harm residents.

The Guidance defines “*Accidents*” (h)(2) as an “unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence

of treatment or care, (e.g., drug side effects or reactions)” and are situations like “falls”, “burns” in a hot tub not checked by the CNA or where a picture frame falls off a wall and hits the resident.

We will focus on “accidents” (h)(2), rather than “accidental hazards”, (h)(1), as we find that a much greater percentage of falls occur in this area.

**IV.(A)(1)(a) Intent of §483.25 (h)(2), 10 NYCRR §415.12 (h)(2)** (What does the regulation mean?)

The intent of this provision is that the “facility identifies each resident at risk for accidents and/or falls, *and* adequately plans care *and* implements procedures to prevent accidents”.

Therefore, the nursing home must:

- Assess** if the resident is at risk for falls; and
- Plan Care** adequately; and
- Implement the plan of care** with interventions to prevent accidents

**IV.(A)(1)(b) Procedures under 42 CFR§483.25 (h)(2), (10 NYCRR §415.12(h)(2)** (The “procedures” walk the surveyors through this regulation and show how to establish whether the nursing home is in compliance or has violated the regulation.)

The federal regulators instruct that:

**IV.(A)(1)(b)(1)** “If a resident(s) selected for a comprehensive or focused review has had an accident, review the facility’s investigation of that accident *and* their response to prevent the accident from recurring.”

Therefore the nursing home has the duty to investigate all accidents. Further, the nursing home must respond by trying to prevent a recurrence of the accident. Therefore, it is incumbent on the nursing home to have an investigation done and to evaluate the care plan and discuss changes to the care plan with the inclusion of new interventions tailored to help to avoid accidents/falls.

**PRACTICE POINT:** *In disclosure, get the facility’s investigation. (It should exist and it must be “reviewable” and therefore “written”) Did the supervisor of the investigation find findings? Was the Care Plan followed before the accident? Was the Care Plan faulty in the process? Did the Care plan need modification after the accident? If the Care Plan was not followed, it was due to neglect by staff? Was it modified? How?*

**IV.(A)(1)(b)(2)** “Identify if the resident triggers any RAPs for falls, cognitive loss/dementia, restraints, and psychotropic drug use and whether the RAPs were used to assess causal

or decline or lack of improvement.”

The Guidance for this “Procedure” indicates that a full assessment must have been done.

The indication in the Guidance that a “RAP” consideration is needed indicates an analysis of the MDS.

The MDS assessment process is required to have been done. If a RAP should have been triggered, but was not, due to an improper assessment, there is a violation.

If the MDS assessment was done and RAPs were triggered in this area, the RAP guidelines require an investigation to “assess causal factors for the decline or lack of improvement” in this area.

**PRACTICE POINT:** *If a RAP is triggered in the MDS form, (**Exhibit “C”**) the form dictates what to do. On the top of the last page of the MDS form, it states the nursing home is to “use the RAP guidelines to identify areas needing further assessment”. A RAP guideline for “falls” is attached as **Exhibit “E”**. This document is a deposition handbook in itself. Each “assessment area” is a trove of areas of inquiry.*

On the second page of the RAP guideline for “falls”, the Nursing Home is told that “Falls are the most common cause of accidents in people over 65 “and “Falls cause more deaths than pneumonia or diabetes and all other types of accidents combined”.

**PRACTICE POINT:** *Ask the Director of Nursing if she knew that?*  
*Ask*

*them if they knew that “hip fracture is the most common fall - related injury that leads to hospitalization and that approximately 25% of these patients die within 6 months of injury and 60% have decreased mobility after a hip fracture”.*

One must keep in mind, that once there is a decrease in mobility, the nursing home is then presented with an **increase in the risk for pressure ulcers**. Did the nursing home change the care plan to reflect this?

Regarding an analysis of the MDS assessment the surveyor (and therefore the plaintiff’s attorney in disclosure, before deposing the defendant), has to secure all the MDS’ done by the home and use the last full MDS done on the resident before the critical fall.

**PRACTICE POINT:** *At the EBT- question the nursing home witness:*

was

the MDS form completed? Take the witness through the answers in the MDS and the content of the chart. Were the answers consistent with the chart? If MDS was completed contrary to the history, and what the nursing home knows in the chart, it is a violation.

Did a RAP get triggered? (anything in “red” and answered “yes” triggers a RAP (Resident Assessment Protocol) which is a full assessment of that issue. (Last page of MDS form – the # corresponds to the red # on the questionnaire.) Did the nursing home use the RAP guidelines (to identify factors contributing to the risk of falls)? Take the nurse or administrator through the RAP guideline for falls and inquire how the nursing home completed the “assessment”. Did they write on page 10 of the MDS form, (**Exhibit “C”**) under #11, how the assessment was done? Where in the chart did they document the RAP assessment?

*Case History I-*

A 93 year old male, who was wheelchair bound at home most of the day. He walked with a shuffling gait and was not stable. He fell while walking and fractured 2 ribs . He treated at a hospital for two (2) weeks and was transferred to defendant nursing home for rehabilitation . After multiple falls in the nursing home, he suffered a catastrophic fractured hip . He was properly noted to be "high risk for falls", but each time he fell the staff did not re-evaluate the situation. They did not hold care plan meetings to discuss why he fell? What time he fell? Was there a pattern? Was it usually connected with toileting? Would a toileting schedule have helped? The duty to update the care plans was breached.

*MDS §J(4) on accidents (page 6): “a “ should have been checked, since the patient had a fall that hospitalized the resident before the transfer to the deft nursing home. This should have triggered a RAP for falls (#11 and #17) and see MDS final page for #11 and #17. RAPs being guideline” for that issue or those issues.*

**IV.(A)(1)(b)(3)**

“If the survey team identifies a number of or pattern of accidents, ... review the quality assurance activities of the facility to determine the facility’s response to accidents.

**PRACTICE POINT:** *Were a number or pattern of accidents identified? What actions did the nursing home take to avoid the accidents – before and after?*

**IV.(A)(1)©) PROBES: §483.25 (h)(2)** (probes are questions to ask, and items or ideas to look for). Three probes are suggested. The third probe, noted below as (A)(1)©)(3) has four separate inquiries

- (A)(1)©(1) Are there a number of accidents or injures of a specific type or on any specific shift (e.g., falls, skin injuries)?**
- (A)(1)©(2) Are residents who smoke properly supervised and monitored?**
- (A)(1)©(3) If the survey team identifies residents repeatedly involved in accidents or sampled residents who have had an accident:**

(i.e.: case history - I - see page 15 - prior accidents)

**(a)Is the resident assessed for being at risk for falls?**

**PRACTICE POINT:** *Did they do a “Falls Risk Assessment” upon admission? (before the MDS was done)*

**(b)What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk?**

**PRACTICE POINT:** *What did they do to prevent falls? Did they develop a “care plan” to prevent falls?*

**( c)How did they facility fit, and monitor, the use of that resident’s assistive devices?**

**PRACTICE POINT:** *i..e.: wheelchairs with and without non-tippers, walkers, cane, ...-the therapist (PT/OT) usually determines how much assistance a resident needs. Examine the PT and OT charts and evaluations done on day 1 or day 2.*

**(d) How were drugs that may cause postural hypotension, (stand up and blood pressure drops), dizziness, or visual changes monitored?**

**PRACTICE POINT:** *Was the resident’s medical status or medications contributing to the risks of accidents? If “dizziness” was occurring, MDS page 5§J(l)(f) (**Exhibit “C”**) should have been checked off and #11 and #17 would have been triggered RAPs and RAP guidelines would have questioned the “falls” and “ medication” issues.*

#### IV.(A)(2) INVESTIGATING THE “FALLS” CASE:

When doing the initial intake ask the family members whether there was a pattern of falls.

Find out from the family whether they advised the facility upon intake that the resident had a history of falls in their

home and if that is the

reason the resident was brought to the facility. If a resident with a history of falls is accepted into the facility, and the facility assured family members that the resident would be carefully watched to avoid falls, this is evidence of express promise.

Since nursing homes are required by federal law to report all falls and to prepare a report regarding the same, you should not be surprised to find out that the family is well aware that there was a long history of falls.

Secure the State DOH surveys concerning the nursing home and any incidents.

Review the federally mandated initial assessment and falls risk assessment and care plan that was developed as a result of the assessment, (F279)(PP-77) (42CFR§483.20(d)), and “use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care”.

Also review follow up comprehensive assessments that are also mandated by federal law to first determine whether the resident was at risk for falls when he entered the facility, and second, what precautions were recommended as a result of that initial evaluation.

##### 1. Did the care plan include precautions?

For example: **Exhibit “F”**- the nursing home noticed significant risks for falls upon admission, in its initial assessments and classified the patient as “HR” (High Risk) (**Exhibit “F” - Page 3**) for falls, yet put in no precautions. (Case history - 2:

Plaintiff was an angry, agitated, schizophrenic 65 year old woman , on psychotropic medication . She underwent an ORIF at a hospital for a fractured hip. She was transferred to defendant nursing home for rehabilitation. She was obviously a high risk for falls. On the initial

assessment (upon admission) she was noted as "high risk for falls".

An initial care plan was put into effect, but it failed to contain anything concerning the wheelchair, in which she would spend a significant amount of time. On day 2, she fell and was injured, trying to get out of her wheelchair to go to the bathroom. The case could have gone forward on failure to have toileting interventions or alarms or lap belts on the wheelchair but our expert found that the clearest wheelchair specific intervention that was omitted was the failure to have "anti-tippers" on the wheelchair which are inexpensive interventions which inhibit leaving a wheelchair for an unstable person.

2. Determine whether the facility implemented the care plan.

For example: a care plan called for a bed alarm and one was not being used.

3. Were adjustments made in the care plan to prevent falls as circumstances dictated?

For example:

if no bed alarm was recommended as a result of the initial assessment, was one provided after the first fall?

What was the prima facie case? No bed rails were ordered, (frowned upon), but did they lower the bed to the floor or use alarms, or since she was in a wheelchair and non ambulatory by herself and not toileted sufficiently, should she have had non-tippers on the wheel chair (at \$60 apiece!).

#### **IV.(A)(3) SPECIAL TOPICS INVOLVED IN "FALLS CASES" - OTHER FACTORS, SCENARIOS AND THEORIES OF LIABILITY IN NURSING HOME "FALLS" CASES:**

1. TOILETING SCHEDULE- was the schedule appropriate in order to serve the resident safely? Was it modified as changes in diet or medication occurred (i.e.: diuretics) ?
2. COGNITIVE LOSS- some precautions: alarms, buzzers will not work; esp. high risk in conjunction with incontinence this patient will not use the call bell! A pressure sensitive alarm, in bed, is a better alarm and the call bell rings at nurses station alerting to particular patient.
3. PRIOR FALLS- as in Case History - I, (Page 15) the falls kept

happening, especially in the early morning. Did they modify the toileting schedule or otherwise study why he was getting up then and whether that could be avoided?

4. DEATH WITH OR SHORTLY AFTER THE FALL- be wary of the case where there has been a fall followed by unconsciousness and then death. There is a problem with this type of case in that the resident would have had no conscious pain and suffering. Find out from family whether the resident showed any visible signs of consciousness and pain and suffering. If you have consciousness at any level following the fall, you can make out a case for pain and suffering. Review the records for pain and suffering. Was the resident found on the floor moaning? *Clearly this is evidence of pain and suffering.*

**PRACTICE POINT:** *damages typically can be established through depositions of employees and former employees.*

5. MEDICATIONS and POLYPHARMACY- may contribute “falls”.

42 CFR 483.25 - residents must not be administered unnecessary drugs or excessive doses of drugs

6. FALLS OF UNKNOWN CAUSE - Lorber v. Prospect Nursing Home 289 A.D.2d 303, 734 N.Y.S.2d 865 (2d Dept. 2001). This case was dismissed after plaintiff was found in bed with a fractured leg .Did the plaintiff allege “res ipsa loquitur”? Did plaintiff depose the witness who found plaintiff resident in bed in pain? How did the injury occur? Did he fall from bed and was put back in bed? Was he able to get himself back into bed? Was an expert retained concerning the duty to examine resident and investigate and the abilities of the resident to climb back into bed?

7. RESTRAINTS - The federal regulation (42 CFR 483.13(a) that states“residents have the right to be free of physical or chemical restraints imposed for discipline or convenience”. The New York State regulation on restraints (10NYCCR§415.4) is more detailed and constantly tests the nursing home to see if they are used “only to protect the resident”, but also “to assist the resident to attain and maintain optimum levels of physical and emotional functioning”.

**PRACTICE POINT:** *Challenge them on the use and lack of use of restraints. Did they justify the “use” or “non use”? Serious falls may occur due to restraints (high bed rails), yet falls may occur due to lack of restraints. The defense may argue that the fall occurred because they could not use restraints due to the above law. That is a MYTH and studies show that wise and judicious care, without restraints, actually reduces injuries. (Exhibit “D”)*

#### IV.(B) PRESSURE SORES/ULCERS

##### IV.(B)(1) Introduction to Pressure sores, pressure ulcers, bedsores and skin ulcers

In my forty-five minute presentation, you will get up or shift position three to five times. Can you imagine not moving your rear end for all that time? Try crossing your legs for twenty minutes and take a look at the red marks on your legs. Can you imagine that the red marks did not disappear after the next half hour? What if the pressure exerted of the soft tissues on the underlying bone started to damage the deep soft tissue? One has to imagine being in a wheelchair, possibly mentally or physically unable to shift your position. In a few hours the person would begin to develop a pressure ulcer. Can you imagine a blister on the bottom of a toe and continuing to walk in those same shoes. Wouldn't you take off those shoes and put your feet up, massage them, ice them, place lotion on them?

What is a pressure ulcer? Have you seen photographs of a pressure ulcer?

The pain and horror of these injuries make them the cases with the highest exposure for defendants. A pressure ulcer is defined in the "Guideline To Surveyors" for 42 CFR §483.25 ©). The stages, I through IV are defined and described in the "Guidance" provided to these regulations. Attached as **Exhibit "G"** are pages PP-93 to PP-96, of the "Guidance to Surveyors" for pressure sores.

##### IV.(B)(2) REGULATIONS IN THE "PRESSURE ULCER" CASE

The Federal regulation (42 CFR§483.25©)(1) and (2)) in this area was strengthened by the more stringent New York State regulation, 10 NYCRR§415.12©)(1) and (2) (**Exhibit "H"**) which states that:

The facility must ensure that:

(1) 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 despite every reasonable effort to prevent them; and

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

The underlined portion of 10 NYCRR § 415.2©)(1) above was added to the New York DOH Regulations. It is not in the Federal regulation, 42 CFR§483.25©)(1). Therefore the defense cannot *simply* argue that the pressure sore was "unavoidable". In New York, the defendant must argue that it was unavoidable "despite every reasonable effort to prevent them".

This is a much higher standard and requires defendant not only to prove its efforts to prevent pressure ulcers but also to rebut plaintiff's evidence that:

- defendant nursing home failed to assess properly; or
- failed to appropriately plan the care; or
- failed to try certain interventions in the care plan to prevent the pressure ulcer; or
- failed to carry out or implement an appropriately designed care plan; or
- failed to update the care plan.

Defendant would be hard pressed to argue that they "exercised every reasonable effort to prevent" the ulcers.

In analyzing whether or not the above regulation has been violated by the nursing home, the "Guidance to Surveyors" helps us. As with the "Falls" situation, the "Guidance To Surveyors" details the "**intent**" of the regulation, certain "**guidelines**" (definitions), the "**procedure**" to be used to evaluate compliance by the nursing home and the specific "**probes**" to be used by the surveyors.

**IV.(B)(2)(a)** The "**intent**" of the regulation "is that the resident does not develop pressure sores while in the facility." Further, "if the resident is admitted with or develops a pressure sore he or she receives care and treatment to heal and further prevent development of pressure sores."

Therefore the regulation is in place to stop a pressure sore from starting and if it exists to compel the nursing home to get it healed and avoid any new pressure sores. With that absolutely clear "intent", the regulators issued "guidelines" which define a "pressure sore" and its "staging." "A pressure sore is defined as an ischemic ulceration and/or necrosis of tissues overlying a bony prominence and has been subjected to pressure, friction or shear." Further "the seriousness of the ulcer is staged from one to four, but the 'staging' is to be done after the dead tissue has been removed (by sloughing off or debridement)". (Finally vascular ulcers due to PVD are considered separately.)

**IV.(B)(2)(b) Procedures:** The "Guidance to Surveyors" provides "Procedures" used by the surveyors to test nursing home compliance or violation of the regulations. The "Procedures" outline the "clinical conditions that are the primary risk factors for developing pressure sores. If a resident is "immobile", that is the highest risk factor for pressure ulcers. "Immobility" combined with a positive

result from any of criteria 1,2,3 and 4 below, informs the surveyor, the nursing home and the attorney of whether or not the resident is at “ high risk for pressure ulcers”. We will examine the effect of a finding of a “high risk of pressure ulcer” below, after analyzing the risk factors below.

The following is quoted from the Guidance To Surveyors to 42CFR§425©).

Clinical conditions that are the primary risk factors for developing pressure sores include, but are not limited to, *resident immobility* and:

1. The resident has *two or more of the following diagnoses*:
  - (a) Continuous urinary incontinence or chronic voiding dysfunction;
  - (b) Severe peripheral vascular disease;
  - ©) Diabetes;
  - (d) Severe chronic pulmonary obstructive disease;
  - (e) Severe peripheral vascular disease; (repeat of (b))
  - (f) Chronic bowel incontinence;
  - (g) Continuous urinary incontinence or chronic voiding dysfunction; (repeat of (a))
  - (h) Paraplegia
  - (i) Quadriplegia;
  - (j) Sepsis;
  - (k) Terminal cancer;
  - (l) Chronic or end stage renal, liver, and/or heart disease;
  - (m) Disease or drug-related immunosuppression; or
  - (n) Full body stat.
  
2. The resident receives *two or more of the following treatments*:
  - (a) Steroid therapy;
  - (b) Radiation therapy;
  - ©) Chemotherapy;
  - (d) Renal dialysis; or
  - (e) Head of bed elevated the majority of the day due to medical necessity.
  
3. Malnutrition/dehydration, whether secondary to poor appetite or another disease process, places resident at risk for poor healing, and may be indicated by the following lab values:
  - (a) Serum albumin below 3.4 g/dl
  - (b) Weight loss of more than 10% during last month

Use these values in conjunction with an evaluation of the resident’s clinical condition.

4. If laboratory data are not available, clinical signs and symptoms of malnutrition/dehydration may be:

- (a) Pale skin;
- (b) Red, swollen lips;
- (c) Swollen, and/or dry tongue with scarlet or magenta hue;
- (d) Poor skin turgor;
- (e) Cachexia;
- (f) Bilateral edema;
- (g) Muscle wasting;
- (h) Calf tenderness; or
- (i) Reduced urinary output.

The nursing home is charged with knowing all of the above risk factors for developing ulcers. The above risk factors are supposed to be accounted for by properly assessing the resident. The care plan must then include interventions and plans to minimize those risks.

The MDS assessment considers many, but not all of the above risk factors. When the risk factors in the MDS assessment are present, the MDS form triggers a Resident Assessment Protocol (RAP) for "pressure ulcers". The RAP is a more thorough and detailed interrogation of the risk for the harm – in this case ulcers. The "Procedures" in the "Guidance" ask the surveyor, separate from the above tests for "high risk" to "identify if the resident triggers RAPs for urinary incontinence, nutritional status, cognitive loss/dementia, psychotropic drug use, and physical restraints." In addition, the surveyor is ordered to evaluate "whether the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement."

Therefore a very detailed investigation of risks to this particular resident is required by this regulation "which is intended to have the resident avoid ulcers or have them healed."

**The defense** would like to argue the pressure ulcer was "**unavoidable**". The nursing home's possible defense is discussed in the "Guidance to Surveyors". First, "if the resident is moribund (i.e.: terminally ill, semi comatose and/or comatose)" that is not even a complete defense unless the resident also has had "life sustaining measures withdrawn or discouraged as documented in the record".

Second, with all other residents, that are not moribund, an "unavoidability" determination "may be made only if routine preventive and daily care was provided." In fact, the "Guidance" defines "routine preventive care" as meaning "turning and proper positioning, application of pressure reduction or relief devices, providing good skin care (i.e., keeping the skin clean, instituting measures to reduce excessive moisture), providing clean and dry bed linens, and maintaining adequate nutrition and hydration as possible". There is no defense of "unavoidability" unless the nursing home did all routine preventive measures and daily care first.

Therefore, if the family or other visitors testifies to continual wet bed linens or food trays that were regularly taken away full of food, or the resident had wet skin, or other common problems of care, the plaintiff has accomplished a “prima facie case” that the “routine preventive and daily care” was not done and the defense of “unavoidability” is a shell defense without substance.

If lab values show low albumin, inadequate nutrition may be present. If lab values show high “BUN”, dehydration may be evident. These indicate a failure of “routine preventive care” unless defendant has an additional defense that a metabolic disease is the cause.

Further, where the high risk criteria are satisfied, through the above checklist, or through the MDS assessment, “routine preventive and daily care” involves much more care and many more interventions, in order for the defense to point to an “unavoidability” defense.

Finally, we call the reader’s attention to the addition to the New York State Department of Health regulation that “**unless the individual’s clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them**”, makes the burden on the defense even higher. In additional to providing “routine preventive care” and if at higher risk, providing a higher level of care, in New York, “**every reasonable effort**” must be utilized. Your expert nurse, whether for the plaintiff or for the defense, will easily provide you with a list of care interventions that are utilized to assist in prevention of ulcers. If the nursing home failed to utilize some or many of these and the resident was “high risk” through the above criteria or through the MDS process, the defense will fail under the New York regulation.

**IV.(B)(2)©)** The “**Probes**” provided in the “Guidance to Surveyors” track the requirements of the regulations and provide the surveyor and therefore anyone investigating the nursing home’s performance, with specific areas of inquiry.

**IV.(B)(2)©)(1)** The first probe addresses itself specifically to the first portion of the nursing home regulation, that is 42 CFR §483.25©)(1). This regulation applies to residents *who enter the facility without pressure sores*. The surveyor is to look at the *resident before they have gotten a bed sore and evaluate the resident* and his risk of developing a pressure ulcer at that point. “If the resident was at risk of developing pressure sores, they are to determine if aggressive preventive care was provided”. This is the essence of assessment, care planning with interventions and carrying out the care plan.

The next investigatory methodology involves the resident *who upon admission to the*

*facility did not have a pressure sore but now has one* and a determination is to be made “if the pressure sore development may have been avoided”. In this regard the first question to be asked is “did the nursing home identify the resident as being at risk for pressure sores.” In other words was the resident properly assessed?

The second question to be asked in this regard is “did the nursing home provide aggressive/appropriate preventive measures and care specific to addressing the resident’s unique risk factors”. (The guidance provides specific examples such as an albumin level below 3.4 and that additional protein is then to be provided in snacks.) Therefore the ultimate question in this regard is whether or not the plan of care, with interventions, was made?

The third area of inquiry with these patients is whether or not the “preventive care plan has been implemented consistently.”

**IV.(B)(2)©(2)** The second probe applies to 42 CFR §485 ©)(2), where residents who have suffered pressure sores. The regulation deals with the requirements that a nursing home provide the “necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.”

When looking at a resident who has a pressure sore at the moment of the survey or the moment that we are investigating, whether the pressure sore started at a nursing home or at a hospital does not matter.

The first inquiry in the probe for ©)(2) is whether or not “measures to assist healing are provided for in the care plan.” The guidance specifically provides examples of interventions, for example, “relieving pressure, moving the resident without causing sheering, instituting topical therapy which creates a favorable environment for healing and debriding eschar”. Therefore the question is: does the care plan have interventions within it which will promote healing?

The second inquiry in the probe for ©)(2) asks whether or not the care plan has interventions to “prevent further contamination” and is that care plan being followed? For instance, washing of the hands, sterile technique, the recognition of an infected wound and the like are considered.

The third inquiry to this probe asks whether or not the care plan has in it measures for infection control and are those measures being followed.

The fourth inquiry is whether or not the care plan objectives have been evaluated? Is the care plan being updated with new interventions if the pressure sore is not healing or getting worse? This is a critical inquiry regarding defendant’s possible liability. Finally, the fifth inquiry asks generally if the chart notes whether improvement has occurred.

Taking these five inquiries to the probe for ©)(2) together, it is easy to assume that if the chart does not note improvement then the care plan should have been updated with new interventions to try to promote healing and improvement.



**IV.(B)(3) SPECIAL TOPICS IN EVALUATING PRESSURE ULCER CASES:**

**a. WAS THE RESIDENT AMBULATORY?**

If the resident was confined to a wheel chair and/or bed there is a much greater likelihood of developing pressure ulcers. What preventive measures were put into place to relieve pressure? (i.e.: wheelchair cushions, special mattresses, heel booties, heel protectors, turning and positioning...)

If no pressure ulcer has yet formed, but the RAP was triggered by the risks being presented: §G(1)(a) Bed Mobility. Was this filled out on the MDS using "A" or "B" criteria? For "A" - 2 or 3 or 4 or 8 will trigger RAP 16 for pressure ulcers and therefore trigger the RAP Guideline for "ulcers" before the ulcers appear! (Exhibit "C")

**b. WHAT STAGE WERE THE BEDSORES?**

1. Stage I - redness not disappearing and over a bony prominence. Appearing like diaper rash.
2. Stage II - superficial break in skin, "cut", "blister".
3. Stage III - significant break in skin with *depth* of layers exposed.
4. Stage IV - is right down to the bone, or any ulcer with necrotic, "black", tissue (even without a break in the skin).

**c. WAS THE RESIDENT INCONTINENT?**

Incontinence is a significant risk factor for pressure ulcers. Was the initial assessment done? Was the MDS done by day 14? Was the MDS done so that RAP 16 was triggered? Was the RAP guideline for "ulcer" followed?

**d. THROUGH MDS ANALYSIS, THE FOLLOWING AREAS WILL TRIGGER A RAP FOR PRESSURE ULCERS: (Exhibit "C")**

- a. The presence of an actual pressure ulcer (M2a=1,2,3 or 4)
- b. History of resolved pressure ulcers (M3a=1)
- c. Bowel incontinence (H1a=1,2,3 or 4)
- d. Bed mobility requires assistance (G1a=2,3,4 or 8)
- e. Peripheral vascular disease (ilj is checked off)
- f. Bedfast (G6a is checked off)
- g. Use of trunk restraint daily (P4c=2)

If the resident already has pressure ulcers, MDS §M(2)(a)

will trigger RAP 16 for ulcers and require the RAP guideline to be followed.

The RAP Guideline for “ulcer” is attached as **Exhibit “I”**. Once again, as in the RAP Guideline for “falls”, the areas listed that must be assessed are varied, numerous and significant. Depositions in each area can be detailed directly from the Guideline and questions will center on how the nursing home did or did not do each assessment owed to the resident under the regulations.

Was a Plan of Care put into effect? How often was the resident “toileted”? How often was the resident given perineal care (getting cleaned, lotion, new diaper, ...)

e. **URINE SMELL**

Ask the family whether the resident often sat in urine for long periods of time. Ask them whether on their visits they often discovered that their loved ones needed to be changed, or did the family smell urine? If you smell someone, it has been a long time since the person was changed.

f. **DEHYDRATION AND/OR MALNUTRITION**

1. There is a direct medical link between bedsores and dehydration and malnutrition.
2. Inquire of the family members whether the resident suffered from dehydration and/or malnutrition.
3. Review records to see if there were hospitalizations for dehydration and/or malnutrition.
4. Does the Care Plan address poor intake or weight loss, with corresponding interventions and nutritional supplements, such as “ensure” (a high protein shake)? Was the Care Plan for nutrition followed?
5. Under 42CFR§483.25(J) and 10NYCRR§415.12(J) “the facility shall provide each resident with sufficient fluid intake to maintain proper **hydration** and health”.
6. Under 42CFR§483.25(i) and 10 NYCRR§415.12(i), “based on a residents comprehensive assessment, the facility shall ensure that a resident:
  - (1) maintains acceptable parameters of **nutritional** status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible; and
  - (2) receives a therapeutic diet when there is a **nutritional** problem”.

**PRACTICE POINT:** *Your expert will analyze the labs in the chart. Low albumen (a protein breakdown product) may indicate malnutrition and is a risk factor for ulcers and will inhibit healing of existing ulcers.*

*High BUN indicates dehydration. With less fluid, or a fluid imbalance, the skin gets rigid and increases the risk of breakdown of the skin. Is your client*

*getting diuretics? Increasing the urine may contribute to a loss of fluid and fluid imbalance.*

**g. ADMISSION ASSESSMENT**

Was the resident properly assessed when first admitted as being at risk for bedsores? If so, what measures were taken to avoid bedsores?

**PRACTICE POINT:** *Many facilities will conduct a standardized Pressure Ulcer Risk Assessment form upon admission to fulfill their duty to assess for risk factors. Other facilities will have questions incorporated into the Nursing Admission Assessment, Nutritional Admission Assessment and Medical History and Physical which identify the risk factors that place the resident at risk for developing pressure ulcers.*

**PRACTICE POINT:** *For example, was a special mattress provided? Was the resident turned and repositioned every two hours? Were there any doctor's orders that facility failed to follow? How often were skin assessments done? If the resident has a high risk for bedsores, skin checks should be done daily by a direct care giver (CNA) and assessed weekly by the nurse.*

**h. TURNED AND REPOSITIONED**

Review the "turn and repositioning records" in the Nursing Home chart.

**i. CIRCULATORY DISEASE (PVD)**

Does the resident have any circulatory diseases? (ie: peripheral vascular disease, diabetes, ...) This would be another risk factor that should have been assessed from the beginning as an indication that your client was at risk for pressure ulcers.

**j. COGNITIVE LOSS** -The resident may not think to change positions

**k. MEDICATIONS** - Medications can make the resident lethargic and therefore not change position.

**l. RESTRAINTS** - Restraints restrict movement and therefore increases risk for pressure ulcers.

**m. PLAINTIFF'S FAMILY'S DEPOSITION** - Defense counsel may ask whether the family ever noticed the bedsores. Often counsel is implying that they should have noticed. A typical response you hear from children of a resident is that they did not remove the diaper and look at their mother's buttocks. They respected her right to privacy.

- n. **DEFENDANT’S DEPOSITION** - Who were the hourly and daily care givers? Who changed the diapers? Discover the schedule of the care givers on the unit.
- o. **ATLA ARTICLE**-“Wound care and nursing home liability-(Trial, Nov. 2002 -pages 42-47)(**Exhibit “J”**)
- p. **STASIS ULCER** - Defenses to a pressure sore case may include that: It’s not a pressure ulcer, it’s a stasis ulcer and not an indication of any neglect. A stasis ulcer is a non-healing medical condition caused by poor circulation and not over a bony prominence and generally lower extremities.

**V. VIOLATION OF PUBLIC HEALTH LAW SECTION 2801-d**

**V.(A) PHL §2801-d AS AN ADDITIONAL AND CUMULATIVE TORT REMEDY**

Not only is a cause of action pursuant to PHL §2801-d separate and distinct from other causes of action, such as negligence, medical malpractice, intentional tort, or breach of contract, which may be also available, it provides an additional and simultaneous or cumulative tort remedy to a victim of nursing home neglect and/or abuse. Violations of PHL §2801-d should be pleaded as such.

The text of PHL §2801-d(1) reads as follows:

“Any residential health care facility that *deprives any patient* of said facility of any right or benefit, as hereinafter defined, *shall be liable to said patient for injuries suffered as a result of said deprivation*, except as hereinafter provided. For purposes of this section a *"right or benefit"* of a patient of a residential health care facility *shall mean any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation*, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority. No person who pleads and proves, as an affirmative defense, that the facility exercised all care reasonably necessary to prevent and limit the deprivation and injury for which liability is asserted shall be liable under this section.”

A copy of PHL §2801-d is attached as (**Exhibit “K”**) Subdivisions 2 - 6 cover statutory minimal damages, attorneys fees, punitive damages, injunctive relief, class actions, and the effect of awards upon Medicaid.

Most importantly for this paper, Subdivision 4 provides states, “the remedies provided in this section are in addition to and cumulative with any other remedies available to a

patient, in law or in equity or by administrative proceedings”. Subdivision 4 also allows class action lawsuits.

In Doe v. Westfall Health Care Center, 755 N.Y.S.2d 769 (4<sup>th</sup> Dept. 2002), a mother brought an action against a skilled care nursing facility in negligent hiring, training, and supervision of its employees, breach of contract, strict liability and breach of warranty of habitability when her incapacitated daughter was raped at the facility. The Court ruled that the case was also actionable pursuant to the statutory mandates of the Public Health Law, even though the common law causes of action for negligence and breach of contract survived the motion for summary judgment. In fact, the Fourth Department, in Doe, noted that “the Legislature has explicitly expressed its intent to add to the available tort remedies” by the language set forth in PHL §2801-d(4).

In Doe, the Fourth Department also expressly overruled, in part, Goldberg v. Plaza Nursing Home, 222 A.D.2d 1082, 635 N.Y.S.2d 841(4<sup>th</sup> Dept. 1995) “insofar as we determined therein that summary judgment dismissing the Public Health Law cause of action was appropriate despite doubt concerning the efficacy of the remaining common law cause of action”. The remaining cause of action in Goldberg was a wrongful death claim predicated on negligence. The incident underlying the claim in Goldberg happened when the decedent awoke from a nap, called the defendant’s employees to release her from a vest restraint, and after her calls for help were allegedly ignored, the decedent became agitated and tried to release herself from the vest, which in turn, lead to her strangulation in the vest and/or cardiac arrest.

However, there is apparently still a battle in the Fourth Department as to the scope of PHL §2801-d. See Bielewicz v. Maplewood Nursing Home, 778 N.Y.S.2d 666 (Sup. Ct., Monroe Cty. 2004)(in denying the motion to add a PHL 2801-d cause of action, the court concluded that “the Fourth Department did not overrule Goldberg in its latter case [(Doe)], and under the facts of the present case [(unattended patient drove his wheelchair into a location where he fell)], it is the Goldberg precedent that this court must follow “). A Notice of Appeal has been filed in the Bielewicz case. See also Begandy v. Richardson, 510 N.Y.S.2d 984 (Sup Ct.; Monroe Cty. 1987)(PHL §2801-d cause of action held not to exist where the plaintiff had a viable negligence cause of action based upon an unattended patient, who wandered down the hallway, opened a door leading to a cellar stairway, and fell down the stairs).

In the First Department, the controlling authority is Zeides v. Hebrew Home for the Aged, 300 AD 2d 178, 753 N.Y.S.2d 450 (1<sup>st</sup> Dept. 2002). Notwithstanding the existence of common law negligence and wrongful death causes of action, the Court upheld the viability of a separate cause of action under the Public Health Law against a nursing home where pressure ulcers and a failure to maintain adequate nutrition were involved. The Court stated “Article 28 of the Public Health Law contains nothing that would indicate an intent to equate its private right of action with one for either medical malpractice or ordinary negligence.” It stated further, “the statutory basis of liability is neither deviation from accepted standards of medical care practice nor breach of a duty. Rather it contemplates injury to the patient caused by deprivation of a right conferred by contract, statute, regulation, code, or rule”. The Zeides case settled on its way to the Court of Appeals.

In the Second Department, the only case known to this author on the issue of the scope PHL §2801-d is the yet unpublished decision in Monzert v. Southside Hospital (Sup. Ct.,

Suffolk Cty. 9/21/04 Justice Paul Baisley). In Monzert, the PHL §2801-d cause of action was premised upon the nursing home’s failure to provide adequate nutrition and hydration, which resulted in the death of plaintiff’s decedent. The Court, in relying upon Doe, Zeides, and the language of §2801-d(4), held, “the fact that plaintiff may have other available remedies, including a claim arising under common law negligence, does not preclude plaintiff’s claim under Public Health Law §2801-d”. No Notice of Appeal was filed. The Monzert decision is attached as **Exhibit “L”**.

In short, remedies provided under PHL 2801-d subdivisions are in addition to and exist simultaneously or cumulatively with those remedies, common law or otherwise, provided and available under State or Federal law and should not be not construed to limit those remedies in any way. The case law supports such a conclusion, as does the plain language of the statute.

Like other statutory causes of action, a PHL §2801-d cause of action is governed by a three (3) year period of limitations. CPLR 214(2).

## **V.(B) EXTENT OF LIABILITY IMPOSED BY VIOLATION OF PUBLIC HEALTH LAW 2801-d**

### **V.(B)(1) Strict Liability?**

Although Section 2801-d, subdivision 1 states that a facility which deprives a patient of any right or benefit (ie: violation of a regulation) enumerated in the statute “shall be liable” to said patient for injuries as a result of said deprivation, the statute, as interpreted by the courts, does not impose strict or absolute liability. See Goldberg v. Plaza Nursing Home, 635 NYS2d 841 (4<sup>th</sup> Dept. 1995)(concluding that “it is unlikely that the legislature envisioned the extension of the principle of strict liability to residential health care facilities for injuries and damages that are traditionally the subject of tort liability”); Begandy v. Richardson, 510 NYS2d 984 (Sup. Ct., Monroe Cty. 1987)(correctly noting that Section 2801-d, subdivision 1 allows a facility to avoid any liability under the statute by pleading and proving that it “exercised all care reasonable and necessary to prevent and limit the deprivation and injury for which liability is asserted.”); see also Doe v. Westfall Health Care Center, 755 NYS2d 769 (4<sup>th</sup> Dept. 2002)(implying same by upholding cause of action pursuant to Section 2801-d, but dismissing cause of action under strict liability theory).

### **V.(B)(2) Negligence Per Se?**

The statutory language in §2801-d(1) stating that a residential health care facility “shall be liable” for injuries resulting from a deprivation of a right or benefit (ie: violation of a regulation) as defined by the statute also begs the question of whether a violation of §2801-d imposes negligence as a matter of law. At least where, as is the usual case, violation of

PHL §2801-d is based upon a violation of Federal and/or State rules and/or regulations, the quick answer is most likely “no” given the long line of Court of Appeals cases culminating most recently with Elliott v. City of New York, (724 N.Y.S.2d 397)(2001), in which the Court analyzes the extent of liability imposed by various statutes, codes, ordinances, rules, and/or regulations.

In Elliott the Court stated, “this Court has long recognized a distinction between State statutes on the one hand, and local ordinances or administrative rules and regulations on the other, for purposes of establishing negligence (see, Long v. Forest-Fehlhaber, 448 N.Y.S.2d 132, see also, Rizzuto v. Wenger Contr. Co. 670 N.Y.S.2d 816, ). As a rule, violation of a State statute that imposes a specific duty constitutes negligence per se, or may even create absolute liability (see, Van Gaasbeck v. Webatuck Cent. School Dist. No. 1, 287 N.Y.S.2d 77). By contrast, violation of a municipal ordinance constitutes only evidence of negligence (see, Martin v. Herzog, 228 N.Y. 164).

The rationale for this distinction was enunciated in Major v. Waverly & Ogden, 197 N.Y.S.2d 165, which involved a claim dependent upon a violation of rules established by the State Building Code Commission and adopted by the Village of Mamaroneck. Cautioning that the elevation of a violation of an ordinance, or administrative rule or regulation, to a negligence per se standard would "substantially recast" the common law of the State, this Court found that such a change in import and status was more properly left to the Legislature and not to a "subordinate rule-making body" such as the Commission or local government. Further, we contrasted the procedures for amending or repealing the Commission's rules with State statutes which, " 'once passed, cannot be changed or varied according to the whim or caprice of any officer, board or individual' " (*id.*, at 336, 197 N.Y.S.2d 165, 165 N.E.2d 181 [quoting Schumer v. Caplin, 241 N.Y. 346, 351, 150 N.E. 139] ).

Indeed, the Court of Appeals in Long, supra (a construction site accident case involving a violation of New York State Labor Law §241(6) predicated upon breaches of 12 NYCRR 23-1.30 (mandating certain illumination) and 12 NYCRR 23-1.7 (mandating that

‘passageways’ be free of “tripping and other hazards”)) stated that a violation of an administrative regulation, though promulgated by leave of a statute, is simply some evidence of negligence. Similarly, the Court stated, “that the case at bar cannot be regarded as one which arose from a statutory violation is evident. In contrast to the first five subdivisions of section 241, in which the Legislature set out specific safeguards on its own, subdivision 6 does no more than broadly provide that the owner and contractor see to it that the area where the work is to be performed is “so constructed, shored, equipped, guarded, arranged, operated and conducted as to provide reasonable and adequate protection and safety”. This language, which does not in terms provide how these ends are to be met, is, like subdivision 1 of section 200 of the Labor Law, but a reiteration of common-law standards, the implementation of which is left to a subordinate body, the Board of Standards and Appeals. An illustrative contrast is available in section 240 of the Labor Law, a self-executing statute which, containing its own specific safety measures, does not defer to the rule-making authority of the board.”

Applying the above analyses to PHL §2801-d, one could say that a violation of PHL §2801-d, not predicated upon a breach of a statute which sets forth “specific” duties, measures, safeguards, and/or mandates, but rather upon rules and/or regulations as is the usual case, will not result in a finding of negligence per se or as a matter of law.

On the other hand, the cases discussed above derive from either a violation of a rule or regulation of a municipality or in the case of Labor Law§241(6) there is no commandment of liability. **PHL §2801-d, by its own plain language terms, does set specific duties or measures:** It references the terms of any contract or any Federal or State statute, code, rule, regulation and sets forth strong specific words that “**the facility... shall be liable** for injuries suffered as a result of a patient’s deprivation and well being provided by state or federal regulations”. The ultimate violation of PHL §2801-d does derive from a violation of a specific regulation which by the statutes words renders the facility liable. Same would be negligence per se.

However, in terms of published opinions and cases of which we are aware, the issue of whether a violation of PHL §2801-d constitutes negligence per se is an issue of

first  
impression in New York and a good faith argument can be made that a violation of  
the  
statute by violating 10NYCRR Part 415 is negligence as a matter of law.

While making no attempt to exhaust all plausible good faith arguments, the  
practitioner  
may make a plain language statutory construction argument. In particular, statute  
says what  
says in unequivocal terms; i.e.: that, a residential health care facility “shall be  
liable” when  
there is a violation of a term of a contract or a term of a statute, code, rule, or  
regulation,  
which was created or established for the well-being of the patient. While liability is  
not  
strict or absolute given the provision of an affirmative defense in cases where the  
facility  
exercised all care reasonably reasonable necessary to avoid such violation and  
injury, it can  
be argued that the language of PHL §2801-d is stronger than other statutes where  
violation  
is merely evidence of negligence, such as labor Law §241(6).

Thus, the Legislature, in no uncertain terms and by the plain language of  
§2801-d, has  
evidenced its intention that, subject to the affirmative defense, negligence, at the  
very least,  
should attach when a residential facility does not keep a promise by contract  
and/or fails to  
comply with a Federal or State Regulation and such breach results in injury.  
Similarly, it  
can be argued that, because the language of §2801-d is so strong, the Legislature  
has left it  
to the experts - The Center of Medicare/Medicaid Services, (the Federal rule  
making body)  
and the New York State Department of Health (State rule making authority) in the  
rules and  
regulations to create the standard of care or suitable duties and obligations,  
violation of  
which, should be negligence.

As noted in the commentary to PJI 2:25, the generally accepted view is that a  
violation  
of a statutory duty constitutes negligence for the reason that non-observance of  
what the  
Legislature has prescribed as suitable precautions is, as a matter of law, failure to  
act  
reasonably under the circumstances. In the context of PHL §2801-d, the  
Legislature has

unequivocally prescribed that a facility's contract and/or Federal and/or State statutes, codes and regulations. are the suitable precautions which constitute the standards of care underlying a PHL 2801-d cause of action.

As noted by the introductory statement to PJI 2:25, when a statute, in the interest of the general public, defines the degree of care to be used under specified circumstances, it does not create a new liability, but rather, defines an enforceable duty. Citing Schmidt v Merchants Despatch Transp. Co., 270 N.Y. 287; Martin v Herzog, 228 N.Y. 164, Duncan v. Kelly, 671 NY.S.2d 841. Introductory Statement to PJI 2:25, Third Ed. 2004, p. 254.

Similarly, "when a statute is designed to protect a definite class from a particular hazard which they themselves are incapable of avoiding a violation establishes absolute liability without regard to principles of negligence, Lopes v Rostad, 412 N.Y.S.2d 127; Vincent v Riggi & Sons, 334 N.Y.S.2d 380; Van Gaasbeck v Webatuck Cent. School Dist., 287 N.Y.S.2d 77; Koenig v Patrick Constr. Corp., 298 N.Y. 313; Pierce v International Harvest Co., 402 N.Y.S.2d 674 (citing PJI)". Introductory Statement to PJI 2:25, Third Ed. 2004, p. 252-253.

These two propositions, along with the legislative intent underlying PHL §2801-d, which is cited throughout the case law in this section of the paper, of protecting a vulnerable class of people not only for the benefit of individual residents, but in the interests of society as well, may, in addition to the plain language argument, be used to argue that violation of PHL §2801-d imposes negligence as a matter of law.

### **V.(B)(3) Some evidence of negligence?**

In all cases one should allege and attempt to prove violations of the Code Of Federal Regulations (42 CFR Part 483), as enacted by the Omnibus Budget Reconciliation Act (OBRA) of 1987 (42 USC 1396r; 42 USC 1395i-3) and interpreted by the Guidance to Surveyors for Long Term Care Facilities, and violations of the New York State Department of Health regulations, 10 NYCRR Part 415 et. seq. setting forth standards for nursing homes.

It is well settled that violation of these type of rules and regulations may be considered by a jury as *some evidence of negligence* and at trial, PJI 2:29 should be requested. See e.g., Elliott v. City of New York, 724 N.Y.S.2d 397 (2001)

(violation of provision of New York City Building Code (Administrative Code) requiring protective guards on bleacher seating may be used as evidence of negligence); Rizzuto v. Wenger Construction Company, 670 N.Y.S.2d 816 (1998) (violation of 12 NYCRR 23-1.7 constitutes some evidence of negligence under Labor Law §241(6); Hand v. Gilbank, 752 NYS2d 501 (4<sup>th</sup> Dept. 2002)(violation of State Uniform Fire Prevention and Building Code (9 NYCRR Part 600 et. seq.) may be considered of some evidence of negligence); Gruber v. Latello, 617 NYS2d 700 (4<sup>th</sup> Dept. 1994)(defendant’s violation of 10 NYCRR 6-2.14, as determined at an administrative proceeding by the Erie County Department of Health does not constitute negligence per se, as a “violation of a rule of an administrative agency lacking the force and effect of a substantive legislative enactment is merely some evidence which the jury may consider on the question of defendant’s negligence”)(citing Long v. Forest – Fehlhaber, 448 N.Y.S.2d 132).

## VI. STATUTE OF LIMITATIONS CONCERNS

### A. ALTERNATE PERIODS OF LIMITATION

- i. .Intentional Tort (1 year under CPLR §215(3)) - If the victim was intentionally harmed, as may be the case in an abuse situation and/or assault and/or battery, the statute of limitations may be as short as one year.
2. Wrongful Death (2 years under EPTL) - In any case, including a nursing home litigation type case, where the injured person is dead and there may be a causal link between wrongdoing and the death, one must consider a wrongful death cause of action and its two year statute of limitations from the date of death.

However, from a practical point of view, and as important as any statute of limitation concern, one must also consider whether the usual lack of wrongful death type damages (i.e.; pecuniary damages), warrant such a cause of action.

3. Death of Claimant and less than one year remains on the subject statute of limitations (1 year from death under CPLR §210(a)) - If the injured person dies and less than a year remains on the subject statute of limitations, CPLR Section 210(a) allows for the decedent's representative to bring suit within a year after the death. This is an alternative period of limitations as opposed to an extension or toll and is needed *only if there is less than a year remaining on the limitations period when the injured person dies.*

### B. MEDICAL MALPRACTICE (2 year 6 month) vs. NEGLIGENCE (3YEAR)

1. Be aware of the distinction between negligence and malpractice. This is an a important issue because of the *differing statutes of limitations*, *different attorney's fees*, and *different expert requirements*, including a certificate of merit, with the Complaint, in the medical malpractice case. From a practical standpoint and to be safer than sorry, it can be argued that one should include medical malpractice causes of action and negligence causes of action in the complaint. Note that by pleading malpractice and negligence, since the fee chargeable by counsel differs, the Court will probably have to decide the fee. As many of these cases result in deceased plaintiffs, the Surrogate Court will apportion between negligence and malpractice. Finally, as a doctor is needed early in the case to consider the causation between the nurse's opinions on negligence and the damages, the doctor can easily opine on the "malpractice".

2. A claim sounds in malpractice when the challenged conduct constitutes medical treatment or bears a "substantial relationship" to the rendition of medical treatment by a licensed physician. A claim sounds in

negligence only if “gravamen of complaint is not negligence in delivering medical treatment but the failure in fulfilling a different duty”. Weiner v. Lenox Hill Hospital, 88 N.Y. 2d 784, 787, 650 N.Y.S. 2d 629. The “malpractice” may be by a doctor or by a nurse!

3. The issue of whether a particular cause of action sounds in medical malpractice or negligence is fact specific. See e.g., Reardon v. Presbyterian Hospital, 739 NYS2d 65 (1<sup>st</sup> Dept. 2002)(fall while being helped down from the examining table sounds in negligence, as there was no claim that an improper assessment of plaintiff’s medical condition played any role in determining how or even to help her off the table); Fields v. Sisters of Charity Hospital, 714 NYS2d 176 (4<sup>th</sup> Dept. 2000)(decedent who had suffered a seizure and was brought to the emergency room was placed on examining table where he had another seizure and struck his head on the CT equipment and fell from the table; “allegations that defendant failed to provide a safe and adequate examining table and that table was not installed, maintained or secured in a safe and proper manner “ sounds in ordinary negligence”); Rey v. Park View Nursing Home, 262 AD 2d 624, 692 N.Y.S. 2d 686 (2<sup>nd</sup> Dept. 1999)(where assessment of mental or physical condition or degree of supervision is questioned, allegations sound in malpractice); Weiner v. Lennox Hill Hospital, 650 NYS2d 629 (1996) (contamination of blood with HIV is ordinary negligence); Toepp v. Myers Community Hospital, 721 NYS2d 177 (use of bandage containing needle constituted integral part of medical treatment and thus, was malpractice rather than negligence); Bleiler v. Bodnar, 489 NYS2d 885 (failure to take proper medical history is malpractice, but failure to provide proper personnel or to set forth and implement appropriate rules is negligence); DeLeon v. Albert Einstein College of Medicine, 566 NYS2d 213 (negligent hiring is negligence); Rice v. Vandenebossche, 586 NYS2d 303 (burning plaintiff on forehead with lamp while doctor treated forehead laceration was malpractice).

4. In Zeides v. Hebrew Home for the Aged, 300 AD 2d 178, 753 N.Y.S. 2d 450 (1<sup>st</sup> Dept. 2002), due to no fault of the attorneys, the complaint in Zeides was not filed until after the 2 years , 6 months statute of limitations for medical malpractice had run and before the three years for negligence. In this pressure ulcer case, defense counsel filed a motion for summary judgment arguing that it was a malpractice case and was barred by the statute of limitation. Motion was denied. On appeal, First Department held that malpractice statute of limitations did not apply to the statutory rights violation in PHL§2801-d. However, the Court did allow the plaintiff to file an amended complaint because the initial complaint did mix malpractice and negligence claims.

5. In our opinion, a nursing home is the “home” of the resident and not a place where acute care is administered, as is a hospital. For the most part, custodial care is the norm. Feeding, bathing, walking, cleaning, etc., is the care that is provided. This has no relation to medical treatment and often when it is provided improperly can harm your

client, i.e.: a bedsore case where they failed to turn and reposition the resident and/or failed to regularly change the resident's diaper.

6. The factual nature of the dispute rears its head in the bad care by nurses or "nursing malpractice" scenario. A nurse's actions or omissions may, depending on their nature, be ordinary negligence or malpractice. Therefore, since a medical doctor should be evaluating your case (at least regarding the "causation" issues between the nurse or CNA negligence and the injuries), have the doctor opine on "malpractice".

### C. EXTENDING THE APPLICABLE STATUTE OF LIMITATIONS

1. Pursuant to CPLR §208, if the plaintiff is alive, but is incompetent, the applicable statute of limitations may be extended for the period of the disability plus three years if a three or more year statute of limitations is applicable or for the period of disability if a less than a three year statute applies, and in no event more than ten years. From a practical viewpoint, one should, at all costs, avoid reliance upon an extension pursuant CPLR §208 because reasonable minds and courts will differ as to the extent disability required to invoke the extension, with respect to a senior citizen with competent family.

### 4. THE SAVING STATUTE (CPLR §205(a))

1. What if the applicable statute of limitations is running out and no one has standing to commence a lawsuit, such as is the case where the injured person is deceased and no representative of the estate has been appointed or in the case where your client is incompetent and no guardian has been appointed? As discussed, do not rely upon CPLR §208 to possibly extend the limitations period; rather, look to CPLR §205(a).

2. Pursuant to CPLR §205(a),

“if an action is timely commenced and it is terminated in any other manner than by a voluntary discontinuance, a failure to obtain personal jurisdiction over the defendant, a dismissal of the complaint for neglect to prosecute the action or a final judgment upon the merits, the plaintiff or if the plaintiff dies and the cause of action survives, his or her executor or administrator may commence a new action on the same transaction or occurrence or series of transactions or occurrences -within six months after the determination provided that the new action would have been timely commenced at the time of the commencement of the prior action and that service upon defendant is effective within such six month's period.”

3. In answering the query, CPLR §205(a) effectively allows the following. First, the lawsuit should be commenced (improperly) by filing in the name of the would be representative as a proposed administrator or executor of the estate of the injured

person or as the proposed guardian ad litem of the injured person. This lawsuit must be commenced within the applicable period of limitations. The defendants must be properly served. The defendant(s) will appear and litigate or appear by way of a motion to dismiss on the grounds that the plaintiff has no standing to sue.

Oppose the motion by reiterating the right to renew suit within six months. If the defendant(s) does not appear by way of motion, you might tell them to make the motion or request a Preliminary Conference and get a short form order dismissing the case on grounds of improper standing, if you are now ready. Once the case is dismissed on these grounds, the properly appointed legal representative (the guardian or the administrator/executor of the estate) commences the lawsuit again within six months of the dismissal, even if the applicable statute of limitations has already ended. The lead case regarding legal representatives is George v. Mt Sinai Hospital, 417 NYS2d 231 (1979).

Sometimes defendant will appear and litigate and eventually move to dismiss and the disclosure can usually be stipulated to apply to the renewal action - after dismissal and re-filing.

Often the Court will sign a so-ordered Stipulation allowing for the “improperly commenced action” to be amended and the case will simply continue. Judges often do not like to hear defense counsel indicate a desire to dismiss and repeat the entire case.

**PRACTICE POINT** – *make sure to apply for letters or guardianship at the time of the “improper summons and complaint” or soon thereafter. Do not linger about this.*

**VII. DISCLOSURE AND ADMISSIBILITY OF DOCUMENTS**

**1. DISCOVERABILITY OF SURVEYS, INVESTIGATIONS, REPORTS, AND/OR WRITTEN DETERMINATIONS RELATING TO A COMPLAINT REPORT MADE PURSUANT TO PUBLIC HEALTH LAW §2803-d.**

The Department of Health is required to investigate every allegation of neglect and/or abuse, PHL§2803-d6(a), and make a written determination of whether or not sufficient credible evidence exists to substantiate the allegations...” A copy of such written determination shall be sent not only to the offending individuals involved in the allegations, but to the facility in which the alleged incident occurred. Id.

Although we have had success obtaining surveys, reports and/or written determinations relating to specific complaints through FOIL requests made to the local Department of Health office, such materials, pursuant to §2803-d6(e) may be confidential and “exempt from disclosure under Article 6 of the Public Officer’s Law (FOIL)”. Id.

Note: Notwithstanding the apparent exception or exemption from FOIL disclosure under 2803-d6(e) such materials are discoverable from a party to a lawsuit under CPLR 3101(a). Marten v. Eden Park Health Services Inc., 680 NYS 2d 750 (3d Department 1998).

Finally, in Subpeona Duces Tecum to Jane Doe, 757NYS2d507, (2003) the Court of Appeals determined that any reports generated due to the regulations, is discloseable, if it is not specially made for a quality assurance committee.

**B. ADMISSIBILITY OF DEPARTMENT OF HEALTH SURVEYS AND/OR INVESTIGATIVE REPORTS**

Section 10, Subdivision 2 of the Public Health Law provides:

“The written reports of state and local health officers, inspectors, investigators, nurses and other representative state and local health officers on questions of fact pertaining to concerning or arising under and in connection with complaints, alleged violations and investigations, proceedings, actions, authority and orders related to the enforcement of this chapter, the Sanitary Code or any health regulation shall be presumptive evidence of the facts so stated therein and shall be received as such in all courts and places”.

In other words, statements or findings of fact contained in a report should be admitted into evidence as presumptive evidence of the facts so stated therein but any opinions contained in a report are inadmissible and should thus be redacted. Cramer v. Benedictine Hospital, 737 NYS 2d 520 (Sup. Ct., Ulster County, 2002) affd. 754 NYS 2d 414 (3d Department 2003) (statement in document that nursing care was inadequate was inadmissible as statement of opinion. Court indicated that “factual recitations were

admissible”.; see also, Maldonado v. Cotter, 685 NYS 2d 339 (4<sup>th</sup> Department 1998) (finding that nurse anesthetist did not lighten the anesthetic prior to the end of surgery admissible as finding of fact); Sorrento v. Axelrod, 541 NYS 2d 574 (2d Department 1989) (report which included, among other things, an admission by petitioner in an Article 78 proceeding that he notarized a blank document and gave it to a colleague was properly admitted into evidence as presumptive evidence of facts contained therein); City of Utica v. NYS Health Department 465 NYS2d 365 (4<sup>th</sup> Department 1983) (Department of Health reports showing level of contamination are properly admissible and presumptive of evidence of facts stated therein.); Maraziti v. Weber, 713 NYS 2d 821 (Sup. Ct., Dutchess County, 2000) (Department of Health, Office of Medical Conduct findings of fact held admissible).

Interestingly, at least two Appellate Division cases would seem to allow statements of opinion and/or conclusions into evidence under Public Health Law Section 10. See, Knaust v. Staten Island University Hospital, 682 NYS 2d 346 (1<sup>st</sup> Department 1998) (written findings of New York City Department of Health that a salmonella outbreak on defendant’s premises was attributable to defendant’s negligence supported granting of summary judgment on that issue where defendant failed to set forth facts sufficient to raise an issue as to the accuracy of such findings which are presumptively valid pursuant to Public Health Law Section 10); Lewis v. Board of Examiners of Nursing Home Administrators, 469 NYS2d 216(3d Dept 1983) (three Department of Health reports held admissible in Article 78 proceeding including notations and reports that food portion sizes were inadequate and that patients were not receiving their therapeutic diets).

**PRACTICE POINT:** *Cramer* – improper for plaintiff’s attorney to use DOH reports on opinions on departure in cross-examining defendant’s expert – where the attorney showed poster sized text of opinions in jury’s view.)(maybe if used to inquire/challenge to his opinion – in general)

## VIII. THE INITIAL CLIENT INTAKE and SCREENING

### A. Initial Conversation and client intake

1. What is the relationship between the caller and the resident? Was the caller involved in the resident’s life? Did they visit? Is the caller familiar with resident’s medical conditions? Is there a health care proxy or power of attorney? If the contact was not involved and the victim is deceased, was anyone involved (identify them and speak with them)? ***If it turns out the family was not involved and did not visit then be really sure you want to handle the case-would the jury care more about the victim than the family did? Maybe-if egregious enough.***

Find out the family dynamics. Find out if all siblings are

speaking. Is the spouse alive? If there is no spouse, will the siblings understand that they will have to equally share the settlement? You may hear, "but my brother was not involved, he never visited, why should he get anything?" Resolve this issue up front. Tell them that you cannot take the case unless they accept this. This dynamic is present in MANY cases. You must investigate and resolve these issues up front.

2. Meet all potential family members who can legally pursue the intestate's claim, if applicable. Select the most compelling, reliable and knowledgeable individual to act as the estate representative.

*If it's a strong case of wrongdoing and liability, and no family members are sympathetic or likeable, yet they want to go forward, you can get a retired judge or doctor or advocacy group-NCCNHR- to serve as plaintiff or administrator of the estate of the injured.*

3. Discuss the existence of Medicare and Medicaid liens in that first conversation and PHL 2801-d's effect on any Medicaid lien.
4. Fact sheet/intake----sample as Exhibit ()

## **B. Possible Presuit Discovery**

1. Investigation sometimes requires pre-suit discovery pursuant to CPLR 3102©)
  - a. CPLR 3102©) allows a party to obtain disclosure prior to commencing an action but only by Court Order. To obtain the Order, the applicant must show existence of prima facie cause of action.
  - b. This may be a useful discovery tool if you need to preserve evidence, i.e.: the entire chart, or to identify proper parties.

## **IX. PRESUIT CONSIDERATIONS IN NURSING HOME LITIGATION**

Prosecuting a nursing home case is a very expensive proposition. Typically, the attorney handling the case will be required to set up an estate, either before or during prosecution of the matter. In the context of a large family, this can be very expensive and time consuming.

The records to be received can be voluminous as the victim may have lived in the nursing home for a long period and been in and out of the hospital. The initial pre-suit investment will cost several thousands of

dollars. Litigation expenses can quickly mount and easily exceed \$25,000 in a nursing home case. We suggest that you have your reviewing nurse advise you of the minimum types of records needed for a quality pre-suit review.

In some cases you will have to, or want to, conduct as many depositions on issues of liability as well as damages. Many of the depositions will be to establish damages witnesses on the pain and suffering issues. Many witnesses will be former employees of the facilities, and need to be found and subpoenaed.

**A. WHO IS YOUR CLIENT AND HOW TO GET STARTED**

**WHO HAS STANDING TO BE THE PLAINTIFF? (for RECORDS or LITIGATION)**

Before beginning the process of securing records, one needs to consider if your client has “standing” to get the records.

Injured person is alive and competent – injured person is named as the plaintiff.

Injured person is alive but incapacitated/incompetent – for records one needs a health care proxy, executed while the injured person was competent, or one must pursue a time consuming and expensive Article 81 guardianship. For suit a guardian ad litem or power of attorney are sufficient.

a. Procedure for Guardian ad Litem is outlined in CPLR 1202 - (sample petition (Exhibit “ ”)). A G-A-L generally has the power to commence suit, but not to secure records, nor to obtain a court approved settlement or accept settlement funds. Article 81 Guardian must be appointed for that purpose. *Tudorov v Collazo*, 215 AD 2d 750, 627 N.Y.S.2d 419 (2d Dept. 1995). (obviously if the victim is deceased by the time of settlement, the process will proceed as an Estate in Surrogate’s Court)

The plaintiff is named as “Jane Doe, as guardian ad litem for (the injured person)”. There should be an allegation in the Complaint stating that Jane Doe applied for guardianship and setting forth when, where, and how such guardianship was granted.

Injured person is deceased- Letters of administration or letters testamentary will be needed in order to commence the action. Under newly amended (2004) PHL section 18, a

“distributee” may secure the records *without* first securing “letters”.

If there is a will, a Executor of the Estate of the injured person must be appointed by applying to the Surrogate’s Court where the deceased resided at the time of his or her death for letters testamentary. If there are already letters testamentary or after such letters are issued, the plaintiff in the cause of action is named as “Jane Doe, as Executor of the Estate of the injured person”. There should be an allegation in the Complaint regarding the date and Court where the petition was made for and issuance of the letters testamentary.

If there is no will, an Administrator of the Estate must be appointed by applying to the Surrogate’s Court for letters of administration. If there are already letters of administration or after such letters are issued, the plaintiff is named as “Jane Doe, as Administrator of the Estate of the injured person”.

**PRACTICE POINT:** *You might want to associate with a Trusts and Estates attorney who will do the Article 81 guardianship papers and applications for letters on a contingency pending the success of the case and they will do the compromise order at the end of the case!*

**B. WHO WILL BE YOUR CLIENT, LIKEABLE? – see VIII (A) above.**

Who should be the “authorized representative” of the incompetent or deceased resident? see VIII(A)(1) above

**C. TYPES OF RECORDS AND HOW TO SECURE RECORDS**

Once you have someone with legal capacity in order to secure records (see VIII (A) above), you have to obtain all records from the nursing home and all health care providers in order to fully evaluate liability and damages.

In order to evaluate the case, one must consider how many years of records are necessary to secure? This is not an easy answer as there may be many degrading and dehumanizing events in the nursing home that are actionable and a lot of poor care that contributed to the “fall” or the “ulcer” or the “death”. It is suggested that the practitioner secure the records for three months before the incident, for the first view of the case, and secure the care plans, and MDS forms, going back further. (if the resident had a long stay in the nursing home the total records can be very expensive because every facility will charge \$ .75 cents per page. A few years in a nursing home can generate thousands of pages.

Once you have the records YOU MUST HAVE an expert review them immediately and in some cases you may need more than one expert. Once again this is very costly. Some of us use a nurse with nursing home expertise for the first pass through the case. After a nurse affirms deviations, negligence, and regulatory violations, a doctor is consulted on similar issues as well as causation issues.

The attorney can ask the family to pay for the records and then review them in house, in order to determine if they should be forwarded to an expert. For example, in a “fall” case you may only want the initial assessment and the incident reports if you can get them pre-suit. Your expert can help you identify the records that you want to request.

When you request the records from the nursing home advise them that you are requesting the records pursuant to Federal and New York State Law as follows:

48 CFR 483.75 ( I )(1)

The facility must maintain clinical records on each patient

42 CFR 483.10(a)(2)(i) and (ii)

Facility must give access to records within 24 hours of request, and facility must provide copies of the records to the resident or his authorized representative within 2 business days

10 NYCRR 415.22 and 10NYCRR 415.3©) (1) (iv)

Facility must turn over the records to the resident or his authorized representative within 24 hours and copy said record within 2 days, for its own cost or .75 cents per page, whichever is less.

1. NURSING HOME CHART – Looks like a hospital chart but be aware of special types of records in a nursing home chart and what to look for. Plans of Care---duty to update.... RAPS, MDS (Exhibit “ ” MDS form - note that you must secure this form “in color” by color copying), records showing “turning and repositioning”,... .
2. HOSPITAL CHARTS - In addition to obtaining the nursing home chart, it is important to obtain all relevant medical records, especially hospital records. Hospital records will often evidence signs of inadequate care preceding the hospital, (possibly at the nursing home) which are not

necessarily illustrated in the nursing home chart. Obtaining complete copies of all the records from the hospitals that treated your client before, during and after his or her residency at the nursing home will help you understand where the injuries occurred and help you get a more complete understanding of the care, or lack thereof, provided by the nursing home.

The need to obtain all of your client's hospital records is best illustrated in the context of a bedsore case. You should review the hospital records immediately prior to your client entering the nursing home and immediately after leaving the home. By doing so you can determine whether your client developed bedsores prior to his admission to the nursing home, and if so, how severe they were. Often the nursing home records will suggest the bedsores were healed at the time of discharge to the hospital, but the hospital records will suggest otherwise. At the time of admission, the hospital will assess the severity of the bedsore by charting its length, depth and overall appearance. **Often they will take photographs.** *Don't be surprised if the nursing home or hospital that admitted the patient with pressure ulcers, took photographs in order to protect themselves.*

Of course the hospital records may indicate the opposite, that the hospital is primarily responsible, and accordingly you may want to add them as a defendant.

### 3. STATE SURVEYS, LAW ENFORCEMENT INVESTIGATION REPORTS AND OTHER STATE AGENCY INVESTIGATIONS

If your initial contact is a family member, of a nursing home resident and the occurrence of suspected abuse is fairly recent, *one should encourage the caller to report the abuse to the New York State Department of Health hotline for nursing home abuse at 888-201-4563.* It is suggested that the attorney do a written complaint or draft it for the victim's family and include records (if already received) or photos (pressure ulcers). The attorney can attach records to encourage easy investigation and the attorney can get the client to call and keep after the DOH- they are overworked, understaffed and will more likely pursue and survey cases in which the family is more involved.

The Department of Health is required to investigate and survey every allegation of neglect and/or abuse. Furthermore, they will investigate complaints of a suspicious death even if there is not an allegation of neglect and/or abuse.

If the case warrants it, the investigators will interview

witnesses and review the records to determine if there was abuse and/or neglect. *A report will be generated that will be made available to you and your client once it is completed. While there is rarely a finding of neglect, when there is, the report is invaluable.* In any case, the investigators will “find facts” and interview witnesses.

Law Enforcement Investigation: If your client was involved in a case of potential abuse or there is a suspicious death there may be an investigation performed by a New York State law enforcement agency. Again, these reports provide immediate, frontline investigation of such incidents which will serve as a valuable discovery tool in your case. Law enforcement agencies sometimes are eager to discuss an abuse case with you and advise you “off the record”, as to what they have found.

Ombudsman: You should also ask your client whether the neglect and abuse was reported to the local ombudsman. The ombudsman acts as an advocate for the resident in the facility.

4. DEPARTMENT OF HEALTH SURVEYS & PLANS OF CORRECTION

Nursing homes must submit to *annual* surveys conducted by The New York State Department of Health in order to participate in Medicare and Medicaid programs. You should obtain the survey reports for the period of your client’s residency to determine whether there were any systemic problems at the facility (e.g., pressure ulcers), which are relevant to your client’s case. The key to using these surveys is evaluating the “scope and severity” of the deficiencies cited by the inspectors and relating the deficiencies to the issues of neglect/abuse in your case. For example, if you have a pressure ulcer case, you should look for citations relating to the lack of pressure ulcer prevention measures and pressure ulcer development at the facility. (These citations are highly relevant to your case, should be discovered in depth in depositions and should be presented by your expert when testifying about systemic failures at the facility which caused or contributed to your client’s injuries).

Obtain the nursing home surveys by making a FOIL request to:

New York State Department of Health  
Office of Continuing Care  
Bureau of Administrative Services  
161 Delaware Avenue  
Delmar, NY 12054

Obtain summaries of nursing home surveys on line at:

<http://www.health.state.ny.us/nysdoh/nursing/kings.htm>

<http://www.health.state.ny.us/nydoh/consumer/nursing/homenurs.htm>

On occasion you will locate a survey report which identifies your client's problems at the facility. Of course, this is a grand slam because an independent group of inspectors has discovered that your client was neglected and/or abused in violation of the OBRA standards.

**D. OTHER PRE-SUIT INVESTIGATIONS**

1. Investigate whether you have to file a notice of claim.
2. Arrange for photographs to be taken of your client by family? By a professional? By you? Typically we call the facility to arrange a "dressing change photo".
3. Review any website that the facility may have and find out if your client relied on the website in choosing this nursing home.
4. Obtain and review all of the brochures and pamphlets that were given to your client upon admission if the family has them. Often they contain invaluable information such as bold statements that they specialize in caring for Alzheimer's residents. Get someone to go or you go, to the nursing home for a tour and secure brochures.
5. Call the nursing home, get put on hold- do they have "music on hold" where the magical voice tells you how wonderful the nursing home company is? Consider taping it and get this tape in disclosure.
6. Secure the incident reports if the nursing home omitted them from the chart.
  - a. The Court of Appeals in Subpoena Duces Tecum to Jane Doe, 99 NY2d 434, 757 NYS2d 507 (2003) provides an

excellent discussion of what constitutes privileged quality assurance materials and what does not.

- b. Defendant will typically argue that all documents such as infection control reports and accident/incident reports constitute quality assurance documents - the Court of Appeals in the above-entitled case, disagreed, where the records were kept pursuant to statutory or regulatory mandate. Even though this case came up in the course of a Grand Jury investigation of Medicaid fraud in nursing homes, it may be used to successfully argue that all these documents are discoverable in a civil negligence/malpractice case.
7. Are there other defendants besides the Nursing Home. Were incompetent nurses assigned as “temps” by a staffing company? Are the individual nurses insured? (Discussion of case history - 3 and how defendant nursing home received contribution from insurance carrier for individual nurse)