

LITIGATING THE NURSING HOME CASE: Plaintiff's Perspective

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INTRODUCTION

Nursing homes house some of the most helpless residents of our society. Because of their helplessness, they need not only appropriate professional nursing care, but also vigilant protection of their legal rights.

The landscape of nursing home litigation is changing. In the past, many attorneys were not willing to invest their time and money in cases involving death or injury to an elderly victim. Most thought these cases were not economically viable because nursing home residents frequently are in poor health, suffer from pre-existing conditions, have little or no earning capacity, and have a limited life expectancy. Defendants and their insurance carriers generally viewed these as nuisance cases, also refusing to recognize the value of an elderly resident's right to a good quality of life.

This is no longer the case. Juries are beginning to respond. In October, a Texas jury awarded 250 million dollars to the family of a 80 year old man with emphysema who died from malnutrition in a nursing home. In March, a California jury handed down a 95 million dollar verdict against Beverly Enterprises, the country's biggest chain of nursing homes. In 1997, another Texas jury awarded 83 million dollars to the family of an 84 year old woman who died because of an untreated bedsore. Recently, a Florida jury awarded 6.3 million dollars to the family of an Alzheimer's resident who wandered away from the facility and drowned in a pond.

These large verdicts are probably a combination of several factors. The most likely and obvious is juries' anger with nursing homes over the care provided to the residents. Another probable factor is the changing attitudes of people toward nursing home care. With baby-boomers coming of age, many are now faced with having to rely on nursing homes to care for their aging

parents. Another likely reason is innovative trial lawyers shifting the focus of these cases from traditional pain and suffering damages to a "quality of life" strategy.

The combination of (a) increases in the number of persons subjected to nursing home care, (b) profit motive of nursing facility operators running amuck, (c) explicit regulatory standards, (d) inadequate regulatory oversight, (e) the frequency of substandard care resulting in serious injury or death and (f) the lack of other effective remedies for harm to individual nursing home residents, makes nursing home litigation potentially a fertile field for trial lawyers seeking to ensure fair compensation to persons harmed by the negligence of others.

This article will provide some basic information on the investigation, preparation and prosecution of a nursing home case.

Elder abuse occurs in several different forms. The three primary forms are physical abuse, neglect and fiduciary abuse. Physical abuse includes situations where the resident is kicked, beaten or otherwise physically mistreated. Neglect is the most prevalent type of elder mistreatment, and often occurs as a result of understaffing, inadequate screening of employees, and/or inadequate training and supervision of employees. Two of the leading causes of death of nursing home patients (other than natural causes) are dehydration and malnutrition. Other examples of neglect are contractures, where a patient may have been immobilized in a wheelchair or bed for an extended period of time and can no longer flex their joints; pressure sores, or decubitus ulcers; and infection. An example of fiduciary abuse would be mismanagement or conversion of a patient's assets by a nursing home, relatives or others in a relationship of trust with the resident.

Before suing a nursing home, a plaintiff's lawyer must familiarize himself or herself with federal, state and local rules and regulations that deal with nursing homes. Indeed, one of the reasons why nursing home litigation is expanding so rapidly is the extensive regulation of such facilities by federal and state agencies in particular. In many areas, these regulations provide explicit standards of care by which such homes must abide. This regulation is one price nursing homes pay for receiving public funds (Medicaid) for services provided to residents who otherwise would be unable to pay.

The leading federal regulatory standards are found in *Requirements for States and Long-Term Care Facilities*, 42 C.F.R. part 483; and the Omnibus Budget Reconciliation Act of 1987 (or “OBRA”), popularly known as the *Nursing Home Reform Act*, 42 U.S.C. §1396r. The leading state standards are the *Rules of Alabama State Board of Health, Division of Licensure and Certification*, Ala.Admin.Code chapter 420-5-10, Nursing Facilities (basically a recodification of the federal standards, with several requirements in addition to in lieu of the federal regulations); and Code of Alabama §22-21-20. These regulations address areas such as resident rights, quality of life, quality of care, nursing services, and many others. Key federal and state regulatory standards are discussed in section IV below.

Of critical importance in a nursing home case is knowing that your cause of action will be governed by Code of Alabama § 6-5-540 *et seq.*, the Medical Liability Act of 1987. These statutory provisions affect key areas of a nursing home case, including pleading, venue, discovery, expert testimony, and damages. In particular, section 6-5-551 governs the contents of the complaint, and the scope of discovery. After two earlier decisions in which it read section 6-5-551 as limiting discovery, the Alabama Supreme Court has recently allowed broad discovery where relevant to properly pleaded theories of liability such as negligent hiring, training, staffing, supervision and retention. *See Ex parte McCollough*, ___ So. 2d ___, no. 1962015 (Ala. Jan. 8, 1999). Pleading, discovery and other procedural matters under the Medical Liability Act are discussed in section X.

We begin with some information about the demographics of nursing home residents.

I. The Graying of America/ the Graying of Alabama

A. Nursing Homes -- Defined:

“Nursing homes may be identified as licensed facilities providing inpatient care for convalescence or other persons not acutely ill and not in need of acute general hospital care, but requiring skilled nursing care. Nursing home care is not to be confused with long-term hospital care.” Ala. Admin. Code § 410-2-4-.03(1) (1996).

B. Nursing Home Population -- Generally:

Both nationally and in Alabama the percent of the population aged 65 and older is increasing. Persons aged 65 and older comprise a disproportionate percentage of admissions to skilled nursing care facilities.

- Nationally, 1.5 million Americans lived in 16,700 nursing facilities during the period of July through December 1995
- About 5 percent of persons aged 65 and older are in a nursing facility at any one time.
- An estimated 43 percent of persons who were aged 65 in 1990 will use nursing facilities at some point in their remaining years.
- 90 percent of the nursing facility population in the U.S. is aged 65 and older. More than 35 percent are 85 years and over.
- 75 percent of nursing facility residents are women.
- Approximately 13.5 percent of Alabama's population consists of persons aged 65 and older. This percentage is projected to increase gradually during the coming years.
- In Alabama, as of February 1997, there were 231 certified nursing facilities with early 25,000 beds.
- As recently as 1995, according to a national survey, Alabama nursing facilities overall had an occupancy rate of 98.6 percent.
- According to the Alabama State Health Plan 1996-1999, as of March 1996 the average occupancy rate for the 224 licensed nursing facilities then in operation was approximately 94.8 percent for fiscal year 1995.
- In Alabama, as of September 1996, Medicaid patients occupy 68 percent of the available beds, private pay patients 27 percent, and Medicare patients the remainder.

C. Vulnerability of Nursing Home Residents:

The same factors that predict persons' entry into nursing facilities also show how vulnerable such residents are to abuse, neglect and/or mistreatment. These factors also explain the difficulty residents have in safeguarding their health and welfare and asserting their legal rights.

- Greater level of chronic disability than other persons their age
 - More likely to lack a family member to provide help when needed
 - More likely to have deteriorating cognitive functioning
 - More likely than not are female
 - More likely to have spent time in a hospital or other health facility
 - Tend to have multiple impairments: Of the approximately 24,000 residents in licensed facilities in Alabama in 1995, about 60 percent had five (5) or more deficiencies in their activities of daily living (i.e., needed assistance with common everyday activities such as bathing eating, grooming and walking) ¹
- **Note:** As these factors increase the level of nursing care needed by nursing facility residents, whether individually or as a group, the **duty** owed by the nursing facilities to those residents **also increases**. The reason: A skilled nursing care facility is required to "provide services by sufficient numbers of licensed nurses and other nursing personnel on a 24-hour basis to provide

¹ The Alabama Administrative Code defines activities of daily living ("ADLs") as follows: Those activities necessary to health, grooming, personal sanitation, financial security, and well-being which reasonably competent and healthy individuals can ordinarily perform for themselves. Such activities include, but are limited to walking, bathing, shaving, brushing one's teeth, combing one's hair, dressing oneself, managing one's money, shopping, food preparation, self-administration of medication, recreation and leisure activities.

Ala. Admin. Code. § 420-4-4.01(c) (1996).

nursing care to all residents in accordance with resident care plans.” Ala. Admin. Code § 420-5-10-.11 (1996); *see also* 42 C.F.R. § 483.30 (1996).

II. Historical Background of Nursing Home Reform – Summary

- A. Generally, substandard care and neglectful and abusive treatment in nursing facilities has been repeatedly documented in the media and in Congressional reports over the past two decades.
- B. Advocacy groups such as the National Citizens Coalition for Nursing Home Reform and the federally mandated Long Term Care Ombudsman program, *see* 42 U.S.C. §§ 3027(a)(12), 3058g, have been created in direct response to this long-standing problem.
- C. In 1983, the Health Care Financing Administration of the U.S. Department of Health and Human Services commissioned the Institute of Medicine to conduct a study of nursing home care and to recommend ways to improve nursing facility regulation. The Institute’s study, published in 1986, found nursing facility care in this country “grossly inadequate” and “appallingly bad,” marked by abuse of residents.
- D. In response to the Institute’s report, in 1987 Congress passed federal legislation to try to improve nursing facility care. That legislation (the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 [“OBRA”], *codified as* 42 U.S.C. § 1396r and its implementing regulations have imposed specific standards for nursing facilities that participate in Medicare and Medicaid programs.
- E. Federal and state regulatory agencies are jointly responsible for monitoring residents’ care and ensuring that substandard care is upgraded. Nursing facilities are regulated through federal certification and state licensure for continued participation in Medicare and Medicaid. 42 U.S.C. §§ 1395i-3(g) (Medicare), 1396r(g) (Medicaid). Generally, states have contracts with the federal government to survey nursing homes to determine whether they meet minimal governmental quality standards.
- F. Each state participating in Medicare/Medicaid is required to promulgate regulations conforming to those established by the federal government. Alabama’s regulations governing nursing care facilities are found at Chapter

420-5-10 of the Alabama Administrative Code.

G. In Alabama, the State Board of Health has authority to issue, deny, re-issue and revoke a license to operate a skilled nursing care facility. *See Code of Alabama § 22-21-20 et seq.*; Ala. Admin. Code § 420-5-10-.02 (1996). Surveys of skilled nursing facilities to determine compliance with minimal governmental standards are conducted by the Division of Licensure and Certification of the State Department of Health.

H. By federal law, a facility must operate and provide services in compliance with all applicable federal, state and local laws. It must comply with regulations and codes and with accepted professional standards and principles that apply to professionals providing services in a nursing home. 42 C.F.R. § 483.75 (1996).

I. Enforcement of minimum standards for nursing facility care continues to be uneven. The survey and enforcement system often is not adequately staffed. Even if it were, the survey and enforcement system generally is not intended to monitor and ensure compliance in individual cases. Federal regulators report that facilities are inspected infrequently, and surveyor usually respond only to widespread and recurring violations.

J. In 1995, Consumer Reports reported that about 40 percent of all facilities certified by the federal Health Care Financing Administration had repeatedly violated federal standards over the previous four (4) years.

K. According to the U.S. Senate Committee on Labor and Human Resources, billions of tax dollars are spent annually on damage resulting from poor care, such as treating bedsores that were avoidable, hydrating residents who should not have become dehydrated, etc.

L. According to the Alabama Ombudsman, quality of care in Alabama nursing facilities has deteriorated since 1994. Particularly common problems include over medication, and an inability or unwillingness on the part of the nursing facilities to meet the residents' needs.

III. Why Nursing Home Litigation

As advocates for persons harmed by the negligence of others, plaintiff's lawyers have numerous good reasons for suing nursing homes in appropriate cases:

- Helpless victims, usually with little or no other recourse
- Too many nursing facilities placing profits over people
- Inadequate regulatory oversight
- Even when operating as intended, regulatory oversight not designed to remedy individual harm.
- Governmental regulation intended to be cumulative of existing remedies
- Individual suits necessary part of promoting good quality care to individual residents

IV. Applicable Standards

A. **Standards applicable to skilled nursing facilities:**

As noted above, the nursing home industry is highly regulated, for good reason.

The standards applicable to such facilities include the following:

- Federal nursing home reform amendments to OBRA 1987/ "Nursing Home Reform Act" -- 42 U.S.C. 1396r
- Federal implementing regulations -- Requirements for Long Term Care Facilities -- 42 C.F.R. Part 483, subpart B (42 C.F.R. §§ 483.1 - 483.75 (1996))
- Federal implementing regulations -- Survey and Certification of Long-Term Care Facilities -- 42 C.F.R. Part 488, subpart E (42 C.F.R. §§ 488.300 - 488.335 (1996))

- Rules of Alabama State Board of Health, Division of Licensure and Certification for Nursing Facilities -- Ala. Admin. Code chapter 420-5-10 (Ala. Admin. Code §§ 420-5-10-.01 through 420-5-10-.18 (1996))²

- “Accepted professional standards and principles that apply to professionals providing services in such a facility” -- *see* 42 C.F.R. § 483.75

B. General Principles:

The federal and state regulations identified above establish numerous requirements and/or standards of care, some of which can be *generally* summarized as follows:

- Adequate numbers of nursing personnel, including nurses and nursing assistants

- Competent nursing personnel (nurses and nursing assistants) who were screened when hired and have been monitored throughout their employment to eliminate personnel who are unfit

- Adequate and systematic planning to create an individualized care plan for each resident

- Continuous and systemic assessment of each resident, and notification of the attending physician when necessary

- A record-keeping system that accurately documents the clinical condition and progress of residents as well as delivery of care

- An adequate quality assurance program that identifies and corrects care deficiencies

C. Specific Standards -- Policy and Administration

² The state regulations include the text of the federal regulations, and in many areas impose additional requirements or standards. The most recent “blue book” version of those regulations, obtainable from the Division of Licensure and Certification, sets out the federal regulations in regular type, and the state requirements in addition to/or in lieu of the federal regulations in bold type.

The following list includes some specific standards promulgated under federal and state law in the areas of general policy and administration. This list is by no means exhaustive. It is intended to include some of the standards with which a lawyer representing any nursing home resident on a personal injury or death claim should be familiar:

1. **Quality of Life:** A nursing home is required to "care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." 42 C.F.R. § 483.15.

2. **Quality of Care:** This regulation spells out the bedrock or "bottom line" duty the nursing home to provide appropriate nursing services to each and every resident, to maximize **each** resident's well-being.

Under this standard: "**Each** resident must receive and the facility must 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.**" 42 C.F.R. § 483.25.

Under this standard: The facility has a duty to ensure that a "**resident's abilities** in activities of daily living **do not diminish unless** the circumstances of the individual's clinical condition demonstrate that diminution was **unavoidable.**" 42 C.F.R. § 483.25(a)(1).

The facility's duties with respect to the comprehensive assessment and plan of care are discussed in further detail below.

3. **Facility Administration:** "A facility must be administered in a manner that enables it to use its resources effectively and efficiently to **attain or maintain** the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75.

· Under this standard, the facility must be licensed under applicable Alabama law -- 42 C.F.R. § 483.75

· The administrator must be licensed under applicable Alabama law -- 42 C.F.R. § 483.75

4. **Resident Rights:** This standard protects a resident's right to "a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility."

· The regulations protecting resident rights address such matters as access to records, refusal of treatment, notification of changes (e.g., health status, treatment, transfer or discharge), transfers, management and protection of the resident's funds, free choice (e.g., personal physician, care and treatment), grievances, and examination of survey results. These and other resident rights are spelled out in detail in 42 C.F.R. 483.10 and Ala. Admin. Code §420-5-10-.05.

5. **Access to Records:** Although often ignored by nursing facilities, the regulations clearly give "the resident or his or her legal representative" the right to **review and obtain copies** of that resident's records:

· "Upon an oral or written request, to access **all records pertaining to himself or herself** including current clinical records **within 24 hours** (excluding weekends and holidays)" and

· "After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard **photocopies of the records or any portions of them upon request** and two working days advance notice to the facility" -- 42 C.F.R. § 483.10(b)(2)

· For obvious reasons, this right of access to records is a critical tool in attempting to evaluate whether a resident or her representative has a viable cause of action.

6. **Notification of Changes:** Look for this rule to be violated when a facility is trying to cover up an injury or other problem.

Federal and state regulations require a facility to “**immediately** notify the **resident**; consult with the **resident’s physician**; and if known, notify the **resident’s legal representative or an interested family member** when there is --

(a) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(b) A significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(c) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(d) A decision to transfer or discharge the resident from the facility ...” 42 C.F.R. § 483.10(b)(11)

7. **Comprehensive Assessment/ Plan of Care:** The comprehensive assessment of a resident, and the individual plan of care developed to address any nursing care needs identified in that resident’s assessment, are the foundations upon which any resident’s care is built. The assessment and care plan provide a benchmark against which the care actually received by the resident may be evaluated.

Assessment: The requirements of the comprehensive assessment are spelled out in detail in the regulations. See 42 C.F.R. § 483.20. Generally, the assessment is based on a uniform or minimum data set specified by the government regulators, and must describe the resident’s ability to perform daily life functions and any

significant impairments in the resident's functional capacity. See 42 C.F.R. § 483.20(b).

A comprehensive assessment must be done (a) no later than 14 days after admission; (b) "promptly after a significant change in the resident's physical or mental condition"; **and** (c) always at least once every 12 months. 42 C.F.R. § 483.20(b)(4).

Care Plan: Based on the resident's "medical, nursing, and mental and psychosocial needs" as identified by the assessment, the facility must develop a "comprehensive care plan for each resident" to meet **each** such need.

The comprehensive care plan must describe "the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25." 42 C.F.R. § 483.20(d)(1).

The care plan must be developed within 7 days after completion of the assessment, must be prepared by an interdisciplinary team, and must be periodically reviewed and revised after each assessment. 42 C.F.R. § 483.20(d).

Services: Services provided under the care plan must "meet professional standards of quality" **and** must be provided "by **qualified** persons in accordance with each resident's plan of care." 42 C.F.R. § 483.20(d)(3).

The fitness or qualifications -- or lack of fitness or qualifications -- of the persons providing care to nursing home residents is a common issue (and potential cause) in nursing home injury and death cases. Relevant standards are discussed under "staffing" below.

8. **Staffing:** Insufficient staffing, or lack of **qualified** staff, often contributes to abuse, mistreatment, neglect or other substandard care. Related issues include the training, monitoring and supervision of such staff.

General standard for staffing (federal regulations): "The facility must have sufficient nursing staff to provide nursing and related services to **attain or maintain the highest practicable** physical, mental, and psychosocial **well-being** of **each** resident, as determined by resident assessments and individual plans of care."

42 C.F.R. § 483.30.

The requirement that a facility provide sufficient staff applies on a 24-hour basis, and requires that the facility provide "sufficient numbers" of both "licensed nurses" and "other nursing personnel ... to provide nursing care to **all** residents in accordance with resident care plans." 42 C.F.R. § 483.30(a).

"Other nursing personnel" typically refers to nurse aides, i.e., "any individual providing nursing related services to residents in a facility who is not a licensed health care professional, a registered dietitian, or someone who volunteers to provide such services without pay." 42 C.F.R. § 483.75(e)(1).

Required staff include (but are not limited to):

(a) medical director: a physician designated by the facility, who is responsible for implementing resident care policies and coordinating medical care in the facility -- 42 C.F.R. § 483.75(I)

(b) director of nursing: the facility must designate a registered nurse to serve as director of nursing on a full-time basis -- 42 C.F.R. § 483.30(b)(2)

(c) licensed nurses: at least one (1) registered nurse must be used "for at least 8 consecutive hours a day, 7 days a week," 42 C.F.R. § 483.30(b)(1); and the facility must designate a licensed nurse (which includes licensed practical nurses) to serve as a charge nurse on each tour of duty -- 42 C.F.R. § 483.30(a)(2)

Prior to the publication of the 1996 "blue book," the state regulations prescribed specific minimum staffing ratios for skilled nursing homes (Ala. Admin. Code § 420-5-10-.08(6)):

(a) licensed nurses (registered or licensed practical): "shall be employed full time (40 hour week) at the ratio of one nurse per ten patients, or major fraction thereof. The director of nursing services may be included in this ratio."

(b) licensed nurses per shift: "At least one registered nurse or licensed practical nurse shall be on duty in the home on each shift."

(c) "non-professional nursing personnel": "Aides, orderlies, and other non-professional nursing personnel shall be provided according to the following ratios or major fraction thereof."

One per 10 patients	Day shift
One per 15 patients	Evening shift
One per 25 patients	Night shift"

Note that even under the specific state-mandated staffing ratios, compliance with those ratios would **not** satisfy the **federal** requirement that the facility provide sufficient staff to meet the total nursing care needs of the residents **if** compliance with the residents' assessments and care plans required use of more staff.

Competency requirements for nurse aides: Among nursing facility staff, nurse aides normally have the most direct contact with facility residents; and are responsible for most "hands-on" care in assisting residents in the basic activities of daily living (e.g., eating, bathing, grooming, bowel and bladder function).

The facility's general duty is to "ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care." 42 C.F.R. § 483.75(f).

Generally, a facility may not use an employee as a nurse aide for more than 4 months unless that individual has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program. 42 C.F.R. § 483.75(e)(4).

Generally, before allowing an individual to serve as a nurse aide, the facility must receive verification from the state nurse aide registry that the individual has met competency evaluation requirements. 42 C.F.R. § 483.75(e)(5).

In-service education: To ensure continuing competence after initial certification, a facility "must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews." The in-service education "must address areas of weakness as determined in nurse aides' performance reviews," but in any event must be at least 12 hours per year for each aide. 42 C.F.R. § 483.75(e)(8).

9. **Record-keeping requirements – clinical records:** The facility's general duty is to "maintain clinical records on each resident in accordance with accepted professional standards and practices that are (i) complete; (ii) accurately documented; (iii) readily accessible; and (iv) systematically organized." 42 C.F.R. § 483.75(l).

The clinical record must contain the following:

- (a) sufficient information to identify the resident;
- (b) a record of the resident's assessments;
- (c) the plan of care and services provided;
- (d) the results of any pre-admission screening conducted by the State; and
- (e) progress notes. 42 C.F.R. § 483.75(l)(5).

The clinical record must be retained, for an adult resident, for five (5) years from date of discharge when there is no other requirement under State law. 42 C.F.R. § 483.75(l)(2).

As a general matter, nurse aides chart entries with respect to activities of daily living, while licensed personnel chart nearly all other record entries. Common records may include medical records, nursing notes, progress notes, medication administration records, physician orders (including medication orders), activities of daily living records, assessments, and care plans.

10. **Reporting and investigation requirements – Suspected abuse or neglect:**

Duty to report: “A facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).” 42 C.F.R. § 483.13(c)(2).

Duty to investigate: “The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.” 42 C.F.R. § 483.13(c)(3).

Timing of report to state licensing agency: Results of all investigations must be reported to the administrator and the Division of Licensure and Certification within 5 working days of the incident. 42 C.F.R. § 483.13(c)(4).

Neglect – defined: Federal surveyors define “neglect” as “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs on an individual basis when a resident does not receive care in one or more areas (e.g., absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces).”

D. Specific Standards – Areas of Nursing Care

The regulations provide specific standards of care in various areas of nursing care for conditions that occur with regularity in nursing home residents. The following is an illustrative, but again not exhaustive, list.

1. **Pressure Sores:** Based on the comprehensive assessment, a facility must ensure two things:

- (a) a resident who enters the facility **without** pressure sores does not **develop** pressure sores unless they are clinically unavoidable; and
 - (b) a resident **with** pressure sores “receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.” 42 C.F.R. § 483.25(c).
2. **Falls and fractures:** A facility again has two duties in preventing falls and fractures:
- (a) ensuring that “the resident environment remains as free of accident hazards as possible”; and
 - (b) ensuring “each resident receives adequate **supervision** and **assistance devices** to **prevent** accidents.” 42 C.F.R. § 483.25(h).
3. **Misuse of chemical and/or physical restraints:** A resident “has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.” 42 C.F.R. § 483.13(a); *see also* 42 C.F.R. § 483.25(l)(1) (unnecessary medications).
4. **Dehydration, malnutrition, choking:** Again based on the resident’s comprehensive assessment, the facility must ensure that a resident “maintains acceptable parameters of nutritional status, such as body weight and protein levels” unless clinically not possible. The facility likewise “must provide each resident with sufficient fluid intake to maintain proper hydration and health.” 42 C.F.R. §§ 483.25(I), (j).

5. **Care of “tubes” -- catheters, feeding:** A resident who enters a facility without an indwelling catheter should not be catheterized unless clinically necessary. Similarly, a resident who has been able to eat alone or with assistance should not be fed by naso-gastric tube unless clinically unavoidable. In both instances, the facility has the duty to provide appropriate treatment and services to prevent related medical problems (e.g., urinary tract infections, aspiration pneumonia) and to restore as much normal bladder function or eating skills as possible. 42 C.F.R. §§ 483.25(d), (g).

V. **Clinical Outcomes Frequently Linked with Neglect:**

There are various clinical conditions or outcomes that the medical and nursing communities have recognized as being preventable in nearly all nursing home residents through implementation of ordinary nursing care, or that have been subjects of frequent and successful litigation, or both.

These include:

- A. Injuries precipitated by progressive failures and omissions of care
- Decubitus ulcers -- Stage III or IV
 - Infected decubitus ulcers
 - Severe dehydration
 - Severe protein-calorie malnutrition
 - Septic shock

- Gangrene
- Aspiration pneumonia
- B. Injuries precipitated by medication prescription and administration failures
- C. Injuries precipitated by untoward incidents
 - Strangulation
 - Drowning
 - Scalding
 - “Wander-off” cases, where resident suffers serious injury or death after wandering off from facility
 - Falls and fractures resulting from failure of staff to follow accepted protocols and implement necessary preventive measures
 - Rape and/or sexual assault
 - Physical abuse and/or assault

VI. Potential Legal Theories of Liability/Causes of Action in Injury or Death Cases

Defendants frequently contend that the Medical Liability Act of 1987 limits plaintiffs to a claim for negligence or wantonness, in effect arguing that the Act “pre-empts” other potential causes of action. But, there are no reported cases that so hold. And, the Act itself refers in numerous places to actions “for injury or damages or wrongful death, whether in contract or in tort,” indicating there is no limitation on the types of claims that may be brought under the Act.

So, although all claims under the Act may be subject to the same heightened pleading requirements, the same restrictions on discovery, and the same limitations and venue provisions, there are a wide variety of potential theories of liability in nursing home cases, including:

- A. Wrongful death
- B. Negligence and wantonness
- C. Breach of express contract for rendition of medical (or related services) or of a contract implied in fact

-- See, e.g., *Moore v. Averi*, 534 So.2d 250, 251-52 (Ala. 1988); *Taylor v. Baptist Medical Center, Inc.*, 400 So.2d 369, 274 (Ala. 1981); *Horton v. Northeast Alabama Regional Medical Center, Inc.*, 334 So.2d 885, 890 (Ala. 1976); *Berry v. Druid City Hospital Board*, 333 So.2d 796 (Ala. 1976)

- D. Fraud

-- See, e.g., *Trammer v. Bernstein*, 596 So.2d 572 (Ala. 1991) (plaintiff's fraud or misrepresentation claim under Medical Liability Act not barred by statute of limitations)

-- but see *Ex parte Golden*, 628 So.2d 496 (Ala. 1993) (in determining scope of discovery, substance of action governed; plaintiff's cause of action for fraud construed as malpractice, and discovery limitations in Code of Alabama § 6-5-551 applied) (*Trammer* not cited)

- E. Civil conspiracy

- F. Assault

In death cases, pleading a claim for breach of an express contract (where the facts support it) has some obvious advantages over asserting only a claim sounding in tort. An unfiled contract claim survives the death of the decedent. See Code of Alabama § 6-5-462. If the contract was for rendition of medical services in accordance with federal regulations or accepted standards of care, breach of that contract should allow recovery of damages suffered by the decedent before death. Such a claim can significantly enhance the value of the suit, especially where death resulted from a progressive, deteriorating condition, such as decubitus ulcers, involving prolonged suffering before death.

VII. Common Defenses and/or Evaluation Concerns

Some of the criteria normally used to evaluate likelihood and amount of recovery in other personal injury and wrongful death cases acquire special significance in evaluating and prosecuting a nursing home injury or death case. Following are some common defenses or defense themes, which need to be scrutinized closely in screening, discovering and presenting a nursing home case. Handled properly, they also present opportunities for maximizing the chances of full recovery for our clients.

A. Witnesses

In non-death cases, client with multiple impairments may not be an effective or even a competent witness.

In all cases, other residents who are potential witnesses are statistically likely to have multiple impairments as well.

Staff witnesses may be controlled by nursing home, or may be bound by a "code of silence."

The executive director of the Alabama Nursing Association recently wrote an op-ed piece in the Montgomery Advertiser arguing that the medical code of silence threatens the lives of Alabamians. She wrote: "Whistleblowers -- who more times than not are whispering, not whistling -- are not welcome in the health care institutions of Alabama. An attempt to report a mistake in such an institution is tantamount to resignation. There is no protection for the nurse, physician or health care employee who tells the truth about patient care." She further noted that "Corners are being cut today that routinely place patients in harm's way. Yet there is no mechanism to ensure that a health care provider willing to stick his or her neck out in the interest of patient care is protected." Referring to her oath as a nurse to do all within her power to preserve the health of her patients, she called for a public policy exception to Alabama's at-will employment rule to protect a nurse or other health care provider who reports inappropriate health care practices from being terminated for

doing so. See Elizabeth A. Morris, "Medical 'code of silence' threatens the lives of Alabamians," Montgomery Advertiser, July 13, 1997, page F1.

On the other hand, given the high employee turnover rate in many nursing homes, particularly at the nurse aide/nursing assistant level, former employees may be good sources of information about resident care, either generally (i.e., the systemic practices of the facility) or specifically (i.e., the care rendered to the plaintiff or plaintiff's decedent).

Ethics opinions available from the State Bar suggest that it is permissible to interview *ex parte* former or even present employees of a facility, at least if such an employee is not a managerial employee in a position to bind the facility by his or her statements or is not the actual tortfeasor (the person whose acts or omissions for whom plaintiff seeks to hold the facility responsible), and provided such employee is not personally represented by counsel.

B. Damages

In non-death cases, nursing home residents may be less likely than the general public to be able to recover for lost earning capacity or, in some instances, future health care expenses.

Punitive damages should always remain available in appropriate injury cases, and, of course, are the sole remedy in death cases. Proof of chronic, repetitious, or systemic abuse, neglect, mistreatment or other negligence, or egregious individual cases provides the "heat" for punitive damages. Defendants frequently argue that Code of Alabama § 6-5-551 bars discovery and proof of such chronic, repetitious or systemic problems. But, this argument has been dealt a blow by the Alabama Supreme Court's recent decision in *Ex parte McCollough*, ___ So.2d ___, no. 1962015 (Ala. Jan. 8, 1999). The scope and effect

of § 6-5-551 are discussed in the section on pleading and procedure under the Medical Liability Acts of 1975 and 1987 below.

C. Causation

As is generally true, a plaintiff must be able to establish a link between the facility's breach of the standard of care and the harm suffered by the resident. But, it may be difficult distinguishing the effect of neglect from the effect of any underlying disease processes.

As a practical matter, a plaintiff needs to show, in light of the resident's deteriorated condition and limited life expectancy, how the facility's conduct changed the resident's life.

Defendants may play on these causation concerns as follows: (1) we didn't do anything wrong; (2) if we did do something wrong, what we did wrong did not cause her injury or death; (3) the resident was old and sick and was going to suffer those problems or die anyway.

On the other hand, generally an injured person may recover full compensation for all damage proximately caused by the facility's acts or omissions, even though his or her injuries may have been aggravated by reason of his pre-existing physical or mental condition, or rendered more difficult to cure by reason of his or her state of health, or made more serious because of a disease. *See, e.g., Henderson v. United States*, 328 F.2d 502,

504 (5th Cir. 1964) (Alabama law); *Cooper v. Magic City Trucking Service, Inc.*, 264 So.2d 146 (Ala. 1972); *Underwood v. Smith*, 73 So.2d 717 (Ala. 1954); Alabama Pattern Jury Instructions: Civil 11.07 (2nd ed. 1993) (personal injury -- aggravation of pre-existing conditions); APJI 11.08 (subsequent injuries or disease proximately resulting from original injury).

Expert testimony: As in other professional standards cases, expert help and testimony are likely to be critical in identifying and proving the relevant standard of care, the breaches of that standard, and the causal connection between the deviations from that standard and the injuries or death suffered by the resident.

D. Positive Themes

The following case themes may be helpful in countering defendants' usual pyramid of defenses:

- The victim is someone's mother or grandmother, was a caregiver and is now wholly dependent on the care of another, a profit-driven corporation.
- In a death case: No one has the right to decide when someone else will die
- No one has the right to play God, to end life by his or her negligence or other misconduct
- The shorter the time one has left in life, the more precious that time is
- Many adults have wrestled with the decision to place a loved one in a nursing home. Nursing homes hold themselves out as experts in caring for the old and infirm, and assure families that their loved one will receive good care there. By failing to give the care promised, or by its employees' misconduct, that nursing home violated that trust.
- The defendant takes the plaintiff as it finds her
- Every resident is entitled to good quality care, no matter how old, how sick, how poor or what color or religion

The sicker a resident, and the more nursing needs she has, the more nursing services she is entitled to

VIII. Pre-suit investigation – records and plaintiff's counsel

A. Getting the records:

A key part of pre-suit investigation of a nursing home claim is obtaining a copy of the resident's nursing home records and acute care (e.g., hospital and attending physician) medical records. Many instances of elder abuse in nursing homes are a direct result of resident neglect. This may occur for several reasons, particularly understaffing and inadequate training and supervision. Common sense dictates that a facility which is unable to properly care for a resident also will be unable to timely and accurately chart the various records required to be kept on patients. This in turn may result in falsification of records after-the-fact, in an effort to cover up inadequate care. Exposing falsification, where it occurs, can greatly enhance the value of a nursing home case.

If you are fortunate enough to receive one of these cases shortly after the injury happened, you may be able to obtain a copy of the nursing home records before any "cleaning up" occurs. As noted above, 42 C.F.R. §483.10(b)(2) provides that a resident or his or her legal representative has the right to access all of their medical records within twenty-four (24) hours, excluding weekends and holidays. That regulation further provides that the resident or legal representative may obtain copies upon two (2) working days' notice to the facility.

Many nursing homes will not provide this information within the designated time periods. Some have a corporate policy of forwarding all records requests to headquarters before producing the records, if at all. If the facility fails to produce the records within the required time, you may want to document this occurrence and

ask the resident or their sponsor to file a complaint with the state Department of Health, requesting the State to investigate and issue a statement of deficiency to the facility for failing to comply with the requirements.

In addition to gathering the resident's records, it is useful to try to locate and interview former employees of the nursing home, to gather information about the home's practices and procedures, the home's treatment of the resident, *and* the home's treatment of *other* residents. This will be important in alleging additional acts and omissions with the detail required by § 6-5-551, as discussed further below.

Also useful are the reports of the surveys conducted by the Department of Health, Division of Licensure and Certification, reflecting the deficiencies found by the Department during its required inspections. These are public documents, and may be obtained from the Department.

B. The Nursing Home Records

A valuable resource for a plaintiff in a nursing home case is the medical record, both the nursing home records and any other medical treatment records. Skilled nursing facility records are unique because there are so many disciplines that chart in them. All the medical records should be reviewed in great detail. The records in the nursing home records from the various disciplines should be compared to one another. In some cases, it will be hard to tell they are charting the same patient, increasing the likelihood of proving falsification of records.

Gather as much information as possible about the resident from the nursing home. This includes records of current and past admissions of the resident. Specifying *past* admissions is important where the home starts a new set of records each time the resident has, for any reason, left the home (e.g., to be hospitalized) and returned.

One valuable type of document in the resident's nursing home records is the comprehensive assessment, which in turn is based on the Minimum Data Set ("MDS"). The MDS is a form set of documents containing comprehensive data concerning the resident. As required by 42 C.F.R. § 483.20, the comprehensive assessment must be completed within fourteen (14) days of admission. It contains information such as the resident's prior medical status, physical and mental functioning status, sensory and physical impairments, nutritional status, activities potential, rehabilitation potential, cognitive status, and discharge potential. The comprehensive assessment must be conducted at least once every twelve (12) months, and promptly after any significant change in a resident's physical or mental condition; and must be reviewed at least quarterly.

Medicare and Medicaid reimbursement percentages are tied to the resident's acuity level, an indicator of what type of and how much services will be required for adequate care of the resident. (This takes into account conditions such as whether the resident is ambulatory, is incontinent, is prone to pressure sores, requires assistance in activities of daily living such as eating and bathing, etc.) In turn, the acuity level of the nursing home's population will help determine the level of staffing and type of staff necessary to render the required level of care to all the residents, regardless of condition. The acuity level of a resident is based on the information contained in the Minimum Data Set. Therefore, you may find exaggerations of the resident's condition in the MDS.

The comprehensive assessment will be used to develop the patient's care plan, which also is required by federal law. Examine the care plan to assess the quality of the plan, to see what is being addressed by the plan and whether the goals are realistic.

Also review the Activities of Daily Living ("ADL"). These records contain information regarding out-of-bed activity, bowel movements, skin care, oral hygiene, bathing and eating, among other things. Certified nursing assistants or certified nurses' aides ("CNAs"), who deliver most of the hands-on care in a skilled nursing facility, are usually responsible for charting in these records. Despite doing most of the manual labor involving residents, CNAs are generally among the lowest paid employees of the nursing home. They are taught that one of their primary duties is to chart in these records. These records are a "hot spot" for falsification.

- Although not a part of pre-suit investigation, in assessing the ADL, it is important to depose the medical records director, who is responsible for auditing the medical records. The medical records director will usually perform an audit about once every three (3) to six (6) months. During the audit, they may go back and look for gaps or holes in the medical records, which sometimes are then filled in.

Other important records include the Medication Administration Records ("MAR"), sometimes referred to as the Monthly Medication Sheet. These records chart the various medications administered to the resident.

- Some background information may be helpful in assessing the MAR for falsification. When a resident is transferred from the nursing home to an acute care hospital, certain records go with the patient. Upon arrival, the patient will again be diagnosed by the acute care hospital. The hospital may call the nursing home and inform the director of nursing of the diagnosis. If inclined to falsify records, the director of nursing can then get the nursing home chart, review it for inconsistencies with the hospital's diagnosis, and then try to clear up or explain any inconsistencies.

In addition to the MAR, it is important to compare all acute care hospital records to those of the nursing home for other possible discrepancies and contradictions. You will also want to assess each of the additional nursing home records such as physical therapy, occupational therapy, speech therapy, and social activities. Once all the various records have been assessed, make a comparative

chart, preferably on a daily basis for each set of records. This will assist you in identifying and exposing areas of deficient care, as well as possible falsification of records.

In a wrongful death case, obtain a copy of the death certificate and, if there is one, a copy of any autopsy report. If the resident died in a hospital, the death certificate will normally be based on diagnosis and treatment obtained during the hospital stay. If the resident died in the facility, however, the cause of death may simply be listed as cardiac arrest. That cause may be reasonable, or may simply obscure the other processes that led to death.

Review by nursing care experts, and frequently medical experts, is usually necessary and almost always worthwhile to evaluate a potential claim before filing suit. The desirability of using experts is enhanced by the cold facts that bad outcomes for nursing home residents may not result from bad care and/or may not be preventable; and even where there has been bad care, it may be difficult to separate the results of the care from any underlying disease processes or health problems.

Numerous other categories of nursing home and corporate records are useful in preparing a nursing home case from the plaintiff's perspective. These generally are listed in the next section, concerning discovery strategies.

IX. Discovery Strategies

Obviously, discovery must be tailored to the facts and theories of a particular case. The following is a list of illustrative categories of discovery requests that may be generally applicable in nursing home injury or death cases. (Not surprisingly, many of our requests have provoked objections from defendants, and we have not obtained all this information in each instance.)

A. **Requests for production**

- Documents reflecting ownership or management of the facility
- Articles of incorporation or partnership agreements
- Minutes of the governing board
- Organizational chart reflecting all officers, directors, departments, committees, and employees
- All state or other licenses
- Insurance agreements
- List of names and last known addresses and telephone numbers of present and former nursing personnel (e.g., nurses and nurse aides/nursing assistants)
- List of names and last known addresses and telephone numbers of former nursing personnel
- All guidelines of any local, state or federal governmental entity relating to facility's resident care policies and procedures
- All documents reflecting facility's resident care policies and procedures
- All documents reflecting facility's personnel policies and procedures
- All documents pertaining to complaints of alleged abuse, neglect or mistreatment of any resident, or to the health, safety and/or welfare of any resident
- All documents pertaining to investigations of alleged abuse, neglect or mistreatment of any resident, or to the health, safety and/or welfare of any resident
- All documents obtained from or provided to any expert
- All charts, documents, photos, and other tangible items relating in any way to plaintiff/resident

- All clinical records, charts, documents, photos and other tangible things relating in any way to plaintiff/resident (including but not limited to assessments; care plans; medical, hospital, and autopsy records; nursing notes; medication records; incident reports relating to plaintiff/resident; notes charted by nursing assistants, such as activities of daily living records; physician orders; records of notifications of plaintiff/resident's attending physician)
- All documents and other evidence pertaining to investigation of alleged abuse, neglect or mistreatment of plaintiff/resident
- Legal notices provided to residents (e.g., notices of resident rights)
- Documents pertaining to advertisements or other representations to the public concerning the quality, characteristic, type and standard of care provided to residents at the facility
- Documents reflecting resident occupancy and characteristics of those residents (e.g., daily resident census)
- Documents reflecting level of staffing (e.g., work schedules and time sheets showing the identity, number and classification of staff) as to area in which plaintiff/resident was housed
- Employee work schedules
- Clocked time cards
- Personnel records of persons involved in providing care to plaintiff/resident
- Personnel records of facility administrator
- Documents pertaining to disciplinary action or investigation of persons involved in providing care to plaintiff/resident
- Evaluations of persons involved in providing care to plaintiff/resident
- Employment application form and all other forms used in screening applicants for employment
- Floor plans or other documents reflecting layout and number of rooms in facility

- All documents pertaining to in-service training of employees (e.g., syllabi or other documents reflecting content of training sessions, materials distributed, attendance records, results of any tests)
- All documents relating to inspections, adverse findings, proposed sanctions, or responses
- Witness statements

B. Interrogatories

- All persons with knowledge of discoverable facts
- Experts
- Persons from whom statements have been taken
- List of names and last known addresses and telephone numbers of present and former nursing personnel (e.g., nurses and nurse aides/nursing assistants)
- List of names and last known addresses and telephone numbers of former nursing personnel
- List of names and last known addresses and telephone numbers of persons who provided care to plaintiff/resident
- Other lawsuits or threatened lawsuits
- Any other potential parties
- Other previous and subsequent incidents occurring in substantially the same or similar way as incident made the basis of suit

C. Non-party subpoenas duces tecum

- Documents relating to licensure and certification surveys or inspections, adverse or deficiency findings, sanctions, and facility response -- State Health Department, Division of Licensure and Certification
- Documents related to any investigations of alleged abuse, neglect or mistreatment at facility-- State Health Department, Division of Licensure and Certification

- Licensing status (including initial licensing and any renewals) of licensed nurses -- Alabama Board of Nursing
- Documents relating to alleged violations by licensed nurses of Board rules and regulations, or to any investigations of alleged abuse, fraud, neglect or exploitation by licensed nurses, or to any disciplinary proceedings -- Alabama Board of Nursing
- Licensing status of nursing home administrator -- Board of Examiners of Nursing Home Administrators
- Documents relating to alleged violations by nursing home administrator of Board rules and regulations, or to any investigations of alleged abuse, fraud, neglect or exploitation by nursing home administrator, or to any disciplinary proceedings -- Board of Examiners of Nursing Home Administrators
- Medicare and Medicaid reimbursement documents
- Acute care hospital records
- Treating physician records
- Police reports

X. Pleading and Procedure -- Medical Liability Acts of 1975 and 1987

A. **Introduction:** Succumbing to special interest pressure, the Legislature has twice (in 1975 and 1987) enacted significant legislation addressing causes of action against medical professionals in the context of patient-doctor and patient-hospital relationships. The Medical Liability Act of 1987 (Code of Alabama §§ 6-5-540 through 552) was intended to supplement the Medical Liability Act of 1975 (Code of Alabama §§ 6-5-480 through 488). Some of the most significant provisions, particularly regarding damages, have been invalidated as unconstitutional. The remaining provisions, however, continue to have a practical effect on nursing home injury or death cases.

B. **Application to nursing homes:** The Eleventh Circuit (implicitly) and the Alabama Supreme Court (explicitly) have indicated that actions against nursing homes are governed by the medical liability statutes. *Jackson v. Pleasant Grove Health Care Center*, 980 F.2d 692 (11th Cir. 1993); *Husby v. South Alabama Nursing Home, Inc.*, 712 So.2d 750 (Ala. 1998); *Ex parte Northport Health Services, Inc.*, 682 So.2d 52, 55 (Ala. 1996).

C. **Limitations:** Generally, any claim against a covered health care provider “for liability, error, mistake, or failure to cure, whether based in contract or tort,” must be brought within 2 years after the act or omission giving rise to the claim. Code of Alabama § 6-5-482. If the act or omission could not reasonably have been discovered within that period, the action must be filed within 6 months of discovery of act or omission or facts that would reasonably lead to such discovery, but in **no** event more than 4 years after the act or omission. *Id.*

The Supreme Court has held that an action based on **fraud or misrepresentation** arising out of an act or omission of a health care provider may be filed within **2 years** of discovery, provided it is filed within 4 years of the act or omission. *Trammer v. Bernstein*, 596 So.2d 572, 575 (Ala. 1991).

D. **Venue:** “In any action for injury or damages or wrongful death whether in contract or in tort against a health care provider based on a breach of the standard of care, the action must be brought in the county wherein the act or omission constituting the alleged breach of the standard of care by the defendant actually occurred.” Code of Alabama § 6-5-546; *see also Ex parte B.L.H.*, 677 So.2d 1152 (Ala. 1995).

If plaintiff alleges the acts or omissions resulting in injury or death took place in **more than one county**, the action **must** be brought in the **county where the plaintiff** (in a personal injury action) **resided at the time of the act or omission**, or where the plaintiff's decedent (in a wrongful death action) resided at the time of the act or omission. Code of Alabama § 6-5-546; *Ex parte Kennedy*, 656 So.2d 365 (Ala. 1995).

Section 6-5-546 determines proper venue as to **all** claims against health care providers brought under the Medical Liability Act, **even if** those claims are joined with other claims against entities or persons that are **not** health care providers. *Ex parte Kennedy*, 656 So.2d 365 (Ala. 1995); *Ex parte Father Walter Memorial Child Care Center*, 656 So.2d 369, 371 (Ala. 1995).

E. **Degree of care owed to patient:** The Medical Liability Acts do not expressly prescribe the degree of care owed to a patient by a nursing home. "In the case of a hospital rendering services to a patient, the hospital must use that degree of care, skill, and diligence used by hospitals generally in the community." Code of Alabama § 6-5-484(a).

In *Ex parte Northport*, the Supreme Court reached the conclusion that nursing homes are covered by the Medical Liability Acts by first concluding that a nursing home falls within those Acts' definition of hospital. 682 So.2d at 55 and n. 1. Accordingly, it is inferable that the same standard of care would apply to nursing homes.

The "community" to which the standard of care refers is the "national hospital community." *Henson v. Mobile Infirmary Association*, 646 So.2d 559, 563 (Ala. 1994); *see also, e.g., Hawkins v. Carroll*, 676 So.2d 338, 340 (Ala. Civ. App. 1996) ("community" interpreted to mean the "national medical community").

F. **Need for expert testimony:** A medical liability action plaintiff must generally present expert testimony to establish the breach of the applicable standard of care by the defendant health care provider. *E.g., Jones v. Bradford*, 623 So.2d 1112, 1114 (Ala. 1993); *Sledge v. Colbert County Northwest Alabama Healthcare Authority*, 669 So.2d 182 (Ala. 1995).

Exceptions to the need for expert testimony include the following:

- (a) where a foreign instrumentality is found in the plaintiff's body following surgery
- (b) where the injury complained of is in no way connected to the condition for which the plaintiff sought treatment
- (c) where the plaintiff employs a recognized standard or authoritative medical text or treatise to prove what is or is not proper practice, or
- (d) where the plaintiff is himself or herself an expert qualified to evaluate the provider's allegedly negligent conduct -- *Jones*, 623 So.2d at 1115.

In a proper case, the testimony of the **defendant** can establish the appropriate standard of care. "There is no requirement that the plaintiff produce an independent expert where the testimony of the defendant establishes the standard." *Henson v. Mobile Infirmary Association*, 646 So.2d 559, 563 (Ala. 1994).

G. Type of expert testimony required – "similarly situated health care provider"

Section 6-5-548 requires that the standard of care be established by a "similarly situated health care provider." Different credentials apply depending on whether the defendant provider is classified as a specialist as to **the specific area of the alleged breach**.

See, e.g., Code of Alabama § 6-5-548(b), (c); *Olsen v. Rich*, 657 So.2d 875, 881 (Ala. 1995).

The expert witness need not have "**identical** training, experience, or types of practice, or even the same specialties" as the defendant provider to satisfy the requirement of being similarly situated. "To be 'similarly situated,' an expert witness must be able to testify about the standard of care alleged to have been breached in the procedure that is involved in the case." *Rodgers v. Adams*, 659 So.2d 838, 842 (Ala. 1995); *accord, e.g., Healthtrust, Inc. v. Cantrell*, 689 So.2d 822, 827 (Ala. 1997); *see also, e.g., Husby v. South Alabama Nursing Home, Inc.*, 712 So.2d 750 (Ala. 1998).

The Alabama courts have repeatedly addressed whether a given proffered expert qualifies as a "similarly situated health care provider" with respect to the standard of care at issue. *See, e.g., Healthtrust, supra* (proffered expert similarly situated); *Sledge v. Colbert County*

Northwest Alabama Healthcare Authority, 669 So.2d 182 (Ala. 1995) (not similarly situated; expert affidavit stricken); *Biggers v. Johnson*, 659 So.2d 108 (Ala. 1995) (similarly situated); *Rodgers v. Adams*, 659 So.2d 838 (Ala. 1995) (similarly situated; exclusion of proffered expert testimony reversible error); *Olsen v. Rich*, 657 So.2d 875, 881-82 (Ala. 1995) (similarly situated); *Dowdy v. Lewis*, 612 So.2d 1149 (Ala. 1992) (similarly situated); *Medlin v. Crosby*, 583 So.2d 1290 (Ala. 1991) (similarly situated; exclusion of expert testimony reversible error).

Typically, a plaintiff in a nursing home case must offer testimony, or at least should offer testimony, from a nursing care expert. Depending on the cause of injury or death, testimony from an appropriate medical expert may be required to establish a causal connection between the breaches of care by the nursing home and its personnel on one hand, and the resulting injury or death. Experts in nursing home administration and other types of experts may be required, or may be helpful to the jury, depending on the facts of the case.

H. Pleading requirements -- Code of Alabama § 6-5-551

Section 6-5-551 imposes two separate pleading requirements, one requiring specific pleading of the alleged acts or omissions, and the other imposing an early deadline for pleading the specific acts or omissions.

Section 6-5-551 provides:

In any action for injury, damages, or wrongful death, whether in contract or in tort, against a health care provider for breach of the standard of care **the plaintiff shall include in his complaint filed in the action a detailed specification of each act and omission alleged by plaintiff to render the health care provider liable to plaintiff. The plaintiff shall amend his complaint timely upon ascertainment of new or different acts or omission upon which his claim is based; provided, however, that any such amendment must be made at least 90 days before trial.** Plaintiff shall be prohibited from conducting discovery with regard to any other act or omission or from introducing at

trial evidence of any other act or omission. **Any complaint which fails to include such detailed specification and factual description of each act and omission shall be subject to dismissal for failure to state a claim upon which relief may be granted.**

Specific pleading: The Alabama Supreme Court has deemed this pleading requirement to be analogous to the requirement that fraud be pleaded with specificity. *Mikkelsen v. Salama*, 619 So.2d 1382, 1384 (Ala. 1993). “[A]lthough every element need not be pleaded with particularity, the plaintiff must give the defendant health care provider fair notice of the allegedly negligent act and must identify the time and place it occurred and the resulting harm.” *Id.*

It is difficult to see how actions against nursing homes can be deemed “disfavored” (the justification for requiring specific pleading in fraud actions). Still, the Supreme Court to date has **not** applied the specific pleading requirement stringently. *See, e.g., Mikkelsen*, 619 So.2d at 1385 (allegations in complaint deemed sufficient); *Baptist Medical Center Montclair v. Wilson*, 618 So.2d 1335 (allegations in pretrial order deemed sufficient); *Mobile Infirmary v. Delchamps*, 642 So.2d 954, 958-59 (Ala. 1994) (plaintiff not required to “allege with specificity the date on which the plaintiff first suffered legal injury,” so as to overcome limitations defense; emphasized limitations bar is affirmative defense); *see also Ex parte McCollough*, ___ So.2d ___, no. 1962015 (Ala. Jan. 8, 1999) (explicitly allowing discovery relevant to theories of negligent hiring, training, supervision, retention and staffing; implicitly finding allegations of those theories sufficient). Although some trial courts have read the pleading requirement more strictly, such a reading is *not* supported by the Supreme Court’s interpretations of the statute.

Deadline for amending pleadings: Perhaps more burdensome is the requirement that any additional acts or omissions must be specifically pleaded at least 90 days before trial. *See* § 6-5-551. The Act is silent as to whether the deadline runs from the first trial setting, in contrast to Ala. R. Civ. P. 15. Accordingly, a continuance may give rise to the running of a new 90-day period for seeking leave to make amendments. *See Ex parte Children's Hospital of Alabama*, 1998 Ala. Lexis 230 (Ala. Aug. 28, 1998) (Lyons, J., concurring).

I. **Discovery and proof limitations:** The real burden comes from the combination of specific pleading requirements, the possible early deadline for amendments **and** the restrictions on discovery and the introduction of evidence at trial imposed by § 6-5-551.

Section 6-5-551 prohibits a plaintiff **“from conducting discovery with regard to any other act or omission or from introducing at trial evidence of any other act or omission.”**

“Other act[s] or omission[s]” logically refers to acts or omissions other than “each act and omission alleged by plaintiff to render the health care provider liable to plaintiff” -- i.e., the acts and omissions that a plaintiff is required to plead specifically.

Under a fair reading of § 6-5-551, a plaintiff **should** be able to discover and offer evidence at trial concerning any act or omission **relevant to any properly pleaded theory of liability**, including, e.g., theories of **“administrative negligence”** such as negligent hiring, negligent training, negligent supervision, negligent retention, systemic understaffing; **as well as acts or omissions relevant to an award of punitive damages** (whether personal injury or wrongful death).

The Alabama Supreme Court twice, however, appears to have read § 6-5-551 contrary to its most logical meaning. See *Ex parte Golden*, 628 So.2d 496 (Ala. 1993) (construed plaintiff's fraud claim as, in substance, a malpractice claim; refused plaintiff's request for writ of mandamus directing trial court to allow discovery of a pattern of fraudulent acts); *Ex parte Northport Health Services, Inc.*, 682 So.2d 52 (Ala. 1996) (upon finding that the Medical Liability Act applied, granted writ of mandamus vacating trial court order allowing discovery of similar acts of abuse or neglect). In neither case did the Court examine whether the discovery sought was relevant to theories actually pleaded that are permitted under the Act. In fact, plaintiff in *Northport* argued the statutory interpretation set out above; the Court's opinion did not address that argument at all.

It is not unusual for defendants now to claim that any acts other than those relating to the **immediate** cause of injury or death of **plaintiff/the resident**, e.g., any acts reflecting a systemic problem that actually played a role in the harm suffered by the plaintiff, or even any earlier acts or omissions related to the plaintiff/resident herself, are not discoverable.

Such an interpretation seems contrary to the Supreme Court's decision in *Montgomery Health Care Facility, Inc. v. Ballard*, 565 So.2d 221 (Ala. 1990). In *Ballard*, a nursing home wrongful death case, the Supreme Court held admissible evidence of deficiencies in a survey report done by the State Department of Health, where: (1) the deficiencies noted proximately contributed to decedent's death; and (2) there was evidence that the care given to decedent was deficient in the same ways noted in the survey and complaint reports. In *Ballard*, the evidence **necessarily** went beyond decedent, e.g., the deficiencies note that **23 patients** were found with decubitus ulcers.

In *Ballard*, the Court specifically noted that "evidence of notice to a defendant of an alleged dangerous condition or defect can be relevant to the issue of negligence and is admissible if the alleged defect proximately caused or contributed to the injury involved. 565 So.2d at 223. The Court also strongly suggested the evidence of the deficiencies noted in the State survey report -- including "other acts" evidence -- was relevant to the proper amount of punitive damages to be imposed. *Id.* at 226.

Recently, the Supreme Court has followed the logic of *Ballard*, consistent with the “fair reading” of § 6-5-551 discussed above, and allowed discovery broader than that allowed by *Ex parte Northport*, where relevant to properly pleaded theories of direct liability on the part of the nursing home. See *Ex parte McCollough*, ___ So.2d ___, no. 1962015 (Ala. Jan. 8, 1999).

In *McCollough*, plaintiff alleged that the defendant nursing home was negligent, wanton, willful, or in breach of a contractual duty, in hiring, training, supervising, disciplining, and retaining employees not competent to provide adequate care to plaintiff’s decedent (her grandmother) and other residents, and in failing to provide *enough* qualified staff, proximately causing her grandmother’s death in December 1995. Plaintiff further alleged that the death of her grandmother was proximately caused by the “systemic failure” of the nursing home to provide procedures to minimize the risk of harmful acts such as those that led to her grandmother’s death, and by understaffing, hiring unqualified persons, and failing to train, supervise, and discipline them.

To help prove those allegations, plaintiff served interrogatories and requests for production seeking, among other things, the following:

- 1) A detailed description of any previous and subsequent incidents from 1990 which occurred in the same or a similar way as the incident made the basis of suit;
- 2) All documents pertaining to investigations of alleged abuse, mistreatment and/or neglect of residents or to the health, safety, and/or welfare of residents from 1990;
- 3) All documents relating to complaints about resident care, mistreatment or abuse by defendant’s nursing personnel (including nursing assistants) from 1990;

- 4) All disciplinary reports, memoranda, notes or other documents relating to physicians and nursing personnel for 1990 through 1995;
- 5) All nursing personnel evaluations from 1992 forward;
- 6) All employee complaints for 1990 through 1995; and
- 7) Personnel records for all nursing personnel employed at any time from 1990 forward.

The circuit court granted a protective order denying discovery of these matters, relying on *Ex parte Northport*. Plaintiff filed a petition with the Supreme Court for a writ of mandamus to order the circuit court to compel the requested discovery.

The Court in *McCollough* noted that to prove these allegations, plaintiff would have to prove facts showing that the nursing home had notice or knowledge of the inadequacy of its procedures and its staffing. *Id.*, slip op. at 7. The Court further noted that “[t]he degree of culpability of [defendant’s] conduct would be directly related to the number of similar incidents, because a large number of similar incidents that could be traced to the alleged ‘systemic failure’ would tend to show wanton or even willful disregard for the safety of the persons entrusted to [defendant’s] care.” *Id.*, slip op. at 10. The Court held the requested discovery was “directly relevant to the wrongs alleged in [plaintiff’s] complaint,” *id.*, further asserting that “much of the information [sought] in those items would be *necessary* to prove” those wrongs. *Id.*, slip op. at 7 (emphasis added). Accordingly, the Court granted the writ of mandamus, compelling production of the requested discovery.

The *McCollough* Court indicated that discovery sought as “pattern-and-practice” evidence would not be discoverable under *Ex parte Northport*. The key to discoverability

of the requested information was its relevance to the theories of direct liability or “administrative negligence” on the part of the defendant nursing home, such as negligence in hiring, training, supervision, and retention, and systemic understaffing. In holding the information discoverable, the Court simply followed established principles that apply to analogous claims in other, i.e., non-medical, areas of Alabama law.

J. **Quality assurance or peer review materials:** Defendants sometimes try to hide highly relevant evidence behind the limited statutory protection given to quality assurance materials. *See* Code of Alabama § 22-21-8 (quality assurance); § 34-24-58 (peer review).

Peer review protection “extends only to decisions, opinions, actions and proceedings undertaken or performed within the scope and function of the [peer review] committee.” C. Gamble, *McElroy’s Alabama Evidence* § 356.03 (5th ed. 1996). Quality assurance protection “applies only when materials are **developed** as part of the accreditation or quality assurance **credentialing process** for the hospital or other health care facility.” *Id.* § 356.04. Mere submission of information to a review committee does not automatically bring that information within the protection of either of those statutes. *Ex parte St. Vincent’s Hospital*, 652 So.2d 225 (Ala. 1994).

The burden of proving that materials fall within the protection of the privileges resides with the facility asserting the privilege. *Id.* at 230; *Ex parte DCH Regional Medical Center*, 683 So.2d 409 (Ala. 1996). The entity asserting the privilege must also prove that the admission of any prejudiced information into evidence is prejudicial to it. *E.g., Ex parte St. Vincent’s Hospital, supra; Richard v. Lennox Industries, Inc.*, 574 So.2d 736 (Ala. 1990). As with other privileges, these privileges should be narrowly construed.

XI. Constitutional challenge to § 6-5-551

In *Ex parte McCollough*, plaintiff asked the Alabama Supreme Court to hold Code of Alabama § 6-5-551 unconstitutional on its face and as applied to plaintiffs asserting

injury or death claims against nursing homes. The Court was asked to declare the statute in violation of the Constitution of Alabama (1901) on the following grounds:

- A. Violation of equal protection
- B. Violation of open courts, right to remedy, due process
- C. Violation of right to jury trial
- D. Violation of separation of powers

The constitutional issues were fully briefed before the Supreme Court. A majority of the Court found it unnecessary to decide the constitutional issues, although one concurring Justice (Houston, J.) and the three dissenting Justices (Lyons, Maddox, and See) all found the statute constitutional. If the Supreme Court or trial courts use § 6-5-551 to deny discovery that is available with other causes of action, further constitutional challenges are likely.³

CONCLUSION

The Court put nursing home plaintiffs on more even footing with defendants with its decision in *Ex parte McCollough*. Still, the statutory restrictions on the discoverability and admissibility of evidence under the Medical Liability Act still require plaintiff's counsel to make the most with the least. Organizing, evaluating and comparing various records is the key to exposing systemic problems such as understaffing, inadequate training and overall poor patient care. Systemic problems often can be linked directly to corporate management, and thus provide a basis for enhanced damage awards. This in turn should lead to an increase in the quality of care provided by an industry that is projected to grow by 400 percent in the next 30 years.

³ One of the authors was involved in the constitutional challenge to § 6-5-551 in *Ex parte McCollough*. We offer our assistance in any further challenge to that statute that may arise.