PRAISE FOR *NURSING HOME CASES*

"Mark Kosieradzki and Joel Smith have written the definitive 'Bible' on trying a nursing home case. Whatever indignity your elderly clients have suffered—whether pressure ulcers, fatal falls, sexual abuse, or anything in between—this book provides the discovery, deposition, and trial techniques you need to hold the nursing home accountable. Packed with templates, pleadings, and transcripts from real cases, don't leave home for the courtroom without this book in your briefcase."

—Randi McGinn, past president of the Inner Circle of Advocates and author of *Changing Laws, Saving Lives: How to Take on Corporate Giants and Win*

"Mark and Joel's book is an organized, well-written road map to success in nursing home cases; but it is so much more. They write with compassion and enthusiasm about representing our most vulnerable population. Their generosity of spirit in providing expert advice, insider tips, and real-life examples will allow those courageous lawyers who take on these cases to do so zealously and effectively. I love the checklists and the appendix; I appreciate the advice; and I admire the authors greatly."

—Kathleen L. Nastri, past president of the American Association for Justice

"*Nursing Home Cases: When Caregivers Stop Caring* is an outstanding book that describes how to successfully obtain justice in nursing home cases. Mark and Joel provide a comprehensive, detailed analysis that includes many thoughtful, practical ideas and techniques. This is an excellent book that will help trial lawyers of all levels of experience. I highly recommend it."

—Mark S. Mandell, past president of the American Association for Justice and member of the Inner Circle of Advocates

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"You think you can do a plaintiff's nursing home case and not read this book? Really? Kosieradzki and Smith have distilled decades of hard-fought nursing home litigation experience into an easy to read, practical approach to success. This book provides a masterful—and practical—blueprint to litigating a nursing home case from start to finish, filled with numerous templates for success. Practitioners in the field who fail to read this book do so at their, and their client's, peril."

—Carl Bettinger, author of *Twelve Heroes, One Voice*

"A must-have masterwork! Inspiring, insightful and complete. Kosieradzki and Smith bring us the best guide to winning nursing home cases ever written. Two great mentors share their roadmap to success."

—T. Thomas Metier, Trial Lawyers College

"Mark, along with Joel Smith, has provided another MUST HAVE desk reference—this time on nursing home cases. As with Mark's past publications, this book teaches you how and why to convey your client's stories as well as leading the way in navigating liability land mines, defense tactics, and all common trial issues. By sharing their lessons, Mark and Joel have given us another invaluable resource to help our clients. Well done gentlemen."

—James Bartimus, past president of the International Society of Barrister's, and fellow of the International Academy of Trial Lawyers, the American College of Trial Lawyers, and the American College of Legal Medicine

"This is a fantastic resource for all lawyers of all levels of experience in the handling of nursing home cases. Whether you are a veteran or a novice in the handling of these cases, this is a 'must-have' resource. It will improve your advocacy and the results you achieve for your clients."

—Kenneth L. Connor, licensed in Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee, and Virginia

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"*Nursing Homes Cases: When Caregivers Stop Caring* is the equivalent of a legal architect's set of plans to strategically construct the foundation and building blocks of a winning case. The reader is provided with a guided tour of learning to identify wrongdoing, recognize misconduct, and uncover profit over safety activities by elderly care facility managers, employees, and owners. Kosieradzki and Smith have quarterbacked the handling, litigation, mediation, and trial of hundreds of these cases, accomplishing remarkable results for better than two decades. This is a must-have, must-read, and must-understand "field-manual" to handle these cases to win the discovery battles and to bring home the maximum settlement or verdict for the clients!"

—John F. Romano, past president of the Academy of Florida Trial Lawyers, the National Trial Lawyers, the Southern Trial Lawyers Association, and former chairman of the American Association for Justice's National College of Advocacy

"Mark and Joel have done it again—they have made a complicated subject matter easy to understand. This compendium belongs on the shelf of every lawyer who handles, or wants to handle, nursing home neglect and abuse cases. It is written in a style that encourages the readers to continue on, to keep learning more, and provides a wealth of information regarding the most important areas facing nursing home plaintiffs' lawyers today. In over twenty years of practice, I have not yet encountered such a comprehensive but simply written guidebook in any other practice area. Superbly written."

—Carma Henson, parliamentarian of the American Association for Justice's Nursing Home Litigation Group

"Mark Kosieradzki and Joel Smith, two tenacious litigators who have spent their careers fighting to protect the elderly, have generously shared their wealth of knowledge and experience in this book. It is an excellent resource for attorneys desiring to pursue cases involving neglect of the elderly. It is a must read for anyone undertaking to litigate nursing home cases, including newcomers as well as those experienced in this area."

—Lance D. Lourie, Atlanta, GA

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"Amazing! Mark and Joel have gifted us with the essential guide on how to hold neglectful nursing homes accountable. For many years they have set the standards in their practice and they graciously and succinctly share them here. Simply put, this book is required reading for anyone doing this work."

—Pressley Henningsen, past president of the Iowa Association for Justice

"For those of you who have the courage to stand up and fight for vulnerable nursing home residents against corporate bullies, this book is absolutely essential. Mark and Joel have taken the complexity of nursing home litigation and distilled it into elegantly simple terms. *Nursing Home Cases: When Caregivers Stop Caring* not only provides a roadmap for how to build and present a powerful nursing home case, it contains the tools you need, such as checklists, sample motions, briefs, and discovery requests, to build a winning case from start to finish. For anyone handling nursing home cases, from beginners to experienced attorneys, this book is a must-read!"

—Shayla M. Reed, NCA Executive Committee of the American Association for Justice

"*Nursing Home Cases: When Caregivers Stop Caring* is an extraordinary and must-have resource on litigating nursing home abuse and neglect cases. Using cases studies from their own practice, Mark and Joel illuminate the challenges of documenting abuse and calling those responsible to account for it. The organizational structure of the book, which classifies cases by the nature of the underlying cause of injury, facilitates a methodical approach to investigating and documenting specific kinds of cases. Throughout the book, the authors provide both the theoretical and legal underpinnings for bringing a successful claim, and the procedural and strategic means to achieve results. Every attorney engaged in personal injury litigation against nursing homes needs this book. I cannot recommend it more highly."

—A. Kimberley Dayton, emerita professor (formerly professor of law at the University of Kansas and William Mitchell College of Law) and coauthor of *Advising the Elderly Client*

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"Mark and Joel have done a terrific job of putting together in one place the accumulated wisdom of the many lawyers who vigorously advocate on behalf of nursing home residents and their families. This book belongs in the library of every nursing home lawyer."

—Steven N. Levin, a founding member and one of the original officers of the American Association for Justice Nursing Home Litigation Group

"I highly recommend Mark and Joel's primer on how to litigate nursing home cases. The book is a rare combination of the academic nuts and bolts of the case work-up process interspersed with the wisdom and advice that only comes from actual experience of fighting in the nursing home litigation trenches. My son Evan and I had the pleasure of joining with Mark and Joel in litigating a nursing home abuse and neglect case. We were able to observe firsthand many of the skills and strategies that are discussed in the book. If you have never tried a nursing home case or have made a career of representing victims of nursing home abuse or neglect, Mark and Joel's book should be in your bookcase. Better yet, the book should be on your desk, all marked up and tagged with notes."

—Arthur E. Lloyd, vice president of the Arizona Association for Justice

"Mark Kosieradzki has been dedicated to the education of trial lawyers for more than thirty years. Not only have his CLEs been entertaining, insightful, and presented ground-breaking techniques, his books are grounded in years of research and real-world practice. This work of Mark and Joel's is the culmination of two careers spent dedicated to advocacy for our nation's senior citizens and that same commitment to training lawyers on how to better represent their clients. It will be the go-to treatise for nursing home litigators for many years to come."

—Tad Thomas, secretary of the American Association for Justice

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"As a practitioner of elder abuse law, I am hesitant to buy books about nursing home litigation, as there is seldom new information in them. However, Mark and Joel's book breaks that mold. This book should be in every practitioner's set of resources, whether you are a long-time practitioner or someone that does a nursing home case occasionally, this book is a MUST HAVE."

—Ernest Tosh, Grapevine, TX

"Thirty years from now, the best lawyers in our country who champion the rights of those abused in nursing homes will look back on their careers and cherish the day they found this incredibly comprehensive, well-researched, and practical guide. To try and litigate nursing home cases without it would be a serious mistake."

—Tim Gresback, past president of the Idaho Trial Lawyers Association

"No wasted space here with dry and outdated material! This book is chock-full of practical pointers and loaded from front-to-back with essential information on every aspect of litigating successfully on behalf of our most vulnerable citizens. Kudos to Mark and Joel for writing the book the rest of us have been waiting on for years—an encyclopedic work on nursing home litigation that covers every topic with the same passion and insight that these tireless advocates bring to their everyday practice on behalf of their clients and their mission to educate litigators and trial lawyers to be personally and professionally better every day."

—Camille Godwin, Marietta, GA

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NURSING HOME CASES

WHEN CAREGIVERS STOP CARING

Mark R. Kosieradzki &
Joel E. Smith

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To my wife, Joan, and our three children, Lex, Nik, and Zoe. You have all given a part of yourselves, supporting and enduring the energy and passion I inherited from my parents, Henry and Danuta. I am forever grateful for having shared our lives together. Sto Lat.

—Mark Kosieradzki

To my grandmother, Susan Frances. I see her in the face of every nursing home resident who suffers when caregivers don't care.

To my father-in-law, Bill, who inspired me to become a lawyer who cares about human beings.

To my wife, Lucy, and to our kids—you are my everything.

To my parents, Gene and Marla, thank you for teaching me the importance of family and love since day one.

—Joel Smith

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Without clients, there are no cases. Without cases, there is no experience. Without experience, we would have nothing to share in this book. We deeply appreciate the clients who have taught us so much and allowed us to learn even more. The experiences that we have had with our clients have been personal and at times very painful. We thank all of you for your faith and trust.

We are grateful to the courageous pioneers who showed us that justice can be achieved in our legal system when nursing homes harm their patients. These pioneers include David Marks, Jeff Rusk, the late Tom Rhodes, and Ken Connor. On the heels of the pioneers, forging the path forward, we are grateful for Camille Godwin, Carl Bettinger, Steve Levin, Pressley Henningsen, Lesley Clement, and so many others, many of whom are the dedicated and talented members of the American Association of Justice's Nursing Home Litigation Group. We also appreciate the many talented attorneys who have trusted us over the years to walk the journey with them on their cases, including Phillip Miller, Art and Evan Lloyd, Render Freeman, Tad Thomas, Lance Lourie, and our friend, the late Paul Scoptur.

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Loss: Identifying and Proving Damages in Wrongful Death Cases (with licensed clinical social worker, the late Mila Ruiz Tecala). We also appreciate, not the least of which, the excellent guidance from David Ball in his essential resource, *David Ball on Damages 3*. All of these works are required reading for the members in our firm.

Speaking of the members of our firm, we are fortunate to know what it's like to work with talented and committed attorneys and support staff. Although it's usually the quarterback who gets most of the attention, we know that every successful quarterback has had ten other players on the field who contributed to his success. It's impossible to set passing records if the quarterback doesn't have receivers who get open and catch the ball. The quarterback can't even get the pass off if his linemen fail to hold off the rushing defenders. We have great players on our team who have helped us successfully take on some pretty mighty giants. We especially thank two very talented lawyers in our firm, Kara Rahimi and Andrew Gross, whose DNA runs throughout this book.

Thank you, Tina Ricks (our editor), Travis Kremer (production editor), Patricia Esposito (copyeditor), and the rest of the members of the Trial Guides team who helped make this book a reality.

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PUBLISHER'S NOTE

This book is intended for practicing attorneys. This book does not offer legal advice and does not take the place of consultation with an attorney or other professional with appropriate expertise and experience.

Attorneys are strongly cautioned to evaluate the information, ideas, and opinions set forth in this book in light of their own research, experience, and judgment; to consult applicable rules, regulations, procedures, cases, and statutes (including those issued after the publication date of this book); and to make independent decisions about whether and how to apply such information, ideas, and opinions to a particular case.

Quotations from cases, pleadings, discovery, and other sources are for illustrative purposes only and may not be suitable for use in litigation in any particular case. The majority of cases described in this book are real cases and are cited appropriately. Sample questions and testimony, if not cited, spring from the author's brain only.

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FOREWORD

Pop quiz: Which one of the following terms doesn't belong?

- Vulnerable
- Dependent
- Fragile
- Trust
- Profit

Maybe that was too easy. But if it's obvious to some of us that profit-making doesn't easily fit into the care of vulnerable patients who depend on high quality to keep them safe and healthy, then tell that to the nursing home industry, where seven out of ten of the 15,400 facilities in the United States are owned and run by for-profit enterprises.

Not that there is anything inherently wrong with old-fashioned capitalism. But as the authors of this invaluable book teach, when poor care of patients leads to injury or death, dogged trial lawyers can usually trace the harm to some misguided profit motive. Cutbacks on staff, training, pay, and the other requisites of quality care end up hurting the fragile humans that these homes are entrusted to protect.

Many are elderly, and this will be their last home on the planet. But many are not, and they are expected, with competent care, to return to their own homes after a short stay of rehabilitation from an injury or illness. But whether it is a final life destination or not, everyone entrusted to the care of what the industry calls "skilled nursing facilities" deserves to live with dignity, respect, and no new injuries on top of what they came in with.

That the nursing home industry falls short of this goal, over and over, is not exactly news. Yet the many ways it does so are so varied and sundry, and the stories of the individuals hurt and killed by preventable harms are so poignant, that the mind reels and the heart breaks.

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Kosieradzki and Smith introduce us to Helen, who barricaded herself in her room to keep out a staff member who had crawled on top of her and sexually assaulted the eighty-six-year-old woman. Until the hour that her daughter Susan removed her from the home, the home's manager assured Susan that her mother's dementia had made her dream the event, even though in the meantime the young nursing assistant had confessed to police and to the same supervisor.

We learn about Nicole, who was found frozen to death on the nursing home's patio, eleven hours after she was noted to be missing, and only three days after admission. A visitor pointed out to the staff that they could have seen the huddled body on the concrete patio if they had only looked out the window.

We meet Jim, who one day on a visit to his fifty-four-year-old sister Dana, one week into what was supposed to be a short rehab stay after surgery, reached out his hand to open the door to her room and was overcome by the stench of rotting flesh. He found her with large pressure wounds on her buttocks that had become infected and made her delirious with sepsis.

And so many others: this one killed by an overdose of narcotics delivered by a nurse never trained in the safe use of opioid pain patches, another inflicted with a brain injury from falling face-first off a commode in the presence of two nursing assistants who turned their backs on their charge, yet another who lost twenty pounds in the twenty-one days of his stay and died from what the hospital, where he was finally transferred to, called "profound dehydration."

They are all real people with real tragedies that become real legal cases—with real issues that Kosieradzki and Smith show how to solve. To take but one example: How do the attorneys for Helen hold the defendant home responsible for the beyond-the-scope-of-employment assault by the aide? Answer: A detailed legal memorandum in an appendix laying out the theories and the case law behind them.

What about damages? On the actuarial assessment that too many plaintiffs' lawyers mistakenly make, these cases have little monetary value: no lost wages, few medical bills, just the terrible suffering of a

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helpless victim and the grief of their family. But let's face it, the cold calculus says, here was a life near its end anyway, so where's the beef? Thankfully, juries don't see it that way, nor do trial judges and appellate courts who, confronted with the raw moral outrage of the stories that unfold in courtrooms, have affirmed large verdicts for both compensatory and punitive damages. Many of those appellate decisions, as well as the comprehensive legal briefs supporting them, are collected by the authors for the reader's benefit.

But this book is much more than a collection of cases. Kosieradzki and Smith start with the first intake call from a distraught family member. They provide painstaking guidance for every step: the questions to ask, the medicine to understand, the nursing home regulations to read, the evidence to gather, the briefs to write, and the presentations to make to the jury.

The focus, they teach, must always search beyond the front-line nursing home workers who are usually underpaid and overwhelmed by too much work that requires them to cut safety corners to get through their workdays and nights. In fact, the authors show, long before the COVID-19 pandemic tore through many, but not all, nursing homes, the industry faced such a crisis of infection control that the federal government in late 2019 began to require each home to designate a trained "infection preventionist" on staff to set up and implement comprehensive strategies to test, isolate, and contain outbreaks of communicable diseases. But this, of course, requires more than a paper plan. It needs training, equipment, and enough staff to do the job, which most homes proved in the spring of 2020 that they were utterly unprepared for.

This is a fine and essential book for trial lawyers, but more than that, it is a book that proposes to do nothing less than make us more mature and compassionate human beings. I end this foreword with the authors' admonition, from the end of Part One, whose words I cannot improve:

> When that "case" comes to you, remember that it's not a "case." It's someone's pain and heartbreak. It's their wife, father, or

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grandmother. It's probably one of the worst things that's ever happened to them. The person sitting across from you, exposed and raw, didn't come to you so you can have a "case." Stop being Lawyer-man or Lawyer-woman for a moment. Take those lawyer-glasses off and see what's going on as a human being. Make it personal. What if this had happened to someone you've known and loved all your life? And you knew in your head, heart, and soul that what happened was as wrong as wrong gets? And now you're sitting across the table from a lawyer you don't know, because you do know you have to right the wrong, legally, whatever that means. Somehow. Be what you would want in that lawyer sitting at the table, listening to the tragedy that your loved one suffered.

—Patrick Malone, 2020

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INTRODUCTION

Nearly twenty years ago, we were busy with a range of personal injury and wrongful death cases when a colleague asked us to consider a case that involved the death of an elderly woman. She lived with dementia and diminished physical abilities, and she was a patient of a nursing home. She had fallen, broken her hip, and died three weeks later. The nursing home employees' documentation about how the fall occurred didn't make sense. The death certificate stated that the immediate cause of death was pneumonia and dementia and that she died of natural causes. The doctor who signed the certificate last saw her more than three months before she died. The state health department did not investigate her death. The state had no particular cause of action for nursing home or vulnerable adult liability. The state allowed no survival claim for the pain she experienced (the nursing home failed to assess and respond to her broken hip for nearly twenty-four hours).

The only legal remedy was the state's wrongful death law, which allowed damages for the surviving family members' loss of comfort, companionship, and advice—provided that we could prove that the nursing home was negligent. One of her daughters lived in town and usually visited her mom once or twice a week. Her other children lived out of town and didn't see her often. One of her sons didn't make it back for the funeral. It wasn't obvious to us what kind of advice this "frail" woman with "diminished cognitive ability" had provided to her family. The jurisdiction required thorough expert review and support regarding the standard of care, the breach of the standard of care, and medical causation before we could start a lawsuit. With all the other demands on our time and energy in our practice, accepting the case didn't seem "feasible."

Our decision to decline the case, however, was hard to put behind us. It didn't seem right that this dependent woman could be so seriously injured while entrusted to people who were supposed to keep her safe.

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Why didn't the state's department of health do anything to investigate and hold the nursing home accountable? Why did a doctor who had seen her only one time (months before she died) complete her death certificate? Wasn't anyone going to speak for her and tell her story? It was one of those cases that we kept thinking about even though we believed we had made the right "business" decision to decline the case.

Four months later, we had the chance to review another nursing home injury case. It also involved a fall. The patient had to use the bathroom. He pushed the button he was supposed to use to call for staff to come help him. No one responded to the call. He couldn't wait any longer and tried to get out of bed by himself. He lost his balance and hit his head against the night stand and suffered a head injury. He died after a week in the hospital. But he also had advanced cancer with a limited life expectancy. He had no close family members. What could we do with that case in the legal framework of our jurisdiction? Again, we decided not to take on the case because it didn't seem "feasible" to do so. As before, it was a decision that continued to bother us—how could the people who disregarded this man's safety be able to avoid responsibility?

It wasn't long after that when we had the opportunity to consider another nursing home injury case. We reviewed the records. Images of the pressure wound on an elderly woman's tailbone were hard to get out of our minds. The medical examiner determined that sepsis was the cause of her death and that the open wound on her tailbone was the source of the infection. How could a human being be so neglected by her caregivers? Public records revealed that the nursing home had repeated care violations and deficient inspections. Motivated by this evidence and by our ongoing dissatisfaction with having declined the first two nursing home cases, we accepted the case this time.

Although our sense of justice was motivating, that wasn't enough to achieve the outcome we wanted. We had no reliable roadmap to direct us through the unique twists and turns of a nursing home liability case. On our first nursing home case, we thought it was like any other medical malpractice case. As we subsequently learned, we focused too much

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on the direct caregivers (the nurses and nursing aides) and far too little on the facility's owners and operators. While our first case gave us the satisfaction of "taking this one on" and fighting for the dignity of this vulnerable adult, we learned a lot along the way. Our learning curve and its cost on those first cases were steep.

We were determined to improve our skills. We learned from colleagues in other states who had successfully held nursing homes accountable for harming patients. We practiced what we learned and got better on the next case. We evaluated and studied what worked and what did not. To convey our clients' stories properly, we learned that it isn't enough to establish what had happened and how; it is essential to establish *why* it happened. We continued to learn and were committed to improving our skills on the next case and the next. Now, two decades later, we still evaluate, learn, and practice how to do it better for the next client.

The trust that fellow human beings have placed in us is gratifying, especially after others have let them down. It has been a professionally and personally rewarding experience for us. The challenges and opportunities that we've had in helping clients injured by nursing homes have improved how we evaluate, strategize, and execute our cases in other liability circumstances that involve injuries or death, such as product and premises liability.

We understand that you're on a similar journey. Maybe you're at the trailhead looking at the path and trying to figure out whether you really want to take that first step. You may already be on the trail, but you want to get past some of the obstacles you weren't expecting. Our objective for this book is to create the "travel guide" that we wished for, to ease us through the learning curve when we started this journey of representing people harmed in nursing homes.

We also offer this book to encourage you to represent vulnerable adults and their families. In the introduction to his inspiring book *Trial by Human*, Nick Rowley states: "This book is written for those of you who have the courage to stand up for their fellow humans against the

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big bullies."[1] If you have not already done so, we encourage you to read Nick's insights on his passionate and successful trial practice. We borrow Nick's objective here: We write this book for those of you who have the courage to stand up for the dignity and decency of our most vulnerable humans against those who disregard and harm them.

The need in our society for compassionate, skilled advocates to fight against nursing home maltreatment is great and growing. Today there are about 46 million Americans aged sixty-five or older (which is about 15 percent of our population).[2] That number will more than double to 98 million by 2060 (increasing to about 24 percent of our nation's population).[3] Those aged eighty-five and older will increase from 5.9 million in 2012 to 8.9 million in 2030, and to 18 million by 2050.[4] The number of people in our country living with Alzheimer's disease will increase from about 5 million today to 16 million by 2050.[5] The number of people needing nursing home care will increase from 1.35 million today to about 2.3 million in 2030.[6]

While the need for nursing home care in our country is increasing, the quality of nursing home care is not. In 2014, the U.S. Department of Health and Human Services reported that about 22 percent of

1. Nicholas Rowley and Steven Halteman, *Trial by Human* (Portland, OR: Trial Guides, 2013).

2. Mark Mather, Paola Scommegna, and Lillian Kilduff, "Fact Sheet: Aging in the United States," December 15 2019, http://www.prb.org/Publications/Media-Guides/2016/aging-unitedstates-fact-sheet.aspx.

3. *Id*.

4. Jennifer M. Ortman, Victoria A. Velkoff, and Howard Hogan, "An Aging Nation: The Older Population in the United States" US Census Bureau, May, 2014, https://ncea.acl.gov/whatwedo/research/statistics.html.

5. "Facts and Figures," Alzheimer's Association, accessed July, 2020, http://www.alz.org/facts; and Mather, Scommegna, and Kilduff "Fact Sheet: Aging in the United States."

6. *See* Mather, Scommegna, and Kilduff, "Fact Sheet: Aging in the United States;" and Kaiser Family Foundation, "Total Number Residents in Certified Nursing Facilities," accessed July, 2020, http://www.kff.org/other/state-indicator/number-of-nursing-facility-residents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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nursing home patients experienced adverse events that were preventable.[7] "[S]ubstandard treatment, inadequate patient monitoring, and failure or delay of necessary care" caused much of the preventable harm.[8] More than half of the patients harmed by nursing homes required hospital care, for which Medicare paid an estimated $2.8 billion in 2011 alone.[9] Why should our society subsidize the owners and operators of substandard and dangerous nursing homes? We believe that a better health-care system will emerge by holding wrongdoers accountable.

We appreciate your time and energy in learning more about this important subject. We understand that you're probably not reading this casually as an interesting alternative to a novel. Our objective in this book is to offer you a useful resource. Perhaps one of your current clients injured in a car crash has shared with you her concerns about her mother's safety in a nursing home. Or a colleague has asked you to review a case involving the suspicious death of an elderly man at a nursing home. Maybe you're proactively looking to expand your practice to help people who've been harmed by negligent nursing homes.

Whatever your motivation is, the need for your help already exists and is significant. Many of your clients may be dealing with concerns about the safety of their loved ones who need nursing home care. Where do they turn with their concerns? They already trust you as a lawyer who cares about them. We want to help you develop your knowledge and skills so you can help them confront a negligent nursing home.

7. US Department of Health and Human Services, Office of the Inspector General, "Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries," February, 2014, https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.

8. *Id*.

9. *Id*.

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THE FUNDAMENTAL TREATMENT ALGORITHM

In a nursing home, there are four fundamentals for proper care:

1. **Assessment**

2. **Care planning**

3. **Implementation** of the plan

4. **Evaluation** of whether the plan is effective

If the plan is not effective, the nursing home must reevaluate whether its assessment was accurate, whether its plan needs to be revised, and whether the staff is following the plan. Failure at any of these steps creates unnecessary risk and compromises the patient's safety.

These fundamentals are not extraordinary or complicated. You already know them from everyday life. For example, if you want to take a road trip, applying these fundamentals improves your odds of a successful vacation.

1. **Assessment**
   - When should I go?
   - How much time can I take off of work for this trip?
   - Will my car make it there and back?
   - Where will I stay?
   - How much money will I need for the trip?

2. **Planning**
   - What route should I take?
   - Have I rearranged appointments?
   - Where will we stay?
   - Is the car in good condition?
   - How much will gas, food, and lodging cost?

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3. **Implementation** of the plan
   - What time do I need to start the trip?
   - What do I need to pack in my suitcase?
   - Am I following the map?

4. **Evaluation** of whether the plan is effective
   - Are you on schedule?
   - Are you on the right highway, heading in the right direction?
   - Is there road construction?
   - Did you remember your medications?

These same fundamentals that you already know guide proper care in a nursing home:

1. **Assessment**
   - What are the patient's needs?
   - What are the risks?
   - What are the goals for the patient's admission to the nursing home?
   - Does the nursing home have the ability to meet the patient's needs?

2. **Care planning**
   - What care is necessary to meet the patient's needs and goals?
   - What equipment and outside services are needed?

3. **Implementation** of the plan
   - How is the plan communicated to the staff providing care?
   - Are there enough staff members who are competent and know the strategic plan?
   - Has the nursing home made sure that the staff has the proper training and experience?
   - Has the nursing home properly supervised the staff?

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4. **Evaluation** of whether the plan is effective
   - » Is the patient's condition improving and, if not, why?
   - » If the patient's condition is worse, what course of action is needed to improve it?
   - » If the care plan is not effective, was the original assessment of the patient's needs accurate?
   - » Have the patient's needs changed?
   - » Is the staff performing the services that support the patient's safety and well-being?

These same fundamentals also apply to your consideration of whether to take on a nursing home case:

1. **Assessment**
   - » What happened?
   - » What was the nursing home supposed to do?
   - » Who could have prevented the harm?
   - » What is the medical cause of the harm?
   - » Who cares or should care about what happened?
   - » Do you know what you need to know to be able to help?
   - » Do you have the right team members to handle the case properly?
   - » Do you have the time and budget to handle the case properly?

2. **Planning**
   - » What steps do you need to take to advance the case, and what time factors are involved?
   - » What traps will you likely encounter, and how can you avoid or navigate around them?
   - » What do you need to do to balance the responsibilities of the case with your current commitments?
   - » What external resources will you need to handle the case properly, such as investigators and expert witnesses?
   - » Do you have a clear strategy—a detailed game plan—for proceeding with the case?

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3. **Implementation** of the plan
   - » Do the team members understand the game plan and appreciate the responsibilities each has?
   - » Does each team member understand how to perform designated tasks and what resources are available to do so?
   - » Who is responsible for supervising and managing the team members to measure whether all members of the team are following the plan?

4. **Evaluation** of whether the plan is effective
   - » If it's not working, why isn't it?
   - » Was your assessment accurate?
   - » Was your strategic plan good?
   - » Does your team understand the plan?
   - » Do you have the right people on your team?
   - » Is your team implementing the plan?

This book will help guide you to mastering the fundamentals.

THE ORGANIZATION OF THIS BOOK

We've organized the chapters of this book to guide you through the process of evaluating a potential case and through preparing and litigating it. One of the first things you'll learn when someone contacts you is the type of injury involved. "My husband fell and hit his head." Or, "My grandmother was fine on Tuesday, but when I saw her again Friday night, she was out of it and could hardly open her eyes." Or, "I've got a client I'd like to refer to you. Her father-in-law was in a memory care unit at a nursing home and choked when they gave him the wrong food." Since the particular injury is an immediate priority to you and the person contacting you, that's where we will start in this book.

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PART 1—TYPES OF INJURIES AND DAMAGES

In part 1, we cover the most common types of injuries that we see in our practice, including sexual and physical assaults (by staff and by other patients), pressure injuries, infections, medication errors, elopement and wandering, dehydration and malnutrition, and fall trauma. For each type of injury, we will describe what it is and what criteria you should consider when evaluating the strengths and challenges relating to the injury. In addition, we provide a checklist to help guide your review. Part 1 wraps up with a focus on the purpose and objectives of damages in nursing home cases that you will need to achieve the goals of accountability, deterrence, and punishment. All of this is critical to honoring the dignity of the patients that the wrongdoers have stolen. You can take what we share and apply what's useful to the framework that your state's laws allow.

PART 2—HOLDING WRONGDOERS ACCOUNTABLE

After finding out what harm occurred and confirming that you are talking with the right family member, you want to find out who is liable for the harm. In chapter 9, "Liability Theories about Who's Responsible," we cover liability theories about who is responsible for the damages and harm. For example:

- special relationship
- negligence per se and statutory violations
- ordinary versus professional negligence
- direct and vicarious liability

After considering who is responsible for the harm and the legal basis for their liability in chapter 9, you may have multiple defendants

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in the case. Following are some common types of companies to consider as defendants:

- the entities licensed to operate the nursing homes
- property owners
- parent companies
- regional and other affiliates
- management companies
- vendor entities that provide therapy, laboratory, or pharmaceutical services

For example, the defendants in one case may include the facility licensee, a separate management company, and a regional affiliate that provides nurse consulting services. Each defendant has its own attorney, seeks its own discovery, and at trial wants its own voir dire, opening statement, examination of witnesses, and closing arguments. You're outnumbered. Or are you?

In chapter 10 "Corralling Multiple Defense Interests," we address legal strategies to consider when you have multiple defendants, such as alter ego (veil piercing), direct participant liability, joint enterprise, and principal-agent principles, which can help you aggregate their interests. For example, when the case involves one entity that holds the facility license, and a separate entity that operates the facility, you may be able to unify their separate interests into one defense interest by establishing the existence of a common enterprise or principal-agent relationship. We also cover individual people (for example, the medical director) and third-party entities (for example, the management company or supplement staffing vendor) that may be operating as agents of the nursing home, involved by contract to perform functions that the nursing home has a nondelegable duty to perform. In doing so, the fault of one member can be imputed to the other member in that relationship, and their separate fault may be aggregated in comparing to any fault on the part of the plaintiff.

In chapter 11, "Dealing with Defense Tactics," we address defense tactics that limit your clients' access to justice and the truth. Arbitration

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clauses are common in nursing home contracts throughout the country. The terms of the forced arbitration clauses can shorten the statute of limitations, limit discovery, limit damages, mandate the use of facility-friendly arbitrators, and require that the arbitration be conducted in secret. Court enforcement of these anti-consumer clauses varies from state to state. We also address a common effort by many attorneys who defend nursing homes to control and limit your access to witnesses: involuntary representation of the facility's employees. Knowing the rules may help you break through this improper charade.

PART 3—PRACTICE LOGISTICS

In part 3, we address several logistical concerns that are common in handling nursing home abuse and negligence cases. First, in chapter 12, "Ethical Issues," we address ethical issues to consider, ensuring that we start off on the right foot. In addition to learning about the type of injury, it is important to clarify who is asking you to consider the case. For example, in the scenarios above, the callers are a wife, a granddaughter, and an attorney on behalf of a daughter-in-law. Those are the easy answers about who is calling. The meaningful answer to the question "Who is calling," however, is not always obvious. But you need to know. For example, you need to confirm whether the granddaughter and the daughter-in-law have the legal authority to hire you to represent them or their families. If not, you will need to know who that person is. So, in chapter 12, we cover practical ethics issues that you should resolve right away before you dive headfirst into the case.

In chapter 13, "Presuit Investigation," we discuss a wide variety of information that you can or need to obtain as part of your presuit investigation for your client's case. Publicly available information about the businesses that own and operate the nursing home, government investigations and inspections of the facility, and how the facility receives and spends its money provide insight into the operation of the facility. In addition, the chapter covers the information and records

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about the nursing home patient that you can obtain from your client or, with your client's authorization, from sources that maintain relevant information, such as medical and billing records.

Armed with the information in chapters 1 through 7, you'll be prepared to consider what kind of harm the nursing home patient suffered, who may be responsible for the harm, what the liability theories may be, what types of damages your jurisdiction allows, and the jurisdiction's limitations on the case or the terms of your representation. With this much information, you will be able to decide to accept the case or to let another lawyer help the caller with the case. If you decide to accept the case, there is still a lot of information for you to gather and evaluate.

In chapter 14, "Discovery," we provide you with information and a checklist to help you determine the types of information and documents you'll want to obtain through discovery after you start the lawsuit. We discuss how the four fundamentals produce effective discovery: *assessment* (what do we need to get and why?); *planning* (what is our strategy for getting what we need?); *implementation* (do we have the right people doing the right things at the right time?); *evaluation* (is the plan working and, if not, why not and what needs to be changed?).

Finally, in chapter 15, "Trial," we survey issues that are important to the trial of your client's nursing home case. As we mentioned above, nursing home cases frequently involve multiple defendants. Although nursing homes keep telling everyone that they are losing money, the fact that there are oftentimes a half-dozen entities profiting off a single nursing home suggests otherwise. Multiple defendants at trial means you're outnumbered by defense attorneys. As the party with the burden of proof, it's important to try to increase our odds of success by showing the court, whenever possible, that separate defendants should be treated as one defense interest for purposes at trial, such that only one defense attorney conducts voir dire, the number of defense peremptory challenges do not outnumber the plaintiff peremptory challenges, one defense attorney presents one opening statement and one closing argument, and one defense attorney cross-examines witnesses.

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THE APPENDICES

In the appendices, we share twenty documents that we believe will help guide your case and discovery planning. The documents include complaints, discovery requests, deposition notices, expert affidavits, and motion briefs. In deciding which documents to include in the appendices, we asked ourselves one simple question: What do we have now that we wish we had when we started on this journey in nursing home cases twenty years ago? You'll find it in the appendices.

THE FEDERAL OBRA REGULATIONS

We need to introduce you to some prominent acronyms, terms, and citations that you will encounter in this practice area and will see throughout this book. Most nursing homes participate in the Medicare program and must comply with over one hundred federal requirements to qualify for federal funding. In 1987, Congress enacted the Nursing Home Reform Act, which is commonly referred to as the OBRA (Omnibus Budget Reconciliation Act) regulations. The new law created a broad set of reforms that constitute the *minimum* requirements a nursing home must meet to participate in the Medicare program.[10] We provide citations throughout this book to specific sections of these federal nursing home regulations, which are 42 C.F.R. § 483.1(b) (2017). We share how to use these regulations to evaluate the nursing home's care and establish wrongful conduct.

Also, you will see references throughout this book to CMS (Centers for Medicare and Medicaid Services), which is the official acronym for the federal program we call Medicare. CMS revised the

10. 42 C.F.R. § 483.1(b) (2017).

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nursing home regulations recently to reflect substantial advances in the three decades since 1987, associated with the theory and practice of nursing home services and safety. CMS published the revised regulations in a final rule that became effective on November 28, 2016, which CMS implemented in three phases in 2017, 2018, and 2019. CMS offers an online overview of the key changes.[11] CMS contracts with the State Survey Agency (SSA) for each state, typically the state's health department, to perform the survey process. The SSA is responsible for certifying that the nursing home complies with the federal regulations. The SSA must perform this inspection "in a manner calculated to produce the greatest benefit to residents within the limits of the resources available to the [agency]."[12] The SSA must inspect the nursing home at least every fifteen months, or more frequently in response to complaints of neglect or abuse.

The SSA will issue a deficiency (known as an Ftag, or a specific number that corresponds to the type of deficiency) when the nursing home or its personnel are not in compliance with the federal nursing home regulations. Depending on the severity of the deficiency, the government can fine, penalize, suspend, or terminate the nursing home's operation. The facility may have to create and submit a signed Plan of Correction to address the inadequate care concerns.

The American Health Care Association (AHCA) publishes the *Long Term Care Survey*, which contains all of the federal nursing home regulations, along with numerous forms, procedures, and protocols that surveyors use to determine a facility's compliance with the federal requirements. Because of its pink and green color, the *Long Term Care Survey* manual is colloquially known as "the watermelon

11. *See* "Nursing Homes: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities," Centers for Medicare and Medicaid Services, accessed July, 2020, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html.

12. *In the Matter of an Assessment Issued to Leisure Hills Health Care Center*, 518 N.W.2d 71, 72-73 (Minn. Ct. App. 1992), *rev. denied* (Minn. Sept. 16, 1994), *citing* Minn. Stat. § 144A.10, subd. 2 (1990). (Emphasis added.)

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book." The manual provides authoritative information intended to help nursing homes understand the requirements for participation in the Medicare program, as well as the survey protocols and investigative procedures used.

When investigating and litigating nursing home injury and death cases, the "watermelon book" is an essential resource for understanding the applicable federal regulations and a nursing home's duties to its residents, the survey process, and information contained in a nursing home's survey documents. The manual contains a complete Ftag index. The AHCA offers an electronic version of the manual,[13] which is especially useful due to the ability to perform keyword searches.

So, let's start our journey together to help you develop your knowledge and skills so you can help your clients confront negligent nursing homes.

—MRK & JES

13. American Health Care Association, *The Long Term Care Survey*, (July 2014), available at https://www.ahcancal.org/pages/ltc-survey.aspx.

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PART 1

TYPES OF INJURIES AND DAMAGES

In part 1, we cover the most common types of injuries that we see in our practice, including sexual and physical assaults (by staff and by other patients), pressure injuries, medication errors, elopement and wandering, dehydration and malnutrition, and fall-trauma. For each type of injury, we will describe what it is and what criteria you should consider when evaluating the strengths and challenges relating to the injury, and we will provide a checklist to help guide your review. We conclude with an overview of the types of damages that apply in nursing home cases.

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PHYSICAL & SEXUAL ASSAULT

THE CALLS

We offer the stories of two nursing home patients. A nursing assistant raped Helen in her room. Jerome was physically attacked by his roommate.

HELEN (SEXUAL ASSAULT BY CAREGIVER)

It's 2:39 p.m. You're sitting at your desk working on a brief that must be filed by 5:00 p.m. Your assistant interrupts you to let you know that Dr. Susan Baldwin is on hold for you. You don't recognize the name, but you figure it must be important if a physician is calling you—and it will surely be a short call. You pick up the line, introduce yourself, and ask, "Hello, Dr. Baldwin. How can I help you?"

The caller is frantic and exasperated. You're trying to understand her and to take notes that make sense. You're also starting to wonder

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why you didn't have your assistant screen the call more thoroughly before she interrupted you, knowing that you're working hard to meet the court deadline for your brief. You're wondering if this hysterical caller is really a doctor.

She's trying to tell you about her mother. But she's talking too fast and bounces all over the place. Your attempts to interject are futile. Something bad happened to her mother. You hear the words "rape," "sexual assault exam," and "psych hospital." She also mentions "cuckoo's nest." Next, she tells you that her mother is "in the car with me" and she doesn't know what to do now. She pauses to catch her breath. You finally have a chance to bring some structure to the conversation and you start, "Dr. Baldwin, . . . But you're still trying to get your head around what she's been telling you over the past four minutes.

You piece together the following details during the call with Susan and over the next eighteen months, while representing her eighty-six-year-old mother, Helen. You learn that Helen had called Susan at 6:00 a.m. a week before, and Helen had told her daughter that a young man, Tony, got into her bed the night before and had sex with her. Susan wasn't sure whether to believe her mother's comment because Helen had dementia and occasionally said things that seemed incredible. Susan, who lived about two hours away from Helen's nursing home, called the facility and told the supervisor about what her mother had said, including the name Tony. The night supervisor assured Susan that Helen had had a bad dream and was confused because of her dementia ("your mother is not mentally stable").

Still concerned, Susan called her Aunt Laura, who lived near the nursing home and told Laura (Helen's sister) what Helen had said. Laura picked her sister up from the nursing home at 11:20 a.m. and took her to the local emergency room. The nursing home's nursing director called the hospital to tell them that Helen had dementia and was not a reliable source of information. Neither the nursing director nor any other nurse at the nursing home performed an assessment of Helen's physical or mental condition before she left for the hospital.

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While Laura was driving her sister to the hospital, Susan called the local police department to report that her mother might have been sexually assaulted by a man named Tony, but she wasn't sure whether the information from her mother was accurate. A police officer arrived at the nursing home and spoke to the facility's administrator. The administrator emphasized to the officer that there had been increasing issues with Helen's dementia and that they had been considering recently whether Helen should be moved into the facility's secured memory care unit. (The nursing home's records, however, never validated the administrator's statement.)

Meanwhile, Helen waited for almost seven hours at the hospital before a sexual assault nurse could see her at 6:30 p.m. The nurse documented that Helen "hurt in the vaginal area from the man attempting to put his penis inside her completely," but Helen "was unable to tolerate any physical exam" and refused the physical examination "upon seeing the speculum."

Coincidentally, while Helen was with the sexual assault nurse, the police officer was questioning the thirty-one-year-old male nursing assistant who had been assigned to care for Helen the night before. His name was Tony. The nursing assistant told the officer that he had performed the nighttime care for Helen, including administering her narcotic medication. A few minutes into the conversation, Tony confessed to the officer that he had sexual intercourse with Helen and ejaculated on her. After getting Tony's statement, the police officer called the nursing home's administrator and told him about Tony's confession. The administrator called the facility's nursing director at 10:00 p.m. and told her that Tony had admitted to the police that he had raped Helen. Neither the administrator nor the nursing director called Susan, Helen's sister, or anyone at the hospital to inform them that Tony had confessed to sexually assaulting Helen.

Meanwhile, at 10:36 p.m., unsure of what to do for this dementia patient, the hospital admitted Helen to its mental health unit.

The next morning, nearly twenty-four hours after Helen had gone to the hospital, Tony met with the administrator and nursing director at the nursing home and confirmed what he had confessed

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to the police officer. The administrator and nursing director still did not inform Susan, Helen's sister, or anyone at the hospital that Helen's allegation was true.

The next day, after nearly fifty hours in the hospital, the hospital staff discharged Helen and documented that "we are still not sure whether or not there was any actual sexual assault." She was returned back to the nursing home. The hospital informed the nursing home's director that Helen did not belong in a hospital mental health unit.

After Helen was back in the nursing home for twenty-four hours, a sexual assault advocate associated with the hospital called the nursing home to check on Helen and spoke with the nursing director. Although the nursing director had known for more than a day and a half that Tony had confessed to raping Helen, the director told the hospital's sexual assault advocate that she didn't believe Helen's accusation against Tony was true. The advocate became suspicious of the director during their conversation. The advocate made arrangements to have Helen return to the hospital for another sexual assault examination. When the nursing director discovered that Helen had left the nursing home to return to the hospital, she called the hospital and learned that Helen was being examined by a sexual assault nurse. The nursing director still did not inform the hospital that Tony had confessed three days earlier to having raped Helen.

Helen later described the portrait of her deceased husband that hung on the wall in her room and how his eyes stared at her while Tony was on top of her forcing himself upon her. As the sexual assault nurse testified, she found significant tearing inside Helen's vaginal wall. She characterized Helen's injury as "the biggest tear I have ever seen" and said that it must have been very painful.

Helen was returned to the nursing home after the sexual assault examination at the hospital. The next morning, a week after the rape occurred, a nursing aide was unable to enter Helen's room because she had barricaded the door. A couple hours later, the hospital's sexual assault advocate called Susan to inform her that her mother really had been raped. Susan immediately left her clinic and drove the very familiar 115 miles to get her mother. "I drove ninety miles per hour

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the whole way." Susan called the nursing home from her car to talk to her mother. A staff member told her that her mother was not available to talk and that they were preparing to transfer her to a geriatric-psychiatric unit. Susan told the staff member that she did not authorize such a transfer. The staff member responded, "It's just a matter of time." Susan could feel herself shaking. Her foot pressed even more on the accelerator.

When Susan reached the nursing home, she ran inside and found her mother. As she was walking down the hallway with her mother, both the administrator and nursing director "appeared out of nowhere" about twenty feet from the exit. "We were so close to getting out." Susan pushed past them with her mother holding her hand, trembling, and they made it out the exit door. Susan compared the feeling to breaking away from a kidnapper.

Fifteen minutes later, Susan called your office from her car. Your assistant told her that you were tied up in a court matter at the moment. Susan asked again to please be allowed to talk to you. Your assistant told her that she would check and put the call on hold. The next voice Susan heard was yours, "Hello, Dr. Baldwin. How can I help you?"

JEROME (PHYSICAL ASSAULT BY RESIDENT)

Monica called our firm regarding injuries to her seventy-five-year-old father, Jerome. They hired us, talked with us, and allowed us to obtain his records from the nursing home and a hospital. We learned that Jerome's roommate at the nursing home, Anthony, violently attacked and beat him while Jerome was sitting on his own bed eating breakfast. Anthony punched Jerome several times in the head and face and "head-butted" him. As a result, Jerome suffered a laceration on his forehead, which required stitches, and a bloody nose and lip. These injuries required an ambulance to take him to the hospital. Emergency personnel at the hospital diagnosed a traumatic brain injury, which required surgery and care in the intensive care unit. He

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remained hospitalized for twenty days, until the hospital discharged him to another care facility. The hospital and medical expenses related to the physical assault totaled nearly $200,000.

The nursing home records showed that throughout Jerome's residence, the nursing home knew that he was a vulnerable adult who was susceptible to abuse. He had chronic cognitive deficits, was not physically strong or steady, and the use of one arm was impaired.[1] Due to Jerome's risk of being abused, the nursing home created a care plan for him, which instructed staff that if they suspected or observed abuse, they were to do the following:

1. Remove him from the situation to ensure his safety.

2. Notify a supervisor.

3. Proceed with the facility's abuse prevention protocol.

For the first six months there, Jerome was doing well, was pleasant, and was socializing with the staff and other patients on the fourth-floor long-term care unit. Everything changed, however, when the nursing home moved Anthony into Jerome's room. After several days of enduring Anthony's loud and threatening behavior in their room, Jerome told the social worker on his unit that he planned to kill himself if he had to spend one more night with Anthony. The social worker documented that a plan would be made to address this issue later that day. Despite this assurance, there were no further social service notes regarding Jerome's reported complaint or threat to kill himself and no documented plan to address the issue. Jerome and Monica confirmed that neither the social worker nor

1. Cognitive impairment is a primary risk factor for resident abuse. One study found that "cognitive impairment, and worsening cognitive impairment in particular, conferred a five-fold risk of maltreatment in victims." Tony Rosen, Karl Pillemer, and Mark Lachs, "Resident-to-Resident Aggression in Long-Term Care Facilities: An Understudied Problem," *Aggression and Violent Behavior* 13, no. 2 (March–April, 2008): 77–87, https://doi.org/10.1016/j.avb.2007.12.001.

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anyone else took any action to protect Jerome. Instead, the nursing home kept Jerome and Anthony in the same room. Anthony's abusive behavior continued, leading up to the attack that sent Jerome to the hospital.

The nursing home's records for Jerome also contained a nurse's note that police officers removed Anthony from the facility. We obtained the police report and investigation file, which revealed that Anthony was a forty-six-year-old who suffered from a traumatic brain injury (TBI) resulting from a motorcycle accident over twenty years earlier. The police records also showed that the nursing home knew when it chose to admit Anthony that he had a serious TBI; suffered long-term functional impairments; required twenty-four-hour assistance and supervision due to his inability to care for himself; was impulsive and agitated; had a substantial psychiatric disorder that grossly impaired his judgment, behavior, capacity to recognize reality, and ability to reason or understand; and required treatment with antipsychotic medication.

The police records also showed that the nursing home did not call the police until five hours after the attack. By the time police arrived, the officers discovered that the nursing home had already cleaned up the evidence of the attack. Police arrested Anthony and took him to jail. Subsequently, the county attorney charged Anthony with criminal assault. Then he was transferred to a county adult detention center, and then to a state regional hospital for psychiatric evaluation. After that, he was admitted by court order to an adult foster care facility.

The state health department investigated a report alleging maltreatment. The state determined that the evidence it reviewed did not substantiate the allegation. Given its overall history of investigation findings, which strongly leaned in favor of nursing homes, we were disappointed in, but not surprised by, the health department's conclusion.

We were confident that our own investigation through litigation would produce and reveal evidence that the health department did not bother to obtain or review. So, we started the lawsuit on Jerome's behalf. In appendix P, "Opposing Summary Judgment Motion—Patient Assault," we share our brief opposing the nursing home's motion for summary judgment. The nursing home argued that the

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patient-on-patient physical assault was not reasonably foreseeable. Appendix P shows the discovery strategies we used and the evidence it revealed to prove otherwise, including evidence of the nursing home's disregard for the assailant's disruptive and violent history, how the nursing home ignored an outside counselor's repeated warnings and safety recommendations, and how the nursing home disregarded Jerome's repeated concerns for his safety. This brief also responds to the defendant's attack on our negligent per se claims, which we based on state and federal nursing home regulations relating to properly assessing patients, not admitting or keeping patients whose needs exceed the nursing home's ability, properly assigning roommates, resolving patient concerns and grievances, protecting patients from foreseeable physical abuse by other patients, and proper staffing. The court agreed with us and denied the nursing home's summary judgment motion.

KEY CONCEPTS ABOUT ASSAULT

Sexual assault of the elderly residing in long-term care facilities has been a well-known risk in the industry for many years. Consequently, there are laws that prohibit it, that require nursing homes to train their staff and implement policies and procedures about it, and that require governmental agencies to recognize, investigate, and prosecute it. The violated patients are usually unable to protect themselves against the sexual assault due to diminished physical or mental abilities. Cases have also involved assailants who are assigned responsibility for administering narcotic medications to the patients, which further compromise the patients' ability to protect themselves.

Because of the well-known risk, nursing homes are legally required by federal and state laws to develop and implement policies and

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procedures that protect patients from sexual abuse.[2] When a nursing home admits patients, the facility must protect those who are unable to protect themselves. The nursing home has an affirmative duty to protect the patient from all foreseeable harms—including sexual assault by a staff member, another patient, or other person on the premises.[3]

EMPLOYEE BACKGROUND CHECKS

Every state requires nursing homes to conduct background checks on prospective employees. When facilities pay low wages and provide difficult working conditions, staff turnover is high. To fill positions quickly, a facility may become lazy in the hiring process. When a staff member sexually assaults a patient, hiring and personnel records may reveal whether the facility was responsible and vigilant in its background and reference checks, if any, before hiring the employee.

The nursing home employer may be legally responsible for the intentional wrongdoing of its employee when the employee committed the harmful act in the course and scope of employment, when the source of the attack arises out of the workplace environment and within work-related limits of time and place.[4]

2. 42 C.F.R. § 483.13(c).

3. Restatement (Second) of Torts § 319 (1965). *See, e.g., Dibrill v. Normandy Associates, Inc.*, 383 S.W.3d 77 (Mo. Ct. App. E.D. 2012) (the resident of a nursing center, who was allegedly raped by a housekeeper employed by the nursing center, stated a negligence per se claim by and through her next friend and mother against the nursing center, the nursing center's owner, and the nursing center's director of nursing, by alleging that she was a disabled, vulnerable individual due to mental retardation and cerebral palsy, that the nursing center, owner, and director of nursing violated numerous cited regulations designed to protect residents of skilled nursing and long-term care facilities, and that the nursing center, the owner, and the director of nursing violated their duty of care and in doing so directly and proximately caused the resident to suffer injuries that were caused by the housekeeper's physical assault and rape).

4. *Fahrendorff v. N. Homes, Inc.*, 597 N.W.2d 905, 912 (Minn.1999) (the Minnesota Supreme Court held that a group home operator could be liable for sexual assault of a

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This vicarious liability stems from a public policy determination that liability for acts committed within the scope of employment should be allocated to the employer, not through any fault of the employer, but as a cost of engaging in that business.[5] In appendix R, "Summary Judgment Motion—Facility's Vicarious Liability," we provide a motion memorandum that is related to the story of Helen, the victim of sexual assault we discussed earlier. The purpose of this motion is to have the judge rule in advance of trial that the assailant's former employer be vicariously liable for the assailant's conduct. We offer the motion brief in appendix R to provide you with an example of the procedure and the legal and evidentiary pieces that you may want to explore in your case when the employee commits intentional wrongdoing.

LOOK FOR THE ASSAILANT'S RECORDS

When another patient sexually assaults a patient, the assailant's medical records may reveal the nursing home's direct knowledge of the dangers to other patients, as well as what measures the facility took to protect the vulnerable patient against the dangers posed by the assailant. Courts have found the assailant's medical records to be reasonably calculated to lead to admissible evidence to establish the nursing home's direct knowledge of the dangers to other patients, as well as evidence of measures the facility took to mitigate the dangers posed by this patient.[6]

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patient by a counselor-employee under respondeat superior, applying a two-part test to explain that an employer may be held liable for the intentional misconduct of its employees when: (1) the source of the harm is related to the duties of the employee and (2) the harm occurs within work-related limits of time and place); *see also* Restatement (Second) of Agency § 245 ("A master is subject to liability for the intended tortious harm by a servant to the person or things of another by an act done in connection with the servant's employment, although the act was unauthorized, if the act was not unexpectable in view of the duties of the servant.").

5. *Id.*

6. *Coastal Health Services, Inc. v. Rozier*, 335 S.E.2d 712, 714 (Ga. Ct. App. 1985).

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When the assailant is not an employee or patient of the facility, the nursing home staff must pay attention to the assailant's entry and presence in the facility, and the staff must be vigilant to protect patients against foreseeable harm. The stronger the evidence that the facility knew or should have known that the perpetrator would commit an assault, the stronger the case against the facility.[7]

EFFECTS OF SEXUAL ASSAULT ON ELDERS

Sexual assault is intrinsically harmful. The act of sexually assaulting a vulnerable adult is outrageous and intolerable to the civilized community. One of the known harms a sexual assault victim experiences is emotional distress, which can be made even worse for victims with memory or cognitive issues who experience unresolved and delayed trauma symptoms. There is significant disorganization of a person's life physically, emotionally, and psychologically. In elders with dementia or memory loss, the psychological symptoms are often muted. For example, victims may not be able to tell others of the details of the assault or, following the assault, the thoughts they are having (for example, involuntary repeated memories of the rape). This constriction of expression leads some to think the elder is not suffering. To the contrary, however, withdrawn victims can suffer more intensely as they are not able to reconcile the memories of the incidents and of the aftermath with facility staff.

The unresolved and ongoing aftermath symptoms may manifest as symptoms of fear or protection, such as trying to barricade the entry door to their room. The assault victim's symptoms are often consistent with post-traumatic stress symptoms, including fear, anxiety, social withdrawal,

7. *See e.g., Collier v. Ami, Inc.*, 254 So. 2d 170, 171 (La. Ct. App. 1971) (resident sued nursing home after attack by an intruder, alleging that the nursing home failed to provide a secure environment); *Shepard v. Mielke*, 877 P.2d 220 (Wash. Ct. App. 1994) (holding nursing home has duty to protect its residents from sexual assault by third party, including the duty to take reasonable precautions to protect those who cannot protect themselves); *see also Juhnke v. Evangelical Lutheran Good Samaritan Soc.*, 634 P.2d 1132 (Kan. Ct. App. 1981) (patient knocked to the ground by another patient).

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and emotional numbing. The traumatization of the sexual assault can also impact the victim's capacities for learning and remembering. In addition to the emotional impact, sexual assault often involves physical pain and injury, such as laceration and bruising of vaginal or anal structures.

The effect of sexual assault on an elder in a nursing home depends on the nature of the attack, the response by the system (helpful or not), and support and treatment following the assault. The victim's emotional harm can be compounded by the facility's failure to take appropriate action or, worse, to engage in a cover-up campaign after the assault. Failure to report the sexual assault to family and doctors can increase the victim's anxiety and fear. The facility must provide timely and appropriate response measures to ensure that proper treatment is not delay or deprived, to ensure that police authorities can access and investigate the physical evidence before it is altered or destroyed, and to protect the other patients of the facility. Proper assessment of the victim's physical and mental injuries is essential so that the facility and caregivers can design and implement an effective treatment plan. A plan will help promote and monitor the patient's recovery and functional status. By contrast, returning the violated patient to the scene of the sexual abuse without rape crisis intervention services in place will cruelly aggravate the victim's emotional distress over and beyond that which would have normally followed the abuse.

CHECKLIST

(BRINGING ORDER TO THE CHAOS)

1. **Obtain all details from family members and friends** about the assault. What do they know, and how do they know it? What do they suspect, and what is the basis for their suspicion? Who else might know information related to the incident?

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2. **Obtain all details from the assault victim**, if the victim is able to provide it.

3. **Obtain all information available from emergency responders.** This includes 911 calls (logs, recordings, and transcripts), police call and investigation records (including logs, reports, interview notes, recordings, and transcripts), and paramedic records.

4. **Obtain all information available from the prosecutor's office** if the police investigation was turned over to a prosecuting agency. If criminal charges were brought against the assailant(s), **obtain all related court files** and attend upcoming court hearings in the case.

5. **Obtain all records of the state health department** or similar investigatory agency regarding this incident and any other incidents of abuse at the nursing home. What is the nursing home's track record for protecting its patients from sexual or physical assault?

6. **Check Medicare's online information about the facility** at the Nursing Home Compare website.[8] You will have access to the facility's ratings for health inspections, staffing, and quality of patient care. The site also provides information about federal fines and whether Medicare has denied payments to the facility. You can also access recent inspections of the facility and learn how many health citations have been issued to the nursing home and for which deficiencies, as well as how the facility's performance compares to other nursing homes in the state and nationally. Some categories of deficiencies are specifically related to the facility's failure to "hire only people with no legal history of abusing, neglecting, or mistreating residents" or its failure to "report and investigate any acts or reports of abuse, neglect, or mistreatment of residents." The site also provides information about complaint investigations and the facility's ownership.

8. Medicare's Nursing Home Compare website can be accessed at https://www.medicare.gov/nursinghomecompare/search.html.

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7. **Obtain the licensing file** from the state health department or other licensing agency regarding this facility. The licensing file should reveal who the owners and controlling interests of the facility are.

8. **Obtain the nursing home's Medicare Cost Reports.** Nursing homes that participate in the Medicare program are required to submit cost reports to Medicare annually.[9] These are public federal reports that detail the facility's annual operating expenses and revenues, cost allocations, ownership and financial interests, and related organizations. You can obtain the Medicare Cost Reports from the appropriate Centers for Medicare and Medicaid Services (CMS) intermediary through the CMS website.[10]

9. **Obtain the nursing home's Medicaid Cost Reports.** Nursing homes that participate in state Medicaid programs must submit Medicaid Cost Reports, usually to the state's health department. These state reports contain information comparable to the Medicare Cost Reports, but they may also provide additional information like staff turnover rates and controlling organizations. The Medicaid Cost Reports vary in their format and information from state to state.

10. **Obtain your client's nursing home records.** Review the records to evaluate the four fundamentals for proper care:

    a. **Assessment**—What are the patient's needs? What are the risks? Review the assessment records for information about cognitive or physical conditions that decrease the patient's ability to self-protect and that increase the risk of abuse (for example, dementia and narcotic medications). Look for changes in the patient's

9. 42 U.S.C. § 1395g (2006); 42 C.F.R. § 413.20(b) (2011).

10. Visit www.medicare.gov/contacts. Click on "Do you want to find a specific organization?" and then choose a state/territory and check "Fiscal Intermediary."

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condition (for example, sexually transmitted disease, resistance to staff providing personal cares, agitation, and anxiety).

b. **Care planning**—What care was necessary to protect the patient against abuse? What abuse prevention plan is set forth in the care plan? Talk with family members who attended care conferences in which the patient's needs and care strategies were discussed. Are there recent doctor's orders for new or increased medications or treatment to counter anxiety or emotional or cognitive behavior? If so, why? And did the nursing home staff address those orders in the care plan and Medication Administration Record or treatment assignment records?

c. **Implementation** of the plan—How was the plan communicated to the staff assigned to care for the patient? Did the direct care providers receive and follow the care needs and strategies discussed in the assessments, nursing notes, and care plan? Do the medication and treatment records indicate that the staff was performing those care tasks? Compare the care plan and medication/treatment records against the Minimum Data Set (MDS) records, which must be contained in the facility's records for the patient. The nursing home is required to complete and submit an MDS report with Medicare under penalty of perjury within fourteen days of the patient's admission to the facility and periodically thereafter.[11] The MDS report assesses each patient's physical functioning, cognitive patterns, psychosocial well-being, mood and behavior status, medication received (specifically identifying antipsychotic, antianxiety, antidepressant, and

11. To access Medicare's manual regarding the MDS forms, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. To view a sample of the MDS form itself, including the various categories that must be completed, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Archive-Draft-of-the-MDS-30-Nursing-Home-Comprehensive-NC-Version-1140.pdf.

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hypnotic medications, as well as the number of days that the patient received each medication), and treatments received (including psychological therapy).

d. **Evaluation** of whether the plan is effective—Study the nursing home records to evaluate whether the nursing staff reviewed the care plan to ensure that it was effective for protecting the patient against abuse. What clues do the records indicate that the staff was not following the care plan or that the care plan should have been revised to support the patient's safety and well-being?

11. **Obtain the patient's records from medical facilities and providers** who have recently cared for the patient. These records may include communications between the nursing home and the patient's doctor regarding changes in the patient's condition or requests by the nursing home staff for medications to control anxiety or agitation. These records may also help establish what did not happen, for example, that the nursing home did not contact the doctor when there was a significant change in the patient's condition.

12. **If the assailant was another patient, obtain the assailant's records** through discovery, pursuant to a qualified protective order under the Health Insurance Portability and Accountability Act (HIPAA).[12] As with your client's records, study the assailant's records to evaluate the four fundamentals for proper care:
    - » **Assessment** of the assailant's condition and needs
    - » **Care planning** to meet those needs
    - » **Implementation** of the plan
    - » **Evaluation** of whether the plan is effective

Part of the nursing home's duty to assess the patient includes the responsibility to determine whether the facility has the

12. *See* 45 C.F.R. § 164.512(e)(1).

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ability to meet the assailant's needs. If not, the facility should not admit this patient or, if already admitted, should not keep the patient whose needs it cannot meet. See appendix P, "Opposing Summary Judgment Motion—Patient Assault," for an example of how information about the assailant-patient's condition establishes that the assaultive conduct was reasonably foreseeable.

13. **If the assailant is a nurse, check the state board of nursing** for information that is publicly available regarding the nurse's licensure history, including any suspensions, limitations, or revocations on the nurse's license.

14. **Obtain the personnel file of an employee assailant** through discovery. The file should include details about the assailant's work history and the facility's background checks, screening, and interview process. It must also include details about the employee's training and performance evaluations. The file may also include incident investigations, warnings, and disciplinary actions, including suspension, termination, and rehiring. The information in this record may help establish the nursing home's failure to recognize or respond to an employee with risk factors that commonly lead to abusive behavior (for example, poor attitude, burnout, conflict, disruptive and aggressive patient behavior, lack of supervision, and short staffing). *See* appendix J, "Motion to Compel—Personnel Records," for an example motion to compel the assailant-employee's personnel file records.

15. **Obtain through discovery the nursing home's policies and procedures** related to the prevention and detection of sexual and physical abuse, as well as how to respond to known or suspected abuse. Such records support the fact that abuse is a well-known risk in the industry.

16. **Obtain through discovery the nursing home's staff training records** related to the prevention and detection of sexual and

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physical abuse, as well as how to respond to known or suspected abuse. Like the policies and procedures, the training records support the fact that abuse is a well-known risk in the industry. Reviewing the training records will help you evaluate any steps the nursing home has taken to ensure that its staff has the proper training and experience to protect the patients against the risk of abuse.

17. **Obtain the nursing home's incident or investigation report** regarding the assault. Anticipate and be prepared to address the defendant nursing home's objections and refusal to produce these records. Defendant care facilities try to classify routine accident or incident reports, which employees complete on a regular basis, as quality assurance documents.[13] Courts have held that the quality assurance privilege does not extend to reports containing simple facts concerning accidents and the witnesses to them. Any statements the witnesses have made are not covered by the privilege, and the opposing party must disclose and produce those statements.[14] Appendix J, "Motion to Compel—Personnel Records," is a motion to compel brief that addresses, among other issues, the discoverability of incident reports.

CONCLUSION

Sexual assault is theft of the worst kind—it steals a part of the survivor's soul. The story of Helen shows that sexual assault is not only a crime against nursing home patients, but also against their families. Helen's

13. *See, e.g., Messerley v. Avante Group, Inc.*, 1996 WL 33468268, *2 (Va.Cir.Ct. 1996).

14. *Id.; see also Tampa Medical Associates, Inc. v. Estate of Torres ex rel. Bank*, 903 So.2d 259, 261–62 (Fla. Ct. App. 2 Dist. 2005) (rejecting assertion of privilege over incident reports); *Windman v. Britthaven, Inc.*, 619 S.E.2d 522, 524–25 (N.C. Ct. App. 2005) (incident reports not protected by any peer review privilege).

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daughter was distraught trying to figure out what was going on, even when the nursing home operators knew the truth but hid it. The story of Helen shows the scrupulous measures to which the operators will go to cover up the crime, depriving their patient of the medical and care interventions that are essential to respond to the assault experience.

The story of Jerome demonstrates the obvious red flags and warning signs that the nursing home ignored, resulting in the severe physical beating inflicted upon this defenseless elderly man. Those responsible for his care didn't care, before or after the attack. The story displays the lie-and-deny, catch-us-if-you-can tactics of the defense interests in their efforts to avoid liability.

Both stories, however, represent what you can do for patients like Helen and Jerome, who need you to fight for them and honor their dignity when the nursing homes they trusted failed them. For both Helen and Jerome, holding their wrongdoers accountable empowered them. It was a privilege for us to be part of their important journey.

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