Regulations for Elderly Care Are a Tangled Web

By Steven G. Mehta

As the baby boomers are getting older, there is an increasing need for nursing homes to provide care for the aging population. With that increase in nursing home usage will come a complete array of legal issues relating to providing care to the elderly. Already there is an increase in nursing home litigation involving both regulatory citations and claims of neglect by residents. One topic commonly raised in nursing homes is the application of regulations that relate to providing elderly care. Indeed, according to Kenny Moyle, chief executive officer of Magnolia Health Corp., the nursing industry is the second most regulated industry after the nuclear industry. A major question that arises when dealing with regulations is the effect of certain regulations on the standard of care and on how to interpret the regulations — especially when those regulations have some inherent ambiguity in the terms themselves.

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First, it is important to recognize that in California, nursing home regulations can create the standard of care. "Like statutes, applicable regulations are a factor to be considered by the jury in determining the reasonableness of the conduct in question." *Conservatorship of Gregory* 80 Cal.App.4th 514, 523, (2000). The *Gregory* court concluded the regulations "were designed to protect nursing home residents by defining the care that was due [them]" and therefore the trial court properly included those regulations in its instructions on elder abuse. In *Norman v. Life Care Centers of America*, 107 Cal. App. 4th 1233 (2003), the court added to *Gregory* by explaining that a violation of regulations could also be negligence per se and that a jury could be instructed as much.

As such, the meaning of these regulations is critical when addressing nursing home matters. Recently a federal court, in *Fal-Meridian Inc. v. U.S. Department of Health and Human Services*, 604 F.3d 445 (7th Cir. 2010), addressed the definition of nursing home regulation "as free of accident hazards as is possible." This case is not only helpful in understanding the specific regulation, but it could also be helpful in understanding other state and federal regulations that involve similar terms such as requirements of attaining the highest practicable standard.

In *Fal-Meridian*, the nursing home sought to set aside a final decision by the Department of Health and Human Services that imposed a civil penalty of approximately $7,000 for having violated a regulation under the Medicare and Medicaid provisions of the Social Security Act. 42 U.S.C. Sections 1302, 1395hh. It is important to note that despite the small sum of money at issue, the court reasoned that the appeal was probably taken because of the prospect of civil litigation involving a potential claim for wrongful death. Indeed, many nursing operators appeal the regulatory violations because of this very issue.

The regulation in *Fal-Meridian* required a skilled nursing facility to "ensure that: the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents." 42 Code of Federal Regulations Section 483.25(h).

The circumstances of the citation involved a resident, named only as "B," who suffered from schizophrenia and difficulty in swallowing (dysphagia) to the point that she could not safely consume any food or liquid without risk of aspiration. As such, she had a feeding tube, called a "PEG" (percutaneous endoscopic gastrostomy) inserted into her stomach through the wall of her abdomen.

After insertion of the PEG, she was readmitted to the nursing home in a room with a patient that was allowed to have food orally. Between the date of B's readmission and her death two and a half weeks later, the nursing home's staff repeatedly witnessed her trying to eat and drink her roommate's food and drink, and sometimes succeeding. The nursing home changed its care plan to monitor the resident every 15 minutes. Nevertheless, the behavior still continued. She was found dead on her floor a night after the staff was told by B's roommate that she had eaten food. The cause of death, however, was unclear. One report suggested aspiration, whereas the same doctor later changed his mind.

The court addressed two issues: Whether the facility environment was as free of accidents "as possible," and whether the breach of that duty was "likely to cause…serious injury, harm, impairment, or death to a resident." The cause of death — for purposes of wrongful death — was not at issue.

The court discussed the fact that taken literally, "as possible" would include anything that is physically possible. However, such a reading regardless of cost would result in nursing homes turning away residents because Medicare would not pay them for such a high standard. The court then explained that the "as is possible" language is equivalent to the highest practicable language found in other regulations.

The court then explained that the "as is possible" regulation was similar to a feasibility standard, but not as stringent. It explained that "The per diem limits the precautions that the Medicare administration can realistically require a nursing home to take, for a home will stop admitting residents who require precautions that cost more than the reimbursement that the home can expect to receive. And if we assume that the Medicare administration sets a reasonable per diem rate, then in practice the "as is possible" standard will approximate the balancing of magnitude and likelihood of harm against the burden of precautions that is familiar in negligence cases and summarized in the concept of due or reasonable care."

The court went on to explain that there were many things that could have been done to avoid the risk of harm, such as moving the resident to placing her in a room where no food was allowed. These were all items that were not cost prohibitive and feasible. Therefore, there was causation for purposes of regulatory violations.

There are several implications from this case towards handling nursing home litigation matters. First, nursing homes should really evaluate their specific care plans to determine financial feasibility for the specific precautions. Moreover, nursing homes might consider addressing these financial issues with the family to ensure that the family is part of the decision making process — especially if the family is requesting greater care than would be feasible.

Second, for purposes of litigation in injury cases, the parties should consider inquiring of their experts and of the nursing staff regarding the different alternatives and the cost associated with those alternatives. The parties should also be prepared to address discovery regarding these issues. These discovery and legal issues would also affect how the parties could address the legal standard of care for purposes of trial, motions, or mediation.

It is arguable that where regulations provide language such as "as is possible," "as practicable" or other similar wording, the courts can impose a financial feasibility test to determine whether the alleged precautions would be financially feasible. Although *Fal-Meridian* arose out of the 7th U.S. Circuit Court of Appeals, the cases identified above also explain that regulations can create a standard of care. Here, the 7th Circuit interpretation of a federal statute could be very persuasive to a California court in interpreting the federal regulations that are commonly used in nursing home cases — especially since California courts have not specifically addressed this issue of feasibility. Attorneys should be aware that this standard could be used in law and motion practice as well as for purposes of jury instructions.

With the increasing prevalence of nursing home litigation (both involving regulatory violations and personal injury cases), it is very important for litigators in this field to fully understand the consequences of such regulations, and how to interpret them.

Steven G. Mehta, based in Los Angeles, is a full time mediator that specializes in resolving emotionally complex cases. He can be contacted through his Web site at www.stevemehta.com.

What the Long Term Care Industry Can Learn From the Trucking Industry

By Noelle M. Natoli-Duffy

It's 2:00 a.m. and your cell phone rings. On the other end, the caller, one of your biggest clients tells you that a woman has just died. Her family is raising hell and the authorities have been called. You grab a dictaphone, your camera, a pad of paper, and get in the car, simultaneously dialing the number of your private investigator, and ask him to meet you at the scene two hours away.

This is the start of a typical "emergency response" call. In trucking claims, we see these constantly. Within 48 hours of a fatal accident, we have gathered the names of all officials investigating the accident, contacted all witnesses, inspected the scene, examined physical evidence, hired one or two experts, gotten a line on the police report and slept very little. You have spoken to the driver and/or the owner of the company several times, reported to the adjuster and obtained informal opinions from your experts regarding the cause of the accident. Two years later when the family files suit, you simply pull your file out of storage and get to work — no longer behind the 8-ball.

What astonishes me is that most truck insurance policies have the same policy limits as long term care cases — except there is rarely the possibility of punitive damages, meaning the value of most trucking cases are significantly lower than most long term care cases. Yet, in most long term care cases, the insurer does not receive notice of the incident until suit is filed. At that point, the facility's staff has undergone a complete changeover, the resident's chart has been put in storage, personnel files have been lost, time cards have been destroyed, and volumes of necessary records simply cannot be located. We have often affectionately referred to our first client meeting at long term care facilities as a "smash and grab," arriving and taking all the records and files we could get our hands on, before anything else is lost.

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What we learn in these instances is that valuable evidence for trial and more importantly, for settlement negotiations, has been lost forever. Instead of recorded statements of key witnesses, we are forced to rely on memories, or a California Department of Public Health investigator's report to piece together our evidence. We criticize the perceived lackadaisical efforts of state and federal investigators, but we take no efforts to investigate the case ourselves until it is simply too late. What is wrong with stepping outside the guidelines of "how it's always been done" and being more proactive to best protect our exposure and decrease our risk? Nothing is wrong with that and I would suggest that us exactly what should be done!

The only question that comes to mind is that all of this investigation will potentially cost more. The answer: it won't. The reason is simple. If the case is bad — the facility is going to have a very early opportunity to settle the case pre-suit for a reasonable sum without the expense of prolonged litigation. If it is good, the potential plaintiffs and their newly retained attorney will know they have a challenging road ahead of them from the start, and you will have to do all of this work anyway. Lastly, all of your investigation will be afforded the protections of attorney work-product and attorney-client communication privileges. The facility will be better prepared for the departmental investigator because your experts have already inspected the patient's chart. Conversely, the same investigation conducted solely by the facility is not protected or privileged unless you can show the investigation was conducted truly under the facility's quality assurance program.

So, what can long term care attorneys, risk managers, and adjusters learn from trucking cases?

Here are seven tips to consider: Encourage insureds/facilities to report incidents immediately, however you choose to define "incident." Provide facilities with investigation packets including a disposable camera, an incident report, and witness cards. Retain a firm to handle all "emergency response" matters and have dedicated attorneys assigned to be on call for these matters. Hire an investigator to take recorded statements of witnesses, key employees, and the patient. Hire nursing experts to investigate all "emergency response" matters. Perform an inspection of the facility. Gather the necessary documents immediately i.e. the patient's chart, personnel files (including their performance reviews), California Department of Public Health reports survey and complaint records for the prior 18 months up to current, visitor logs, surveillance videos, time cards, maintenance records, in-service education programs and sign in sheets for subject matter pertinent to the issue at hand, policy and procedure manuals, etc.

Overall, the most important thing to remember is that an early, thorough investigation of an incident can save the facility and their insurance carriers more time, energy, and money in the long run.

Noelle M. Natoli-Duffy is an associate at the Los Angeles office of Foley & Mansfield. Her civil practice is focused primarily on the defense of elder abuse, transportation, and personal injury claims.