# NURSING HOME MALPRACTICE

# IN LOUISIANA

## *SUCCESSFUL CASE MANAGEMENT FROM*

## *INVESTIGATION TO TRIAL*

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## I. STATE AND FEDERAL GUIDELINES IN NURSING HOME LITIGATION

The nursing home industry is one of the most regulated industries in this country. Various state and federal regulations provide the basis for written standards of care for nursing home residents. Nursing homes seeking reimbursement through Medicare or Medicaid are regulated through the Health Care Finance Administration (HCFA) and through corresponding state agencies for issues related to care of residents.

Federal and state regulations require nursing homes to establish minimal standards that ensure the adequate care and safety of residents. Although it is debatable as to whether these guidelines establish an independent cause of action against nursing homes, the plaintiff should argue that these standards establish the standard of care for services in nursing homes.[1] Additionally, the standards should be used in the litigant's presentation of their case at trial. Moreover, these standards must be met as reimbursement guidelines for the facility to be paid for its services.

The specific standards are found in 42 C.F.R. 483 et. seq. State surveyors, through the Department of Health and Hospital, look to these standards and

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[1] For a detailed analysis of this area of the law, see the article, Effective Use of the Nursing Home Reform Law in Residents' Litigation Against Nursing Facilities published in the National Senior Citizens Law Center newsletter, Issue #1, March 23, 2001. NSCLC Telephone Number (202)289-6976.

their interpretive guidelines to determine whether the facility is providing the appropriate care to sampled residents.

Most states have Nurse Practice Acts and licensing acts for long term care facilities that provide standards of practice for nurses and nursing homes. Additionally, Louisiana has a nursing home residents' bill of rights that set forth rights of residents to, among other things, adequate care. All standards will be discussed, *infra*.

### A. Federal Regulations – OBRA (Omnibus Budget Reconciliation Act 1987); 42 U.S.C. §§1395 i – 3 and 1396 r et. seq.

The specific regulations are found in 42 C.F.R. §§483.1-483.480 and are the minimum standards for nursing homes.

The standards that apply to the common nursing home claims will be discussed primarily in this outline. In conjunction with these standards are the interpretive guidelines. These are the standards by which the surveyors determine whether the facility followed the guidelines. Additionally, the litigant should immediately obtain a copy of the facility's survey, complaint and census documents to determine past violations in an attempt to prove a pattern of neglect or short staffing that led to poor care. These documents will reference violations of the standards discussed hereinbelow.

1. **§483.13 Resident behavior and practices.**

This standard covers abuse of residents, restraints, treatment of residents, and investigation of abuse, neglect and injuries of an unknown source.

It requires that:

- The facility thoroughly investigate all alleged violations and take appropriate corrective action if verified.
- That the results of all investigations be reported to the administrator and the appropriate state agency.
- The facility not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents.
- That residents be free from physical or chemical restraints imposed for discipline or convenience.

2. **§483.15 Quality of Life.**

This regulation provides for care of residents in a manner and in an environment that promotes the maintenance or enhancement of each resident's quality of life.

It further provides that the facility must provide care for residents in a manner that maintains each resident's dignity.

3. **§483.20 Resident Assessment**

This guideline requires the facility to conduct an initial and periodic comprehensive, accurate, standardized, reproducible assessment of each

resident's functional capacity. This comprehensive assessment must be based on the resident's needs and should describe the resident's capability to perform daily life functions and significant impairments in functional ability. The comprehensive assessment should include the following information:

(i) Medically defined conditions and prior medical histories;

(ii) Medical status measurement;

(iii) Physical and mental functional status;

(iv) Sensory and physical impairments;

(v) Nutritional status and requirements;

(vi) Special treatments or procedures;

(vii) Mental and psychosocial status;

(viii) Discharge potential;

(ix) Dental condition;

(x) Activities potential;

(xi) Rehabilitation potential;

(xii) Cognitive status; and

(xiii) Drug therapy.

The assessment must be conducted no later than fourteen days after the date of the admission, once every twelve months, and promptly after a significant change in the resident's physical or mental condition. The nursing

home must review the assessment once every three months to assure the continued accuracy of the assessment.

After conducting these assessments, a comprehensive care plan should be developed that is individualized for the resident for his or her conditions. The comprehensive care plan should include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified within the comprehensive assessment. It should describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and should be prepared by an inter-disciplinary team that includes the attending physician, a registered nurse and other appropriate staff and disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident and his or her family.

The care plan should be periodically reviewed and revised by a team of qualified persons after each assessment and the services outlined in the care plan should meet all professional standards of quality.

This regulation is the cornerstone of proper resident care in nursing homes. The importance of this regulation cannot be understated. The regulation is useful in all nursing home cases because it provides plaintiffs with a tool to challenge the nursing home defense that the resident's decline was inevitable.

**4. §483.25 Quality of Care.**

This regulation is one of the most important in nursing home litigation. It provides that residents must receive and the facility must provide necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This standard must be met in the following particulars of care:

(1) Activities of daily living (ADLs) including bathing, dressing, grooming, toileting, eating, ambulation and speech. It requires that these (ADLs) not decrease unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable.

(2) Pressure Sores. This standard requires that a resident who enters a nursing home without a pressure sore not develop one unless the individual's clinical condition demonstrates they were unavoidable, and that a person with pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores.

(3) Urinary Incontinence. States that a resident who enters a facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and that an incontinent resident receives treatment to prevent urinary tract infections.

(4) Range of Motion. Requires services to prevent loss of ranges of motion and treatment of residents with loss of range of motion.

(5) Mental and Psychosocial Functioning. Requires treatment for residents with mental or psychosocial disorders.

(6) Naso-gastric Tubes. Requires appropriate services to prevent residents from needing tubes and to make sure residents with tubes receive appropriate care to prevent aspiration pneumonia, dehydration and vomiting.

(7) Accidents. Requires that facilities remain free of accident hazards and that residents receive adequate supervision and assistance devices to prevent accidents. This section is important as a standard in fall cases.

(8) Nutrition. Requires facilities to maintain acceptable parameters of nutritional status such as body weight. The interpretive guidelines define significant weight loss as 5% in one month or 10% in 6 months.

(9) Hydration. Requires the facility to maintain sufficient fluid intake of residents.

(10) Special Needs. These include injections, tracheal suctioning, foot care and respiratory care.

(11) Medication Errors. Requires the facility to ensure medication error rates of five percent or less and that residents are free of significant medication errors.

All of the above aspects of care are based on a comprehensive assessment and care plan of the resident. A comprehensive assessment of the resident is required by the regulation and is required upon admission every quarter and upon a significant change in the resident's condition. Moreover, it is required by general nursing principles and the La. Nurse Practice Act. Without a comprehensive assessment, the nursing process is compromised.

The assessment encompasses all aspects of a resident's existence, including physical and mental elements. This assessment is called the MDS (minimum data set) and is part of the resident's nursing home record. Also included are RAPs (resident assessment protocols). This assessment is comprehensive and multi-disciplinary. It includes nursing services, dietary services and social services. From this assessment, a comprehensive care plan must be developed, followed and modified if the resident's condition changes. This process is critical to proper care of nursing home residents.

**5. §483.30 Nursing Centers.**

Nursing Services. Requires the facility to have sufficient nursing staff to maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and care plan.

The critical point is that the staff must be sufficient enough to meet the individual needs of the residents based on their care plans. Inadequate or short staffing directly leads to neglect of residents.

**6. §483.35 Dietary services.**

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. The facility must employ a qualified dietician part-time full-time, or as a consultant, or have a director of food service who consults with a dietician if one is not employed full-time. These persons should be part of the interdisciplinary team and the nursing staff should inform them of changes in eating habits of residents.

**7. §483.40 Physician services.**

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician and that another physician supervises the medical care of residents when their attending physician is unavailable.

The physician must review the resident's total program of care including medications and treatments. The physician must visit once every 30 days for the first 90 days after admission and once every 60 days thereafter. This regulation should be checked by viewing the physician progress notes. In many cases the facility provides a retired physician who does not comply with this standard. Though the physician is not a nursing home employee, the nursing home often

advises the family to use this physician who happens to be its medical director. Resident care can be compromised in this situation.

**8. §483.65 Infection control**

The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The facility must keep records of the infections in the facility. These records are beneficial in these cases.

**9. §483.75 Administration.**

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The facility must comply with all federal, state and local laws.

Additionally, this regulation requires a facility to maintain a clinical record of residents in accordance with accepted professional standards of practices. The record must be complete, accurate, and systematically organized. Many nursing home records do not meet this standard. They are incomplete and inaccurate. Failure to accurately chart can lead to compromise of the resident's condition.

## B. State Regulations

### 1. Medicaid Guidelines Standards For Payment For Nursing Home Facilities - 1996

These regulations basically mirror the federal regulations discussed hereinabove. They provide that a facility shall be administered in a manner to attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident. Further, that services to residents by professional staff meet ethical and professional standards governing the profession. Section 2-2 requires that the facility operate in accordance with all local, state and federal laws.

### 2. LA Nurse Practice Act – 46 XLVIII 3901-3915; Chapter 46 of the Louisiana Administrative Code. See Handout #1.

Establishes guidelines and standards for nurses regarding patient care.

### 3. Resident Rights Statute; LA R.S. 40:2010.8 et seq.

Provides for damages, attorney's fees and enforcement of resident rights through a civil proceeding filed by resident, curator, or his legal representative after the resident's death. It includes such rights as the right to receive adequate and appropriate health care and support services consistent with the resident care plan, right to be treated with dignity, and the right to be fully informed of his condition, among others.

**4. La. Administrative Code – 48:I §§9701-9933**

**5. State Survey and Complaint Records of Nursing Homes.**

These records are maintained by the DH&H and are available through a written request to the Department. These records can be very valuable to determine the past conduct of an offending nursing home to establish a pattern of neglect or abuse. The records can also be found on the net at www.medicare.gov and www.hcfa.gov/medicaid.

**6. Pressure Sore Guidelines For Treatment And Prevention Of Pressure Sores Promulgated By The Agency For Health Care Policy And Research ("AHCPR") And Adjunct Of The U.S. Department Of Health And Human Resources.[2]**

**C. Reported Cases, Awards, and Recent Legislative Developments**

1. Procedural and Substantive Law Cases.

**a.** ***Free v. Franklin Guest Home,*** **397 So.2d 47 (La.App. 2nd Cir. 1981)** provided for a ten-year prescriptive period for breach of contract claims in nursing homes. Note: This case is probably legislatively overruled by recent amendments to LA R.S. 9:5628 which amended the law to give a one year prescriptive period for nursing home actions including breach of contract claims.

**b. Jury Charge. See *Jones v. Shepard*, 760 So.2d 554 (La.App.** 3rd Cir. 2000) which states that:

[2] U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, Executive Office Building, Suite 501, 2101 East Jefferson Street, Rockville, MD 20852

"Generally, nurses are required to notify doctors of significant changes or any changes the doctor has requested he be notified about, but case by case analysis must be made as to this issue because the standards may vary."

c. ***Gibson v. Monroe Manor Nursing Home,* 32-806 (La.App. 2 Cir. 3/3/2000), 756 So.2d 5836.**

This case was important because it allowed a private action by the resident's heirs pursuant to the nursing home residents' bill of rights law for violations. It declared that these rights have a longer prescriptive period than a tort action.

2. Louisiana Verdicts and Settlements.

Compensation for inadequate care in nursing homes has changed. In pressure ulcer cases, compensation is growing. In the period from 1987 to 1994, the average award nationally in a nursing home negligence case increased from $238,285.00 to $525,853.00. In addition, while personal injury litigation produces punitive damages in only five percent of cases, the figure is twenty percent for nursing home lawsuits. Although Louisiana does not provide for punitive damages in nursing home cases, we have a Resident Rights Statute which would provide some basis for increased awards and attorney's fees akin to a punitive award.

There are not many reported Louisiana quantum cases. The following cases were settled and provide some guidance for practitioners:

**a. Nursing Home Patient Falls After Being Left on Side of Bed – Suffers Fractured Hip - $110,000 Louisiana Settlement**

The plaintiff, an eighty-one year old lady, contended that at 5:30 a.m. she was left sitting on the side of her bed by a nurse or nurses' aide who left the room and failed to return. When the plaintiff became tired, she attempted to get back in the bed, but fell and fractured her hip. The plaintiff required hip replacement surgery and still requires the use of a walker. The plaintiff had severe pre-existing osteoporosis and there were conflicting reports as to whether or not there was an actual fall. The parties reached a settlement agreement worth $110,000 in early May, 1992.

**b. $60,000 Louisiana Settlement – 77 year old Female Resident Suffers Broken Hip**

A 77 year old female suffered a hip replacement and a fractured right femoral neck, which required surgery, when she fell out of her wheelchair while under the care of the defendant nursing home. The plaintiff contended that the defendant was negligent for failing to properly supervise her. The defendant contended that

the plaintiff's hip replacement happened prior to her falling out of the wheelchair. Berry, pro ami, Lyrse v. Rapides-Iberia Management Enterprises, Inc., d/b/a Bossier Health Care Center, District 86,948, Bossier Parish, LA.

**c. $41,283 Louisiana Settlement in Arm Fracture of Female Resident**

A female suffered a fracture of the left, nondominant humerus when an employee for the defendant nursing home broke the plaintiff's arm while attempting to lift the plaintiff out of the bathtub. The plaintiff contended that the defendant failed to provide proper care. McInnis v. Bossier Health Care Center, Inc., et al., Bossier, Louisiana.

**d. Merritt v. Karcioglu, 95-1335 (La.App 4 Cir. 1996), 668 So.2d 469**

This case was a medical malpractice case. However, an award of $500,000 (reduced from $555,000 because of cap) was upheld for fractured hip and resultant seven months diminution of quality of life before unrelated death for a 92 year old woman.

**e. Nelson v. Ruston Longleaf Nurse Care Center, 32-718 (La.App 2 Cir. 2/1/2000), 751 So.2d 436**

This case disallowed *Lejeune* damages to relatives where plaintiffs did not prove underlying claims (amputation due to pressure sore) was related to poor care.

**f. Batson v. South Louisiana Medical Center, 98-0038 (La.App 1 Cir. 12/22/00, 778 So.3d 54**

This case was a medical malpractice action. However, the injuries suffered were those common in nursing home cases. It allowed different damage caps in a medical malpractice proceeding for different, unrelated injuries. Considering the movement of the industry to PCF protection, this case is critical for damages.

3. Recent Legislative Developments

(1) Act No. 108. Amends LA.R.S. 40:1299.41 to add a nursing home as a health care provider for medical malpractice coverage.

(2) Act No. 95. Amends LA R.S. 9:5628 to provide for one year prescriptive period against nursing homes in all cases including breach of contract claims.

(3) Senate Bill No. 763. Amends LA R.S. 13:3715.3 to limit use of nursing home surveys in trials to those violations that relate to care complained of in lawsuit.

## II. COMMON TYPES OF CLAIMS

### A. Pressure Sores (Decubitus Ulcers)

#### 1. Introduction

Pressure sores are preventable with proper attention to risk factors that cause them. Without pressure, there are no pressure sores. Depending on the risks identified, various preventive techniques are available. After all, most elderly persons in need of long-term care have predisposing risk factors for pressure ulcers.

Pressure sores should not happen if proper precautions for their prevention are implemented. The nursing homes will argue that these sores were unavoidable. The burden of proof should be on the nursing home to prove the pressure sores were unavoidable. Without doing a proper assessment for risk factors and implementing a proper care plan to prevent ulcers, the nursing home cannot argue that ulcers were unavoidable.

**Applicable OBRA Regulation**

> §483.25 (c) *Pressure sores.*
>
> Based on the comprehensive assessment of a resident, the facility must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives

necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

**2. DEFINITIONS**

(a) Terminology has changed.

1. No longer use "decubitus" or "bedsores"

2. Use "pressure ulcers" or "pressure sores"

(b) A pressure ulcer is any lesion caused by unrelieved pressure resulting in damage of underlying tissue. (AHCPR, p.1)

NO PRESSURE - NO PRESSURE ULCER

(c) Pressure ulcers usually occur over bony prominences.

**3. STAGING**

(a) STAGE I

A Stage I Pressure Ulcer is an observable pressure-related alteration of intact skin whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following:

skin temperature (warmth or coolness, tissue consistency (firm or boggy feel), and/or sensation (pain, itching).

(b) STAGE II

Partial thickness loss involving epidermis and/or dermis

(c) STAGE III

Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

(d) STAGE IV

Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

(e) COMMENTS RE: STAGING

1. Pressure ulcers with eschar cannot be staged.

2. The NPUAP advises that reverse staging is incorrect.

3. Some pressure ulcers form without losing epidermis.

4. Timely discovery and treatment should prevent Stage I and II pressure ulcers from becoming Stage III and IV in most cases.

**4. PREVENTION**

(a) Identify at risk residents

(1) Tools

(1) Braden Scale

(2) Norton Scale

(2) Assessment

(1) Initially

(2) Status changes in person and/or environment

(3) Daily skin assessment in at risk residents

b. Risk Factors

(1) Age

(2) Mobility/immobility

(3) ADL abilities

(4) Level of consciousness and cognition

(5) Incontinence

(6) Compromised nutritional intake

(7) Underweight or overweight

(8) Psychotropic drug use

(9) Use of other drugs that affect cognition, blood flow, mobility

(10) History of pressure ulcers

(11) Personality

(12) Impaired sensory perception

(13) Fever/moisture

(14) Friction/shear

(15) Impaired health

## 5. PREVENTIVE MEASURES

(a) START WITH STAFF

(1) Philosophy and attitude

(2) Need for very well—trained staff

(3) Team work

(4) Sufficient staff

(b) ENVIRONMENT

(1) Proper mattress and cushions

(2) Access to toilets

(3) Close supervision of bed/chair bound

(4) Linens smooth and in good repair

(5) Temperature controlled

(6) Proper equipment — chairs, pillows, heel/elbow/ear protectors

(c) RESIDENT

(1) Turn and reposition every 2 hours or more often — use a turning clock

(i) Do not turn more than 30 degrees

(ii) Pad bony prominences, especially back, and protect heels, elbows, ears, shoulders

(iii) If in chair, lift every hour

(2) Provide incontinent care within 15 minutes.

(i) Urine scalds and stool chemical burns

(ii) Wash with soap and water ALL areas soiled

(3) Nutrition

(i) Be creative

(ii) Substitutes and supplements

(iii) Mouth care

(iv) Nutrients, not just calories

(4) Personal Hygiene

(5) Mobility

(i) Active

(ii) Passive

(iii) Whirlpool

6. Avoid friction

**6. TREATMENT**

(a) Assessment

(b) Pressure relief/reduction

(c) Ulcer care

a. Cleansing

b. Debridement

c. Dressings

(d) Infection control

(e) Operative repair

(f) Education

(g) Quality improvement

**7. Information Sources**

(a) U.S. Department of Health and Human Services Guidebooks: AHCPR Publications, 2101 East Jefferson St., Rockville, MD 20852. The following are manuals published by AHCPR that are beneficial.

(1) Pressure Ulcers in Adults: Prediction and Prevention

(2) Treatment of Pressure Ulcers

(3) Preventing Pressure Ulcers

(b) Publication of (NPUAP) National Pressure Ulcer Advisory Panel. 11250 Roger Bacon Drive, Suite 8, Reston, Virginia 20190 –5209, Telephone Number (703) 464-4849.

(c) Photographs of Wounds Within Nursing Home Treatment Records

(d) Hospital Photographs – Most Hospitals Photograph Wounds and Keep Those Photos In Medical Record Department.

## 8. Concluding Comments

(a) "If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed—sore, it is generally the fault not of the disease, but the nursing." (Nightingale, Florence. (Reprint 1970). Notes on Nursing, London, Vertex Books, p.6)

(b) "Pressure ulcers are entirely preventable. They need not and should not occur." "The major determinant of pressure ulcer development is not how sick the patient is, but how good the caregiver is " (Olshansky, Kenneth 1994 Essay on knowledge, caring, and psychological factors in prevention and treatment of pressure ulcers Advances in Wound Care, 7(3) 64—68 )

(c) It is critical that the plaintiff's attorney or expert review the record to determine whether the nursing home properly assessed the resident and implemented a care plan designed to prevent pressure ulcers. Also look at interpretive guideline for 483.25(c).

## B. Injuries Precipitated by Progressive Failures and Omissions of Care

### 1. Introduction

The injuries listed in this category generally result from a prolonged form of neglect, and systematic failures in the administration of care in the nursing home as contrasted with an event which immediately produces an injury, such as a scalding. At the outset, it is important that plaintiff's counsel understand whether the injury in question was caused by recurrent neglect over an extended period of time or was simply the result of a single event which effectively produced injury to the nursing home resident. A pattern of neglect, if proven, should not be tolerated. The injuries listed below have been recognized by the medical and nursing communities as preventable in nearly all nursing home residents through implementation of ordinary nursing care. The nursing home will assert that the injuries were unavoidable; however, you must make sure that there was a proper assessment of the resident, a proper care plan for the resident and adherence to the care before such a defense can be justified.

### 2. Types of Injuries

(a) Stage III, IV Pressure Ulcers, Infected or Gangrenous Ulcers, Osteomyelitis Secondary to Stage IV Ulcer – Usually the result of failure to properly treat and timely discover. Try to link with testimony of family and staff that resident was allowed to lay in urine without timely cleaning.

(b) Severe Dehydration or Malnutrition. – Critical to review labs, weight records and intake/output sheets. Also look at dietary consult records. Severe weight loss should not be permitted without a review of MDS because it is a significant change in resident's condition. Significant weight loss can lead to skin breakdown. The interpretive guidelines define as weight loss of 5% in one month or 10% in 6 months. In many records, there will be discrepancies in weights which could have clinical significance. Look at weight records and compare quarterly weights in MDS. Significant weight loss should be reported to the physician and the Care Plan reviewed for interventions.

(c) Sepsis due to pneumonia, urinary tract infection due to failure to appropriately monitor and change urinary catheter, or other localized sepsis.

(d) Aspiration/pneumonia for failing to properly suction or check residual feedings.

## C. Injuries Precipitated by Medication

### 1. Introduction

Approximately 95 percent of all nursing home patients receive medication on a regular basis. The typical nursing home patient takes five to six medications

daily. The over-use or under-use of certain medications can result in serious injury or death. Plaintiff's experts should review all labs and (MAR's) Medication Administration Records if this injury is suspected. Medication errors can result in misdiagnosis of resident's mental condition, falls, and death.

Drug-related injuries in a nursing home case are usually the result of: (1) inappropriate prescribing by the physician; (2) failure of the nursing home staff to follow physician's instructions by properly monitoring a specific aspect of the patients condition prior to administering the medication in question; (3) administering medications to the resident despite the presence of adverse symptoms which require immediate physician notification; (4) over or under medicating the resident by the nursing home staff or (5) administering Patient A's medication to Patient B. The following list consists of drug-related injuries that commonly occur in a nursing home setting and are the subject of litigation. However, this list is not intended to be all inclusive.

**2. Types of Medication Errors**

(a) Mental or physical deterioration secondary to inappropriate psychotropic medication administration.

(b) Digoxin toxicity.

(c) Untreated congestive heart failure (such condition may be recognized by the following symptomology: edema, difficulty in breathing--especially in a prone position--

chronic cough, swollen ankles, and/or bloated abdomen).

(d) Dilantin toxicity.

(e) Insulin shock/coma resulting from inappropriate administration of insulin.

(f) Improper antibiotic therapy resulting from: (1) the inappropriate prescription and continuation of a broad spectrum antibiotic coupled with the failure to obtain culture and sensitivity or the failure to track the effectiveness of the antibiotic; or (2) the failure to adjust the antibiotic therapy in response to the sensitivity report.

(g) Severe fall resulting from the failure to monitor the effects of any hypertensives and anti-arrhythmia drugs or from negligent use of psychotropic drugs.

(h) Hyperkalemia resulting from dehydration coupled with the use of any hypertensives, diuretics and/or potassium supplements.

(i) Any adverse drug reaction identified in the *Physician's Desk Reference* or product literature of the drug manufacturer.

## D. Injuries Precipitated by Untoward Incidents

### 1. Introduction

Another category of injuries exists for the purposes of nursing home litigation. This category consists of injuries which can be causally linked to a specific event. Causation in these cases is easier to prove. For example, in a case where a resident has drowned in a whirlpool bath, the cause of death is clearly connected to a singular occurrence at a specific time. The time between the negligent behavior and the appearance of the full-blown injury is minimal. In contrast, in the case of a progressive injury such as a pressure ulcer, the wound gradually evolves and cannot be pinned down to a specific time.

For injuries resulting from an unwanted incident, the defense often asserts that the resident was psychologically dysfunctional to the point of being impossible to monitor and control. However, C.F.R. 483.25(h) requires that the facility ensure that the resident environment remains as free of accident hazards as possible. It also requires that each resident receive adequate supervision and assistance devices to prevent accident. In many cases, the facility has neglected to repair a harmful structure or device in the facility.

In the progressive injury case, the defense often asserts that the complex medical history of the elderly resident, coupled with his/her age and deteriorating health status, was the true cause of the injury in question. The defense seizes upon the frail physical condition of the resident (as opposed to the

mental condition), arguing that such condition preordained the occurrence, e.g. the Stage IV sore(s). Plaintiffs must address the causation issue and prove it with their experts. Again, it should be argued that without proper preventive measures, the nursing home can't argue that injuries were inevitable. Thus, it is important to put on evidence of all failures in the nursing home, not just the event that usually triggers a client contacting you.

Thus, the distinction between the injuries identified below and the progressive failure injuries stems not only from the amount of time between the negligent behavior and the presence of the full-blown injury, but also the excuse typically offered by the defense to explain away liability.

**2. Types of Injuries**

Nursing home injuries precipitated by untoward incidents which are frequently the subject of litigation are as follows:

(a) Strangulation (e.g., strangulation resulting from the failure to either monitor restraints or the improper use or application of restraints such as posey restraints)

(b) Drowning

(c) Scalding

(d) "Wander-off' cases, wherein death or serious injury occurs after the resident has wandered away from the facility

(e) Rape and/or sexual assault

(f) Unexplained Injuries

a. Get all incident reports of the resident and ask the court to give you all incident reports of similar occurrences of other residents with their names redacted. These can help establish a systemic problem and failure to address the problem by the facility.

b. Get 24 hour reports, complaints and surveys from DH&H.

c. Quality Assurance documents of safety committee.

(g) Falls and fractures resulting from the failure of nursing home staff to follow accepted protocols and implement necessary preventive measures. These will be discussed separately hereinbelow.

**3. Falls**

A fall in a nursing home is not an unusual occurrence. When is litigation appropriate? As litigating advocates it is important that we properly identify those falls which are the result of a facility's negligence and its failure to provide appropriate care. The presence of a fracture is not necessarily the hallmark of a successful case involving a fall within a nursing home. The failure of the facility

to assess those persons who enter a nursing home for the risk of falling, their failure to provide safeguards and thereafter their failure to appropriately respond to the fall are indicative of a facility's negligence. It is these failures which are the best criteria of liability.

Restraints are not the answer to falls or wandering. Restraints, in and of themselves, may represent a facility's inability or unwillingness to meet the needs of the persons living there. The assessment for the restraints, the application of the restraint, the amount of time the restraints are used and the complications resulting from the use of restraints are all important aspects of a suit concerning restraint issues. The application of restraints often increases the incidence and compounds the severity of falls.

When filing the initial complaint it is important to plead the case in the context of a nursing home negligence case and not a simple slip and fall personal injury. Failure to properly outline this type of case within the initial pleadings may drastically limit your discovery opportunities and eventually impact the final outcome of your case.

Most falls are preventable with adequate assessment, intervention and supervision. Restraints are not the answer to prevention of falls. There has been demonstration that restraints not only increase the severity of falls, but additionally increase the number of falls (Liewellyn, Maring, Shekleton, & Firlit, 1988).

The OBRA regulations provide that there must be appropriate assessment each resident entering a certified nursing home and that an appropriate care plan must be developed and implemented so that each resident is allowed to "attain and maintain the highest practicable mental, physical and psychosocial well-being". Additionally, the regulations require that the facility protect the resident from unnecessary accidents as was discussed *supra*.[3]

An important tool to prevent accidents is an initial assessment of the client's risk of falling. There should be a documented assessment of those clients who are potentially at risk for falling. This assessment should be the catalyst for a plan of care which will step by step outline the facility's plan to protect the client from unnecessary falls. The progress notes of nursing, activities, social services and appropriate therapies should evidence that the plan has been implemented. Without the implementation of an appropriate plan to protect your client from falls, the facility has neglected your client and therefore may be liable for falls and the subsequent injuries and damages.

The assessment may be found within a document entitled fall risk assessment, or there may be an assessment within the Minimum Data Set and the Resident Assessment Protocol.[4] Nursing, the treating physician, pharmacist,

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[3] 42 C.F.R. §483.25(h) *Accidents.* The facility must ensure that – (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

[4] Each facility is required by C.F.R. 42 §483.20 to perform an assessment consistent with the requirements for each state's specified Resident Assessment Instrument (R.A.I) which should include at least the Minimum Data Set (MDS) and common definitions, triggers and utilization guidelines developed by the Health Care Finance Administration (HCFA) which include the Resident Assessment Protocol (RAP).

activity departments, restorative nursing, physical therapy and occupational therapy are disciplines that may participate in the assessment of your client when falls are an issue.

If there is a fall resulting in injuries it is incumbent upon the facility to report the fall to the attending physician and the responsible party[5] and to monitor your client for complications from the fall. The facility has an obligation to investigate the cause of all falls and develop a plan to protect your client from future falls. Failure to do any of these may result in damages to your client for which the facility is liable.

Physical injuries which may occur are skin tears, bruising, fractures, loss of sight, or the eventual loss of a limb. When falls occur, especially in the elderly, there may be a loss of mobility. The loss of mobility may be self-directed or the facility may fail to provide safe assistance for the resident to ambulate. Ambulation is important to the general welfare of the elderly. The facility has a responsibility to assess this loss and respond to it. With the loss of ambulation there is attendant decreased range of motion, increased incontinence, increased risk of respiratory complications, loss of socialization and increase depression.

Falls may result in subdural hematomas which may cause death. The elderly who sustain hip fractures have a mortality rate of 12 to 29 percent within

[5] 42 C.F.R. §483.10(10) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is – (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention.

a year. (Jette et al., 1987; Fitzgerald et at., 1988; Marotolli et al., 1992).

When your client enters the nursing home there is a contract or an admission agreement. There may also be contractual damages derived from this admission agreement. If a facility fails to provide the appropriate supervision so that a nursing home resident can "attain or maintain their highest practicable mental, physical and psychosocial well-being" then that facility may have failed to fulfill its contract to the resident. Contractual damages may also entitle the plaintiff to recover attorneys' fees and costs.

If the facility has been put on notice, either by the frequent falls of your client, or by the number of falls within the facility, there may be an element of willful or wanton conduct. The facility is required to have a quality assurance program which "(d)evelops and implements appropriate plans of action to correct identified quality deficiencies."[6] Although the minutes of the quality assurance committee may be privileged, the absence of an administrative effort to correct problems, such as falling, within the facility is relevant.

Multiple fractures without a plan to prevent or minimize falls is outrageous conduct for a health care provider. The conduct becomes even more outrageous when the facility fails to provide care for the fracture and the fracture results in an amputation due to the defendant's continued neglect.

Staffing constraints are not a defense for falls. The facility has an

[6] 42 C.F.R §483.75(o)

obligation not to admit those persons for whom they are unable to provide care. The burden to provide appropriate care is upon the facility. It is not the resident's responsibility to adapt to institutionalization.

The application of restraints on the confused elderly is taken far too lightly by most health care providers. Families become unwitting accomplices in the application of restraints either during the admission process, when they sign the stack of documents which are presented to them; or after a fall, or episode of wandering when they are approached by staff to sign a consent for restraints.

Before restraints are applied there must be:

1. Evidence of an effort to use a lesser restrictive device;
2. An assessment for the restraint;
3. A medical condition for which the restraint is warranted;
4. Informed consent for the restraint, by either the resident, or if the resident is incompetent, by the family;
5. An order by the physician for the restraint noting the reason for the restraint, the type of restraint and limiting the time of the application of the restraint.

There should be evidence in the record that the use of the restraint is re-evaluated and discontinued as soon as possible. The effects of restraints are egregious and include, but may not be limited to, isolation, social withdrawal,

depression, loss of appetite, pressure ulcers, dehydration, malnutrition, increased urinary tract infections, respiratory complications, contractures, incontinence, muscle atrophy, increased falls, loss of ability to ambulate, increased
injuries and death.

The emotional and physical response of the resident to any restraining device should be assessed. It is a violation of the resident's right to impose a restraint upon the resident whether or not the resident is incompetent if he/she demonstrates refusal or rejection of restraints. A person who is tied to a chair and continues to attempt to walk with the chair tied to him is communicating, vividly, that he needs exercise, not restraints. Juries are increasingly incensed when a facility imposes restraints upon its residents.

Treatment for medical conditions which may necessitate a restraint may include the need for IV antibiotics to treat an infection or the administration of parental feedings. It is important to assess ethical consideration vs. long-term restraint use for the sole purpose of providing nutrition.

If the decision is made that restraints are indicated it is important that the resident be checked frequently and that the restraints be released, at a minimum, every two hours. During the release of the restraints the resident should be assisted to ambulate and toileted. The facility, additionally, has an obligation to toilet the resident *as often as the resident needs* so that the resident may remain continent. The degradation of enforced incontinence is a persuasive issue to a

jury when attempting to argue the inappropriateness of restraints. A former nursing home resident when asked what it was like to be restrained said, "I didn't feel like a person. I didn't want my friends to see me like that."

Restraints often accelerate the behavior for which they were imposed. Restlessness, agitation, confusion and falls can increase with restraint use. A decrease in function may be documented within the nurses' notes, the care plan or the quarterly assessment. Juries will compensate for these damages. Restraints are synonymous with iatrogenic decline.

Restraints are not allowed to be used for the convenience of the staff. Defendants will argue that there is no way that they can provide one to one supervision of a resident in a nursing home. The interesting fact is that when restraints are utilized, the care which is required by the application of the restraints adds an additional two hours to the care of that individual resident. Using restraints in a facility which is already short-staffed increases the chance that your client and others will be neglected.

When a resident demonstrates their refusal to remain restrained by behavior such as: attempting to walk with a chair restrained to them, crawling over bed rails, attempting to get out of the restraints, or any other physical activity, the odds of injury increase. A facility that continues to impose restraints on these residents is acting with an outrageous disregard of that individual's welfare.

The facility has an obligation to report "incidents that reasonably suggest there is a probability that a medical device has caused or contributed to the death of a patient or to a serious injury or serious illness of a patient". Reports may be made to the FDA or the manufacturer. User facilities must submit a semi-annual report to the FDA summarizing the reports. If your client has been injured while in a restraint you may want to see if the injury has been reported as required by the Safe Medical Device Act of 199O. [7] A defendant's failure to do so may appear to the jury to be a callous disregard for the future welfare of its residents.

Pleadings are the roadmap to your case. If the complaint sounds like a slip and fall case, experience has demonstrated that the judge will rule on discovery matters likewise. It then becomes an uphill battle to gather the evidence to prove a pattern of negligence. It is easier to gain access to personnel files when you have pled that there was a failure to train the nursing staff, a failure to supervise the nursing staff, and a failure to provide adequate staffing.

As in any other nursing home case, discovery is critical. It is essential that the attorney obtain the incident reports of the resident and compare those to other aspects of the nursing home record. Incident reports are required by the nursing home regulations. Failure of the nursing home to complete an incident report in instances where the resident is found with a suspicion of a fall is a violation.

[7] Public Law 101-629

Falls should be reported to the physician, and the nursing home staff should adopt a care plan that is designed to prevent falls. Obviously, one-to-one supervision for all persons at risk for falls is not a reasonable possibility. Nonetheless, the staff can construct individualized plans of care that maximize supervision. For example, residents with unsafe behavior and multiple falls can be moved closer to the nursing station. Families can be counseled to become involved in care, and persons at extreme risk can be offered the option of one-on -one assistance. Many assistive devices that prevent accidents can be used. These include but are not limited to walkers, anti-tip devices on wheelchairs, positioning cushions, low beds and bed alarms. Failure of the facility to implement these interventions after a thorough assessment is a breach of the standard of nursing care.

**HANDOUT #1**

PROFESSIONAL AND OCCUPATIONAL STANDARDS

## Chapter 39. Legal Standards of Nursing Practice

§3901. Legal Standards

A. The Louisiana State Board of Nursing recognizes that assessment, planning, intervention, evaluation, teaching, and supervision are the major responsibilities of the registered nurse in the practice of nursing. The standards of nursing practice provide a means of determining the quality of care which an individual receives regardless of whether the intervention is provided solely by a registered nurse or by a registered nurse in conjunction with other licensed or unlicensed personnel as provided in Lac 46:XLVII.3703.

B. The standards are based on the premise that the registered nurse is responsible for and accountable to the individual for the quality of nursing care he or she receives. Documentation must reflect the quality of care.

C. The standards of practice shall:

1. be considered as base line for quality nursing care;
2. be developed in relation to the law governing nursing;

3. apply to the registered nurse practicing in any setting;

4. govern the practice of the licensee at all levels of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:309 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3903. Standard Number 1: Collection and Recording Individual's Health Status**

Data concerning an individual's health status must be systematically and continuously collected, recorded, and communicated in order to determine nursing care needs, according to the following criteria.

1. The priority of data collection is determined by the individual's immediate condition and needs.

2. The collection and recording of data provides for systematic collection, frequent updating, accessibility, and appropriate confidentiality.

3. The appropriate data includes:

   a. growth and development factors;

   b. biophysical status

   c. emotional status;

   d. cultural, religious, socioeconomic background;

   e. performance of activities of daily living;

f. patterns of coping;

g. interaction patterns;

h. individual’s perception of and satisfaction with his health status;

i. individual’s health goals;

j. environmental factor (physical, social, emotional, ecological); and

k. available and accessible human and material resources.

4. The data are collected by:

a. interview;

b. examination;

c. observation; and

d. reading of records and reports.

5. The data are collected from:

a. the individual;

b. family members;

c. pertinent others; and

d. other health care personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursgin LR 3:309 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3905. Standard Number 2: Analysis of Health Status Data**

Nursing diagnoses, nursing care goals, and expected outcomes are derived from an analysis of the health status data, according to the following criteria.

1. The individual's health status is compared to the norm to determine if there is a deviation and the degree and direction of deviation.
2. Nursing diagnoses are documented in a manner that facilitates the determination of expected outcomes and plan of care.
3. Short and long term goals are mutually set with the individual and pertinent others. These goals are:
   a. congruent with other planned therapies;
   b. stated in realistic and measurable terms; and
   c. assigned a time period for achievement.
4. Goals are established to maximize functional capabilities and are congruent with:
   a. growth and development factors;
   b. biophysical status;
   c. behavioral patterns; and
   d. human and material resources.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICLA NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:310 (July 1977); amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (La. 1998).

**§3907. Standard Number 3: Priorities and Actions for Nursing Care.**

The plan for nursing care must include individualized nursing actions to achieve the established outcomes, according to the following criteria.

1. The plan includes priorities for nursing action.
2. The plan includes a logical sequence of actions to attain the goals.
3. The plan is based on current scientific knowledge and nursing practice.
4. The plan incorporates available and appropriate resources.
5. The plan can be implemented.
6. The plan reflects consideration of human dignity and patients rights.
7. The plan includes measures to manager specific patient problems:
   a. what is to be done;
   b. how to do it;
   c. when to do it;
   d. where to do it; and
   e. who is to do it.

8. The plan is developed with the individual, to family, to pertinent others, and to health personnel as appropriate.

9. The plan is documented.

10. The plan provides for continuity of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:310 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3909. Standard Number 4: Implementation of Nursing Care Plan**

The plan for nursing care is implemented according to the following criteria.

1. Nursing actions are consistent with the plan for nursing care.

2. Interventions are implemented in a safe and appropriate manner.

3. Nursing actions are documented by:

   a. written records;

   b. observation of nursing performance;

   c. report of nursing action by the individual and/or pertinent others.

Documentation includes, but is not limited to, written records that attest to the care provided to patients based on assessment data and the patient's response to the intervention.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:310 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3911. Standard Number 5: Evaluation of Nursing Care Plan.**

The plan for nursing care is evaluated according to the following criteria.

1. Evaluation I systematic and ongoing;
2. Current data about the individual are used to measure progress toward established goals.
3. Nursing actions are analyzed for their effectiveness in achievement of established goals.
4. The individual, family, and other significant health care personnel participate in the evaluation of established goals.
5. The individual's response is compared with observable outcomes which are specified in the established goals.
6. The individual's responses to interventions are documented.
7. Determination is made of the long term effects of nursing care on the individual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:310 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3913. Standard Number 6: Continuous Process of Reassessment and Modification.**

The planning for nursing care is a continuous process of reassessment and modification, according to the following criteria.

1. Ongoing assessment data are used to revise diagnoses, outcomes, and the plan of care, as needed.
2. Revisions in diagnoses, outcomes, and the plan of care are documented.
3. The individual, significant others, and relevant health care providers are involved in the revision process; when appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 3:310 (July 1977), amended by the Department of Health and Hospitals, Board of Nursing, LR 24:1293 (July 1998).

**§3915 Standard Number 7: Professional Performance.**

The registered nurse demonstrates the following professional nursing practice behaviors:

1. Evaluates own nursing practice in relation to professional practice standards, relevant state and federal statutes, and relevant administrative rules.
2. Acquires and maintains current knowledge in nursing practice.
3. Considers factors related to safety, effectiveness, and cost in planning and delivering nursing care.
4. Nursing decisions and actions are determined in an ethical manner.
5. Clarifies any order or treatment regimen believed to be inaccurate, or contraindicated by consulting with the appropriate licensed

practitioner and by notifying the ordering practitioner when the registered nurse makes the decisions not to administer the medication or treatment.

6. Makes assignments to others that take into considerations patient safety and which are commensurate with the educational preparation experience, authorized scope of practice, knowledge and ability of the persons to whom the assignments are made.

7. Accepts only those nursing assignments that are commensurate with one's own educational preparation, experience, authorized scope of practice, knowledge and ability.

8. Reports to the board any unsafe nursing practice when there is reasonable cause to suspect actual harm or risk of harm to patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918.
HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 24:1293 (July 1998).

## HANDOUT #2

## PRESURE ULCER QUESTIONS

The questions were compiled by Dolores M. Alford, a pioneer for the humane treatment of nursing home residents. Many thanks to her for allowing these questions to be used.

1. Was a Pressure Ulcer Risk Assessment (e.g. Braden or Norton Scale) done initially and on a planned periodic basis?

2. Did the Care Plan use the risk data and did the Care Plan identity how each risk factor was to be resolved, mitigated, or controlled within a stated time frame?

3. Was there evidence of at least every two hour turning and repositioning?

4. Was there evidence that skin was not touching skin?

5. Was there evidence that the body was properly aligned to prevent contractures from forming, as contractures are a risk factor for skin breakdown?

6. Was there evidence of every hour (or more frequent) body lifts from the wheelchair or other chair?

7. Were bony prominences protected with cushions, pillows, and pressure relieving devices and mattresses? [NOTE: Eggerate mattresses and sheepskin are not pressure relieving devices.]

8. Was there evidence of assessment of skin at each turning and repositioning?

9. Was there evidence that incontinence was prevented, controlled, mitigated, or if impossible, was the resident cleaned promptly after each incontinent episode?

10. Was a comprehensive nutritional assessment done initially and periodically?

11. Was the diet prescription adequate to meet calculated nutritional and fluid needs?

12. Was the diet accepted and tolerated? If not, were changes made to accommodate the resident's wishes anti abilities?

13. Was the resident receiving at least the calculated fluids daily and was the output comparable to the intake?

14. Were linens kept clean and smooth and the bed free of food and soilage?

15. Was there sufficient help to turn, position, and transfer the resident without injuring the skin?

16. Was the resident's skin kept clean and moisturized?

17. Was there an effort to reduce drug therapy that placed the resident at risk for pressure ulcers?

18. Was there evidence that active/passive range of motion exercises were done at least every shift to prevent contractures and to promote circulation?

19. Was there evidence that the treatment ordered for the pressure ulcers was in accordance with current evidence-based best practices?

20. Was there evidence that this treatment was carried out as ordered?

21. Was there evidence that the nurses notified the physician in a timely manner (within 14 days) if the prescribed treatment was not effective?

22. Was there evidence of healing pressure ulcers if the resident came into the facility with these ulcers?

23. Was there evidence that no new pressure ulcers formed while the resident was in the facility?