MALPRACTICE LIABILITY IN LONG-TERM CARE: A CHANGING ENVIRONMENT

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Anxiety about professional malpractice liability has not consumed providers of long-term care in the United States with the same fervor that in the last two decades it has overwhelmed health care professionals and administrators who toil in acute care and medical office environments. Today, however, the American long-term care enterprise is in the midst of a very dynamic period, and changes taking place in the general environment of providing long-term care services to older adults may affect the potential liability exposure of a provider community that had been fairly well sheltered from the malpractice litigation explosion of the 1970s and 1980s.

This Article examines the current legal environment of long-term care and its possible liability consequences. Special emphasis is placed on the nursing home industry. After an introduction to relevant demographics and the structure of long-term care in the United States, the traditional underrepresentation of the elderly in malpractice litigation is discussed. This is followed by comments on the stirrings of interest in nursing home litigation among members of the plaintiffs' personal injury bar. Particular attention is paid to the potential ramifications of new federal nursing home regulations for the tort litigation climate, as well as the influence of voluntary or private standards of care and the network of resources from which attorneys representing nursing home patients may draw support.

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1. See Kapp & Markert, Legal Risk Management Programs in Nursing Homes: Who Has Them and Do They Work? 35 Hosp. Health Services Admin. 603, 603-10 (1990) (noting that nursing homes lag behind hospitals in setting up formal risk management programs, largely because apprehension of malpractice liability has not been a major factor).

THE DEMOGRAPHIC IMPERATIVE AND THE IMPORTANCE OF LONG-TERM CARE

The elderly, the population segment that is most at risk for needing long-term care services, is growing exponentially. In 1900, only twenty-five percent of the population lived beyond the age of sixty-five years, compared with seventy percent in 1985 (with thirty percent living beyond eighty). In 1900, persons age sixty-five and older made up four percent of the population, compared with twelve percent in 1985, of whom forty percent are at least seventy-five years old (expected to increase to fifty percent by the year 2000). The "oldest old," those older than eighty-five, are the fastest growing segment of both the general and the elderly population. Further reductions in cardiovascular mortality are expected to lead to continued increases in life expectancy.

In numerical terms, in 1990 the United States population included 31.3 million people over the age of sixty-five, a number that is expected to rise to 50.3 million by the year 2020. As the population of older people grows, so do both the national need for and the size of expenditures on long-term care services. Although only a small percentage of the elderly receive long-term care at any particular point in time — on the typical day, only 4.6% of the elderly reside in nursing homes — the identity of that population is constantly changing.
Hence, the number of older persons who may need long-term care services at some point in their lives is sizable. In 1990, 2.3 million people were in a nursing home at some time during the year and this figure is projected to increase to 4.0 million by 2020.\textsuperscript{11} Researchers at the federal Agency for Health Care Policy and Research ("AHCPR") estimate that more than one-half of the women and almost one-third of the men turning sixty-five in 1990 will spend some time in a nursing home before they die, and that seven out of ten couples now reaching sixty-five can expect at least one partner to be placed in a nursing home.\textsuperscript{12} Millions more older persons will receive home care services.\textsuperscript{13}

The scope of long-term care services is broad, encompassing diagnostic, preventive, therapeutic, and supportive services designed to help individuals compensate for severe, chronic physical and mental disabilities and functional impairments.\textsuperscript{14} This Article concentrates on the liability issues connected to one major portion of the long-term care industry, in terms of numbers of patients served and dollars consumed, namely, nursing homes. Other, non-institutional, forms of long-term care, such as home health care,\textsuperscript{15} adult day care, respite care, continuing or life care communities, congregate living arrangements, board and care homes, social health maintenance organizations ("SHMOs"), and hospices, are vital in both human and economic terms but are beyond the scope of this discussion.

TRADITIONAL UNDERREPRESENTATION OF THE ELDERLY IN MALPRACTICE CLAIMS

Older persons historically have been underrepresented statistically as plaintiffs in health care malpractice lawsuits.\textsuperscript{16} There are

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\textsuperscript{12} Otten, Nursing Homes Factor Into More Futures, Wall St. J., Apr. 23, 1990, at B1, col. 2.
\textsuperscript{13} A CALL FOR ACTION: FINAL REPORT, THE PEPPER COMMISSION, U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE 93-100 (S. Print 101-114, 1990).
\textsuperscript{15} On the legal aspects of home health care, see generally A. HADDAD, HIGH TECH HOME CARE: A PRACTICAL GUIDE 189-202 (1987); A. HADDAD & M. KAPP, ETHICAL AND LEGAL ISSUES IN HOME HEALTH CARE chs. 4, 6-9 (1991); Kapp, Improving Choices Regarding Home Care Services: Legal Impediments and Empowerments, 10 ST. LOUIS PUB. L. REV. —— (March 1991 — In Press).
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several possible explanations for the disparity between the relatively small number of civil liability claims initiated by the elderly against health care providers based on substandard treatment, on one hand, and the number of such claims that would be expected on the basis of percentage of older persons in the population and their disproportionately high rates of health care consumption, on the other. These factors discouraging litigation by the elderly are especially exacerbated where, as is usually the case for nursing home or home health patients, the potential plaintiffs are frail, seriously sick, and socially isolated from the outset of the provider/patient relationship.17

For one thing, recoverable monetary damages for older plaintiffs usually are low, since large amounts of future lost wages or out-of-pocket medical expenses tend not to be easily provable. Cases involving egregious patterns of patient abuse and neglect, thereby qualifying for the award of punitive or exemplary damages, have been the scenarios most likely to attract plaintiffs' attorneys working on a contingency fee arrangement, and thus to enter the legal system from the nursing home setting.18

Additionally, it frequently is difficult to prove that the provider's negligence was the proximate or direct cause of the injury19 for a patient who was very frail and debilitated already.20 Moreover, an older plaintiff who is severely compromised physically and mentally may not make a persuasive or credible witness on his or her own behalf, and sufficient supportive evidence from other sources may be difficult to uncover and present.21 Indeed, the lawsuit may outlive the older plaintiff. Where the older person lacks the physical or


19. For a discussion of the necessary elements of proof in a medical malpractice case based on negligence, see generally M. KAPP, PREVENTING MALPRACTICE IN LONG-TERM CARE: STRATEGIES FOR RISK MANAGEMENT 4-10 (1987).


mental wherewithal to initiate and prosecute a civil claim personally, there frequently is not available a willing, capable family member or friend to advocate on the injured party's behalf in gaining access to the legal system. Finally, even assuming the other hurdles could be overcome, many potential older plaintiffs who have received large amounts of health care funded by the state through the Medicaid program lack a financial incentive to sue the negligent provider. Many states would exert a right to be indemnified for their Medicaid expenditures on the patient's behalf out of any proceeds of a civil judgment, leaving the plaintiff only with the remainder.

STIRRINGS OF INTEREST IN LONG-TERM CARE ACTIONS

Despite the foregoing impediments, serious interest has begun to arise in the last few years within the plaintiffs' personal injury bar in the malpractice liability potential presented by the activities of the long-term care industry. For example, the American Trial Lawyers Association now contains a formal Nursing Home Litigation Group. In 1991, the Southern Trial Lawyers Association devoted one-third of its three day annual conference to this subject. Especially as nursing homes endeavor to cope with a generally sicker patient population, needing more subacute care as a result principally of earlier hospital discharges motivated by the financial incentives created by Prospective Pricing Systems ("PPS")/Diagnostic Related Groups ("DRGs"), the chances for professional negligence and resultant patient injury may become magnified. This section of the present Ar-

26. Swan, de la Torre & Steinhart, Ripple Effects of PPS on Nursing Homes: Swimming or Drowning in the Funding Stream? 30(3) GERONTOLOGIST 323, 326 (1990).
27. Kapp, Hospital Reimbursement by Diagnosis Related Groups: Legal and Ethical Implications for Nursing Homes, J. LONG-TERM CARE ADMIN., Fall 1986, at 20, 21; Timmreck, Legal and Administrative Aspects of Subacute Care, J. LONG-TERM CARE ADMIN., Fall 1988, at 24, 28.
article focuses on litigation opportunities involving nursing homes as institutional providers of long-term care services.

Multiple factors contribute to growing interest in nursing homes as potential malpractice defendants. First, substantial publicity surrounding several large nursing home-based punitive damage awards, as well as significant compensatory awards for pain, suffering, and emotional anguish, have had a ripple effect in garnering the attention of many plaintiffs’ attorneys. To counter the problem of older plaintiffs being outlived by their legal claims, some states statutorily afford chronological priority to certain categories of civil actions brought by plaintiffs above a specified age threshold. Some courts in recent cases have permitted actions for damages against nursing homes to be continued by a former patient’s estate after the patient has died.

In addition, not all states require prevailing plaintiffs in personal injury actions to indemnify the state for Medicaid expenditures incurred to pay for the plaintiff’s health care. Also, in some states it may be possible to invest the proceeds of a successful civil lawsuit in assets which are exempt from Medicaid consideration, such as improvements to the family home in which the patient’s relatives continue to live. In terms of burden of proof, courts may be convinced to show a more liberal attitude toward application of the doctrine of res ipsa loquitur against nursing homes alleged to have engaged in certain negligent or intentional torts (such as permitting pressure sores or ducubitus ulcers to develop and/or deteriorate), thereby facilitating plaintiffs in advancing their claims procedurally past directed

28. See Paasch & Manson, Nursing Home Chain to Pay $4.5 Million for Gross Neglect, Houston Post, April 19, 1986, at 1A; Wall St. J., Nov. 27, 1990, at B5 (reporting that a North Carolina state court ordered Hillhaven Corporation to pay $15 million in damages — $7.5 million punitive and $7.5 million compensatory — to the estate of a patient who had failed to receive a prescribed painkiller in the final months of his life). See generally P.J. STRAUSS, supra note 17, at 670-76. See supra note 18 and accompanying text.


31. See, e.g., State ex. rel. Department of Health and Human Services v. Brooks, 412 N.W.2d 613, 616 (Iowa 1987) (concluding that welfare department was not permitted to be subrogated to the proceeds of a personal injury judgment because the judgment did not include a medical expenses component). See also, e.g., NEW YORK PUBLIC HEALTH LAW § 2801(d)(5) (McKinney 1985).

verdicts and to jury deliberation. Finally, as discussed below, new federal and state statutes and regulations that envelop the nursing home industry should permit plaintiffs to establish negligence per se in many future malpractice cases.

LEGAL THEORIES AND FACT PATTERNS IN NURSING HOME LITIGATION

Civil litigation brought by or on behalf of a patient against a nursing home may involve a number of different kinds of fact patterns that support one or more of several legal theories. Most malpractice claims against nursing homes — as well as those brought against hospitals and other health care corporations — will be predicated on theories of either vicarious or corporate liability.

Individual health care professionals who act either under an employment or an independent contractual relationship with the nursing home in rendering care to patients are personally responsible for satisfying applicable acceptable professional standards, and may be held personally liable for unexcused deviation from those standards. In addition, negligent or intentional wrongdoing by individual professionals may be imputed to the employing or supervising nursing home under agency principles; the nursing home may be found vicariously liable for the acts or omissions of its employees or supervisees (including independent contractors, volunteers, and trainees), as long as the employee or supervisee was functioning within the scope of his or her employment or supervision. While nursing homes regularly negotiate indemnity or “hold harmless” clauses in their contracts with independent professionals or agencies, such clauses do not affect the right of a patient to assert the vicarious liability rationale, or alternatively the doctrine of apparent or ostensible agency, against the nursing home in the first place.

In practice, the vicarious liability argument often becomes blurred with the related concept of corporate liability. Under the lat-

obvious as that between falling and fracturing a hip); State v. Serebin, 119 Wis. 2d 837, 350 N.W.2d 65, 76-77 (1984).
33. See infra notes 126-44 and accompanying text.
36. On the topic of vicarious liability in the health care delivery context, see generally M. KAPP, LEGAL GUIDE FOR MEDICAL OFFICE MANAGERS 91-107 (1985); M. KAPP, supra note 19, at 58-63.
37. See generally J. Lowrey, Vicarious Liability, in MEDICAL AND HOSPITAL NEGLIGENCE ch. 13 (M. Zaremski & L. Goldstein eds.).
ter theory, a nursing home, as a distinct corporate entity, forms a separate and independent relationship with its patients and owes each of them a direct, non-delegable duty of due care. If a breach of this duty proximately causes a patient's injury, the facility itself will be held directly liable, even though an employee or independent contractor actually committed the specific error or omission proximately resulting in the patient's injury.38

A panoply of fact patterns may give rise to vicarious or corporate liability claims by or on behalf of patients in the nursing home context. Unlike acute care hospitals, where the vast majority of malpractice complaints allege errors and omissions concerning distinct, specific events relating to diagnostic or therapeutic (especially surgical) procedures, the major areas of potential nursing home liability entail relatively longer standing patterns or habits of overall care (or lack of care),39 where corrections could have been, but were not, made. This difference in the underlying factual bases of legal exposure reflects fundamental differences in societal and individual patient expectations between nursing homes, on one hand, and acute care hospitals, on the other. Hospitals are expected to be essentially intensive, short-term, usually curative medically-oriented institutions exclusively. Public attitudes toward nursing homes, conversely, are more schizophrenic. We expect nursing homes to provide optimal medical and nursing care to its patients, but also to operate as more—as total institutions ministering to the long-term psychosocial, emotional, spiritual, and everyday residential needs of their patients.40 Both a medical and a homelike model are demanded simultaneously. Thus, in the nursing home context, the role of individual patient rights41 and potential liability for their transgression take on special importance.

The largest single source of negligence claims against nursing homes is patient injury associated with falls or wandering.42 Since the pervasive fear of liability based on patient falls or wandering has, at least in part, fueled an excessive reliance over the years in Ameri-

39. For cases imposing liability for longstanding patterns of neglect, see supra note 18.
41. Federal regulations concerning the rights of nursing home inhabitants, discussed at notes 126-44, infra, and accompanying text, refer to those inhabitants as "residents" rather than patients, and this is the terminology widely preferred by most advocates of these individuals.
42. Johnson, 18 L. MED. & HEALTH CARE at 264.
can nursing homes on the use of physical (mechanical) and chemical (drug) restraints in a purported attempt to assure resident safety,\textsuperscript{43} the liability implications of falls and wandering and the practice of using restraints\textsuperscript{44} must logically be discussed together.

Contrary to popular belief in some provider circles,\textsuperscript{45} routine employment of restraints on nursing home residents is not effective defensive medicine or good legal risk management. In fact, the exact opposite conclusion is true. Namely, indiscriminate, routine employment of restraints is a practice that has led in the past, and will lead even more in the future, to malpractice liability exposure that is clearly more substantial—in lawsuit frequency and severity—than the quite limited exposure associated with the non-imposition of restraints.

Of those relatively few negligence lawsuits that have been brought against nursing homes based on resident falls or wandering that happened when the resident was unrestrained, many have resulted in judgments for the defendant absolving it of any blame for failure to restrain.\textsuperscript{46} A typical judicial opinion held that "[a] nursing home is not the insurer of the safety of its patients. The standard of care imposed upon a nursing home is that of reasonable care considered in light of the circumstances existing at the time of the occurrence in question."\textsuperscript{43}

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erating the patient’s known mental and physical condition.”

Further, the courts in most of these cases relied on the facility’s compliance with applicable federal and state regulations regarding the safeguarding of resident welfare in holding that the facility had satisfied the legal standard of care, even if resident injury unfortunately took place anyway. This tendency toward judicial deference to regulatory standards as defining minimum acceptable levels of conduct for tort litigation purposes (i.e., the “negligence per se” doctrine) takes on added importance in light of the Nursing Home Quality Reform Act and its implementing regulations, discussed below, and parallel state laws.

Further, even in those cases where nursing homes or their personnel have been found liable for injuries incurred by unrestrained patients who fell or wandered into danger’s path, no lawsuit has been successfully brought against a nursing home yet solely because the nursing home failed to restrain the patient. Prevailing nursing home plaintiffs in non-restraint cases have had to prove by a preponderance of the evidence the presence of one or more other elements of negligence or deviation from the professionally acceptable standard of care, such as improper assessment of the patient’s needs; a failure to monitor the patient’s condition and supervise his or her care adequately, especially where the patient’s ability to function physically and mentally is substantially impaired by the administra-

49. See infra notes 126-44 and accompanying text.
tion of sedative drugs; inadequate documentation concerning patient care; failure to respond to the falling or wandering in a timely and professionally acceptable manner; unreasonable staff conduct which placed the unrestrained resident in jeopardy in the first place; or failure generally to provide needed, reasonable services to the patient.

Importantly, even when finding nursing homes liable where restraints were not used, the courts have consistently emphasized that the facilities could have fulfilled their responsibilities acceptably by implementing means of monitoring and supervising patients other than by imposing restraints. In other words, no court has held that restraining a patient was the only way a nursing home could have satisfied its obligation of due care. This line of cases thus haltingly


55. See, e.g., Kujawski v. Arbor View Health Care Center, 139 Wis. 2d 455, —, 407 N.W.2d 249, 250 (1987) (pushing unrestrained patient in a wheelchair, stopping suddenly, and resulting in the patient being thrust out of the chair) (case settled prior to retrial).


57. See, e.g., Robinson v. United States, No. K85-349 CA (U.S. Dist. Ct. W.D. Mich. 1987). The court held that Veterans Administration medical staff should have monitored and supervised the patient or ordered restraints as needed.

The evidence is clear in the Court's mind and the Court finds that it is unreasonable to expect that Mr. Robinson be restrained 24 hours a day. And to the extent that the staff has not restrained him 24 hours a day, the Court's judgment is that there has not been a violation of the appropriate standard of care in this case. So it is not negligence based on the Court's review of the circumstances in this case to not restrain Mr. Robinson 24 hours a day.

Id. See also Krestview Nursing Home, Inc. v. Synowiec, 317 So. 2d 94, 95 (Fla. Dist. Ct. App. 1975), cert. denied, 333 So. 2d 463 (Fla. 1976); McGillivray v. Rapides Iberia Management Enters., 493 So. 2d 819, 823 (La. Ct. App. 1986) (stating "The findings below refer not to the failure of nurses to place Mr. Fox in the harness that night, but to their failure to guard against his leaving the premises.").
tolerates the use of restraints, but by no means compels or even encourages it.\textsuperscript{58} In several cases, nursing homes actually had implemented appropriate alternatives to the use of restraints, such as purchasing and installing alarm systems, but those systems were not working properly (either because they had broken down and were not repaired, or they had been intentionally dismantled by staff as a matter of convenience) at the time of the patient injury.\textsuperscript{59}

Even in non-restraint cases where plaintiffs have prevailed, the size of judgments or settlements ordinarily has been modest. The courts have disfavored the awarding of punitive damages in these legal actions.\textsuperscript{60} It is noteworthy that in cases holding facilities liable for resident injuries happening in the absence of restraints, the defendant nursing homes generally had not been complying with relevant federal or state statutory and regulatory requirements regarding minimum precautions for resident safety at the time of the injury. In light of the new requirements of the federal Nursing Home Quality Reform Act and its implementing regulations and corresponding state statutes and regulations on this subject, it will be quite unlikely for a court in the future to impose liability on a facility that is in compliance with legislative and regulatory requirements and limitations explicitly concerning the imposition of and alternatives to restraints, even where patient injury occurs.

Future legal exposure of nursing homes associated with falls and wandering actually is likely to be much greater in the presence, rather than the absence, of restraints. A careful review of both the clinical literature and case law precedent support this prediction.

Numerous epidemiological studies conducted over a long period of time\textsuperscript{61} demonstrate that the chance of morbid patient outcomes, including injurious falls,\textsuperscript{62} increases significantly with the prolonged

\textsuperscript{58} See, e.g., Juhnke v. Evangelic Lutheran Good Samaritan Soc'y, 6 Kan. App. 2d 744, —, 634 P.2d 1132, 1137 (1981); Associated Health Systems, Inc. v. Jones, 185 Ga. App. 798, —, 366 S.E.2d 147 (1988) (suggesting that a patient who posed a danger to other patients could have been restricted away from certain areas where the other patients congregated); Golden Villa Nursing Home, Inc. v. Smith, 674 S.W.2d 343, 348 (Tex. Ct. App. 1984) (acknowledging that what constitutes reasonable care necessarily varies according to the circumstances).


\textsuperscript{61} The adverse effects of physical restraints have been recognized in the medical literature for a long time. See, e.g., McLardy-Smith, Burge & Watson, Ischaemic Contracture of the Intrinsic Muscles of the Hands — A Hazard of Physical Restraint, 11-B(1) J. HAND SURGERY, Feb. 1986, at 65-67; Miller, Iatrogenic and Nurisgenic Effects of Prolonged Immobilization of the Ill Aged, 23 J. AM. GERIATRICS SOC'Y 360 (1975).

\textsuperscript{62} See Tinetti & Speechley, Prevention of Falls Among the Elderly, 320 NEW
use of mechanical (as well as chemical) restraints. Patients get injured—sometimes fatally—and trying to escape from their restraints (for example, by trying to climb over siderails to get out of bed) while strangling and suffocating, or otherwise losing control because of improperly applied restraints (for instance, Posey vests being put on the resident backwards), or due to staff failure to monitor and adjust restraints at regular, timely intervals. The range of potential physical and psychological problems associated with restraint use, especially over a prolonged period of time, is very broad, including difficulties with skin, the gastrointestinal and genito-urinary systems, respiration, blood circulation, and musculo-skeletal functioning, as well as anxiety, confusion, panic, depression, and lethargy. The risk of nosocomial infections is vastly magnified for the physically immobilized patient. The nursing home patient's psychological problems caused by restraints often cause behavioral abnormalities in the form of withdrawal from any

ENG. J. MED. 1055, 1055-59 (1989) (noting that patients who were restrained most of the time still had a high incidence of falls).


64. See four-part series by J. Rigert & M. Lerner, Staff Writers, For the Frail and the Elderly, Restraints Are Often Deathtraps (Dec. 2, 1990); Company and FDA Have Done Little to Prevent Deaths (Dec. 3, 1990); Finding Alternatives to Restraints: Innovators Learning to Balance Safety and Freedom (Dec. 4, 1990); His Mind and Body Wander, So His Life Is In Bonds (Dec. 5, 1990), Minneapolis Star Tribune.


68. On psychological problems of nursing home patients directly linked to being subjected to physical restraints, see, e.g., Mion, Frengley, Jakovic & Marino, A Further Exploration of the Use of Physical Restraints in Hospitalized Patients, 37 J. AM. GERIATRICS Soc'Y 949 (1989).

69. For a litany of adverse effects of physical restraints on nursing home patients, see S. BURGER, INAPPROPRIATE USE OF CHEMICAL AND PHYSICAL RESTRAINTS: AN OMBUDSMAN'S RESOURCE PAPER FOR EFFECTIVE ADVOCACY AND AN IN-SERVICE TRAINING GUIDE FOR OMBUDSMEN (National Citizens' Coalition for Nursing Home Reform for the National Center for State Long Term Care Ombudsman Resource Center: Washington, DC (1989)).

social interaction or, at the other end of the spectrum, aggressive actions toward staff or other patients. The latter type of behavior in turn frequently is cited to justify the continued use of restraints. The result characteristically is a vicious cycle leading to greater loss of freedom and higher morbidity.

Bad clinical outcomes, particularly where they are unexpected by the patient or family, are the most reliable leading indicator of eventual lawsuit initiation. Additionally, the rate of serious patient injury falls (over two-thirds of falls in nursing homes are not associated with serious injuries) does not increase appreciably in situations where restraints have been withheld. Put differently, unrestrained patients do not tend to suffer more serious falls than do restrained patients with similar personal characteristics.

In light of the number of nosocomial and iatrogenic injuries occasioned by the imposition of physical restraints, it is understandable that in quantitative terms, cases holding providers liable in the absence of nursing home restraints are far eclipsed by legal judgments rendered and settlements made on the basis of inappropriate ordering of restraints, failure to monitor or correct their adverse effects on the patient, or errors in the mechanical application of the restraint. Claims have been filed on the theories of both negligence,

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74. See, e.g., Tinetti, Liu & Ginter, Falls and Injuries Among High Risk Nursing Home Residents Who Are and Are Not Physically Restrained (Abstract), 38 (2) CLINICAL RES. 517A (Apr. 1990) (finding that 100% of the people constantly restrained fell, while the lowest falling percentage were in the never restrained category and the highest serious injury incidence was among the constantly restrained).
75. See, e.g., Frengley & Mion, Incidence of Physical Restraints on Acute General Medical Wards, 34 J. AM. GERIATRICS SOC'Y 565, 567 (1986); Robbins, Boyko, Lane, Cooper & Jahngen, Binding the Elderly: A Prospective Study of the Use of Mechanical Restraints in an Acute Care Hospital, 35 J. AM. GERIATRICS SOC'Y 290, 293-94 (1987).
or unintentional deviation from acceptable professional standards, and battery—the intentional, unconsented-to invasion of the resident’s personal, physical, or mental integrity. In some cases, patient injuries have so obviously been caused by the improper use of restraints that the court has dispensed with the usual procedural requirement of expert testimony and instead has instructed the jury on the basis of the doctrine of res ipsa loquitur (“the thing speaks for itself”).

As the use of physical restraints is reduced in the future in response to enhanced provider appreciation of the true relative legal risks involved and under the mandate of the new federal nursing home law and implementing federal regulations and state laws, nursing homes will not be able, without incurring substantial liability risk, simply to substitute psychoactive medications as an alternative means of attempted behavior control. Besides the litigation possibilities connected to the substantial risk of severe drug side effects, noted above, the Nursing Home Quality Reform Act and implementing regulations are, as discussed below, quite explicit in their limitations on the permissible extent of psychoactive drug prescription.

Another expanding area of nursing home malpractice litigation consists of cases in which patients are shown to suffer from bedsores, also known as pressure sores or decubitus ulcers. The two major causes of decubitus ulcers, which in later stages can involve deep destruction of fat, muscle, joints, and bone, are unrelieved pressure on the skin in one spot and poor nutritional status. Where a plaintiff can show that injury was caused by the nursing home’s failure to render proper ordinary nursing care, including regular monitoring and repositioning of the patient’s body and maintenance of good nu-

78. See generally J. King, Jr., THE LAW OF MEDICAL MALPRACTICE IN A NUTSHELL § 2 (1986 2d Ed.).
79. See generally id., at 180-81.
81. See supra note 63.
82. See infra note 136.
83. Cf. 42 C.F.R. § 483.25(c) (1990) (stating, “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.”)
tritional status, legal recovery — including punitive damages in cases of especially outrageous patient neglect in permitting the ulcer to begin and then proceed untreated — may be available. These are often the sort of fact patterns that make a deep and shocking impression on juries.

Another potential source of nursing home litigation is violation of the provisions contained in the written admission agreement routinely executed between the nursing home and the patient or his or her legal surrogate at the time the patient enters into the facility. Federal and state statutes and regulations influence the content of these admission agreements, in response to nursing home industry abuses perpetrated in the past, such as facilities requiring patients or their families to sign waivers of the right to impose future liability on the facility even if the patient were to be negligently harmed. Since admission agreements now at least implicitly incorporate by reference federal residents' rights regulations, violation of any of those rights should give rise to a private right of civil action by, or on behalf of, the patient (the intended beneficiary of the enumerated rights) under a breach of contract theory. Many courts already read into admission agreements a promise by the nursing home to comply with all relevant governmental statutes and regulations.

Other potential rationales supporting future malpractice actions against nursing homes include breach of implied warranties of good care, violation of federal and state consumer protection laws, and

88. E.g., Guerin v. New Hampshire Catholic Charities, Inc., 120 N.H. 501, 418 A.2d 224 (1980) (recognizing that the fact that the alleged elements would also support a tort action does not preclude a contract action).
permitting or coercing residents to participate as human subjects in biomedical or behavioral research projects without their valid informed consent and investigator compliance with Institutional Review Board requirements. The question of research participation is likely to gain added importance as larger numbers of nursing homes affiliate with various academic institutions and programs.

Although issues revolving around decisions for the abatement of life-sustaining medical interventions for critically ill patients have engendered tremendous liability-related consternation among long-term care providers, the malpractice and adverse regulatory implications of withholding or withdrawing such interventions from a patient are extremely slight when the provider has acted consistently with the expressed or implied wishes of the patient or, alternatively, with the patient's best interests. However, several battery lawsuits have been brought recently against health care institutions for inflicting unwanted life-sustaining treatment on critically ill patients. The general practice climate surrounding these issues and the nursing home's realistic obligations and liabilities will be influenced significantly by passage of the Patient Self-Determination Act by Congress in late 1990, which requires nursing homes (as well as other health care providers) to inform patients or their surrogates of

See also Cohen, Long-Term Care: A Challenge to Concerted Legal Techniques, 2 OHIO N.U.L. REV. 642, 683 (1975); Regan, When Nursing Home Patients Complain: The Ombudsman or the Patient Advocate, 65 GEO. L.J. 691, 713 (1977).


96. See generally Kapp, Nursing Homes As Teaching Institutions: Legal Issues, 24 GERONTOLOGIST 55, 55-60 (1984); M. KAPP, supra note 4, at ch. 10.


100. This Act was included as § 4206 (Medicare) and § 4751 (Medicaid) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990).
the patient's rights and of institutional and state policies and procedures concerning the use or non-use of life-sustaining medical interventions and to inquire of patients or their surrogates about the existence or desired execution of advance instruction directives such as living wills and proxy directives such as durable powers of attorney.\textsuperscript{101}

**VOLUNTARY STANDARDS**

The significance of voluntary, that is, private or non-governmental, standards in long-term care as a source of competent and relevant evidence in professional malpractice actions is likely to increase in the coming years. For example, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") surveys and certifies nursing homes under its private standards.\textsuperscript{102} JCAHO survey reports may be publicly available records, depending on individual state law. Although a relatively limited percentage of nursing homes currently participate in the JCAHO accreditation program, this is likely to change drastically if a recent federal proposal to grant JCAHO nursing home accreditation "deemed status" for Medicare payment purposes,\textsuperscript{103} such as presently exists for acute care hospitals,\textsuperscript{104} comes to fruition. Even without that development, courts may be persuaded to admit JCAHO standards as probative, albeit not conclusive, evidence in malpractice actions brought against nursing homes.\textsuperscript{105}

Numerous different types of professionals work within nursing homes, and many prominent professional organizations have promulgated private guidelines or standards that are relevant to the conduct of those professionals working within the nursing home context.\textsuperscript{106} These guidelines or standards may be introduced as evidence in malpractice trials on the issue of the legally acceptable standard of care. Nursing homes must assure that applicable professional standards be maintained by all of the facility's employees and independent contractors. The continuing development of clinical practice parameters,


\textsuperscript{102} THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, LONG TERM CARE STANDARDS MANUAL 133-46 (1990).


\textsuperscript{104} 42 U.S.C. §§ 1395x(e), 1395bb (1988).


with all their attendant legal implications,\textsuperscript{107} certainly will eventually have consequences for nursing homes and proof of appropriate standards of long-term care.

\textbf{PATIENT ADVOCACY NETWORK}

Largely owing to broad-based historical public distrust of nursing homes and the quality of care they offer, and the strong impression that nursing home patients often are socially isolated and physically and mentally unable to speak for themselves, an extensive external advocacy and protection network has arisen to represent and speak on behalf of nursing home patients. The existence of this advocacy network, the necessity for nursing homes to deal constructively with its various components, and the availability of this network and its valuable informational and manpower resources to the plaintiffs' bar\textsuperscript{108} in many ways may increase the probability of more nursing home malpractice litigation in the coming years.

The centerpiece of this network is the system of State Long-Term Care Ombudsman offices\textsuperscript{109} established under the federal Older Americans Act ("OAA"). 1987 amendments to the OAA broadened the authority of the Ombudsman, operated by the state Departments or Offices on Aging, with power often delegated to local units, to secure access to long-term care patients and their medical records, for purposes of facilitating patient advocacy.\textsuperscript{110} State and local Ombudsman offices generally maintain a close working relationship with local legal aid programs to obtain assistance of legal counsel in situations where an informal negotiation process is unproductive in resolving conflicts between the patient and the nursing home. In several highly publicized cases,\textsuperscript{111} public prosecutors have sought to impose criminal liability on a nursing home corporation and selected administrative and professional staff members for patient injuries, in-

\begin{itemize}
  \item \textsuperscript{107} See Kapp, 'Cookbook' Medicine: A Legal Perspective, 150 ARCHIVES INTERNAL MED. 496, 496-500 (1990).
  \item \textsuperscript{108} See Butler, Nursing Home Quality of Care Enforcement, Part I—Litigation by Private Parties, 14 CLEARINGHOUSE REV. 622 (1980); Regan, 85 GEO. L.J. at 691.
  \item \textsuperscript{109} See NATIONAL ASSOCIATION OF STATE UNITS ON AGING, COMPREHENSIVE ANALYSIS OF STATE LONG-TERM CARE OMBUDSMAN OFFICES (Sept. 1988). See also NATIONAL ASSOCIATION OF STATE UNITS ON AGING, ANALYSIS OF POLICIES AND PROCEDURES OF STATE LONG TERM CARE OMBUDSMAN OFFICES (Sept. 1988). In 1989, a new resource center for State Long-Term Care Ombudsman programs was established jointly by the National Association of State Units on Aging ("NASUA") and the National Citizens' Coalition for Nursing Home Reform ("NCCNHR"). It may be contacted at: Center, 2033 K Street, N.W., Suite 304, Washington, DC 20006.
  \item \textsuperscript{111} See S. LONG, DEATH WITHOUT DIGNITY (1987). See also People v. T. & S. Leasing, Inc., 763 P.2d 1049, 1051 (Colo. 1989).
\end{itemize}
cluding death. Information discovered during the course of criminal investigations by state Attorneys General and by local prosecutors offices, and certainly information that is introduced into evidence as a matter of public record, can be potent ammunition for plaintiffs' attorneys seeking to hold nursing homes civilly liable for the same or a related pattern of conduct. Criminal convictions may be utilized for impeachment purposes during cross-examination.

Most individual nursing homes have created Residents' Councils and Family Councils to discuss the concerns and desires of residents and families. Although ordinarily these mechanisms work to resolve potential problems and grievances at an incipient stage and without formal legal involvement, occasionally this process is unsuccessful and the Council's dissatisfaction with the facility's position can stimulate and inform a plaintiff's attorney in the commencement of legal action against the nursing home. Other potential sources of information and assistance for the plaintiffs' bar include local legal aid offices, many of which have special programs funded through the Older Americans Act and/or the Legal Services Corporation, that focus on the elderly generally or nursing home patients specifically, and local Adult Protective Services (APS) agencies, especially where alleged abuse and neglect is an issue. Through the Older Americans Act, Congress finances several national legal resource centers that concentrate on supporting attorneys representing older persons, including those who reside in nursing homes. These national resource centers include the American Bar Association Commission on Legal Problems of the Elderly,112 American Association of Retired Persons/Legal Counsel for the Elderly,113 National Senior Citizens Law Center,114 Center for Social Gerontology,115 National Bar Association,116 and National Clearinghouse for Legal Services.117

In sum, this pervasive external advocacy network of public and private watchdogs intentionally creates for nursing homes a very different legal environment than is found in hospitals, where most patient care activities take place well outside the continuous scrutiny of external monitors. Members of the long-term care advocacy network increasingly recognize private malpractice litigation as an acceptable and sometimes desirable instrument for improving the quality of care

112. 1800 M Street, N.W., Washington, DC 20036.
113. 1909 K Street, N.W., Washington, DC 20049.
114. 2025 M Street, N.W., Washington, DC 20036 or 1052 W. 6th Street, 7th Floor, Los Angeles, CA 90017.
115. 117 N. First Street, Suite 204, Ann Arbor, MI 48104.
116. 1225 11th Street, N.W., Washington, DC.
117. 407 S. Dearborn, Suite 400, Chicago, IL 60605.
in nursing homes and are willing to work closely with the plaintiffs' bar in promoting that goal.

FEDERAL MEDICARE/MEDICAID STATUTES AND REGULATIONS

The federal government has set mandatory standards since the early 1970s for nursing homes that chose to participate in the Medicare and Medicaid programs. Enforcement of these federal standards is accomplished through regular survey and certification conducted by a state administrative agency (usually the state health department) which has been designated for that purpose by contract between the state and the federal government. The federal Health Care Financing Administration (HCFA), the part of the Department of Health and Human Services (HHS) that administers Medicare and Medicaid, provides the state survey agency with Interpretive Guidelines, compiled in the Medicaid State Operations Manual, and a survey form for use during facility surveys. Frequently, state surveys examine facilities for compliance with both the federal standards and particular state standards at the same time. Violation of federal standards may lead to decertification of the facility from participation in Medicare or Medicaid financing, while failure to satisfy state requirements may result in serious penalties such as delicensure or intermediate sanctions including civil fines, restrictions on new admissions, or receivership. Violations of federal and state statutory and regulatory standards also may be introduced into evidence in civil tort actions either as some probative evidence of the minimally acceptable standard of care, as prima facie evidence of the standard of care, or to establish negligence per se. Inspection reports are widely available to the public; under the Omnibus Budget Recon-

118. Social Security Act, Title 18 (codified at 42 U.S.C. § 1395i-3 (1988)).
119. Social Security Act, Title 19 (codified at 42 U.S.C. § 1396r (1988)).
120. For a general description of the Medicare/Medicaid regulatory system, see Kapp, State of the Law: Nursing Homes, 18 L. MED. & HEALTH CARE 282, 282-89 (1990).
ciliation Act of 1990 (OBRA 90). HCFA and the states must release survey results within fourteen days after the results have been sent to the surveyed facility.

As noted at several points earlier in this Article, the federal government recently has made some important changes in its standards for nursing homes that participate in the Medicare and Medicaid programs. Still more significant modifications are in the developmental pipeline as this Article is written. The early 1990s are very much a time of flux for nursing home regulation.

As part of the Omnibus Budget Reconciliation Act of 1987 ("OBRA 87"), Congress enacted the Nursing Home Quality Reform Act. This statute is modeled on many of the recommendations proposed in a 1986 Institute of Medicine report that Congress had directed HCFA to commission. Passage of the 1987 legislation represents the impatience of Congress (and, indirectly, of the courts) with what they perceived as the inadequate and ineffectual regulation of nursing homes by HHS. The 1987 statute amends Titles 18 and 19 of the Social Security Act to require substantial upgrading in nursing home quality and enforcement in several areas.

To implement this legislation, HCFA published "final" regulations (with a public comment period) on February 2, 1989. These regulations became effective on October 1, 1990. Among the most significant requirements imposed by these regulations are those relating to ensuring patient privacy and decisional rights regarding accommodations, medical treatment, personal care, visits, written and telephone communications, and meetings with others; maintaining confidentiality of personal and clinical records; guaranteeing facil-

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127. COMMITTEE ON NURSING HOME REGULATION, INSTITUTE OF MEDICINE, IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).
128. See, e.g., Special Committee on Aging, U.S. Senate: Hearing on Nursing Home Survey and Certification — Assuring Quality of Care, 97th Cong., 2d Sess. (July 15, 1982).
ity access and visitation rights to persons of the patient’s choosing;\(^{133}\) requiring issuance of notice of rights at the time of admission;\(^{134}\) implementing admissions policy requirements;\(^{135}\) ensuring proper use of physical restraints and psychoactive drugs;\(^{136}\) protecting patient funds being managed by the facility;\(^{137}\) ensuring transfer and discharge rights, and issuing related notices;\(^{138}\) requiring a minimum amount of nursing\(^{139}\) and social work\(^{140}\) coverage; requiring comprehensive resident assessments and individualized care plans drawn in accordance with those assessments;\(^{141}\) and requiring state prescreening (according to yet to be developed federal criteria) of all prospective nursing home admittees, and prohibiting admission of individuals with mental illness or mental retardation, unless they specifically

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134. 42 C.F.R. § 483.10 (b) (1990).
136. See supra notes 42-82 and accompanying text. The Interpretive Guidelines to these regulations define physical or mechanical restraints as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.” U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, MEDICAID STATE OPERATIONS MANUAL, TRANSMITTAL 232, Sept. 1989, Interpretive Guidelines for Feb. 2, 1989, at P-51 (interpreting 42 C.F.R. § 483.13 (a)). The regulation itself provides that:

The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.

42 C.F.R. § 483.13(a) (1990). The OBRA 87 statute goes even further:

Restrains may only be imposed to ensure the physical safety of the resident or other residents, and only upon the written order of a physician that specifies the duration and the circumstances under which the restraints are to be used (except in emergency circumstances which are to be specified by the Secretary) [of HHS] until such an order could reasonably be obtained.


Regulations implementing OBRA 87 guarantee nursing home patients “the right to be free from any . . . psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.” 42 C.F.R. § 483.13(a) (1990). See also 42 C.F.R. § 483.251(1)(1) (1990) (stating, “Each resident’s drug regimen must be free from unnecessary drugs.”); 42 C.F.R. § 483.251(1)(2) (1990) (stating that a patient for whom antipsychotics have not been used previously may be given them only to treat a specifically identified condition; patients using antipsychotic drugs must receive gradual dose reductions or drug holidays.).

137. 42 C.F.R. § 483.10(c) (1990). These regulations are long overdue. See I. COHEN & M. KAPP, Regulations Implementing the Anti-Fraud and Abuse Amendments, in PROCEEDINGS OF THE NATIONAL HEALTH LAWYERS ASSOCIATION’S FOURTH ANNUAL PROGRAM ON LONG-TERM CARE AND THE LAW 149, 156-59 (J. Skiba ed. 1979).


140. 42 C.F.R. § 483.15(g) (1990).
need nursing services.\textsuperscript{142}

As noted above, HCFA is still in the process of developing additional regulations based on the OBRA 87 legislation. Proposed rules were published on March 22, 1990 on the subject of patient personal funds\textsuperscript{143} and on March 23, 1990 on the subjects of nurse aide training and competency evaluation programs and Preadmission Screening and Annual Resident Review.\textsuperscript{144} These regulations would clarify and expand upon provisions in the February 2, 1989 regulations. Further, HCFA currently is working on additional regulations to expand on and clarify requirements concerning the acceptable use of physical restraints and psychoactive drugs, and in other areas.

In addition to federal requirements tied to Medicare and Medicaid, regulation of nursing homes by individual states under their public health licensure (police power)\textsuperscript{145} authority is extensive, with specific requirements often exceeding those set on the federal level, especially regarding patient rights.\textsuperscript{146} Many states, such as Ohio,\textsuperscript{147} have just enacted or currently are in the process of making necessary legislative amendments to bring their requirements into conformity with OBRA 87. Nursing homes are also subject to state and local fire and building codes and similar business-related safety provisions.

**RELEVANCE OF STATUTORY AND REGULATORY STANDARDS TO MALPRACTICE LITIGATION**

For a number of reasons, federal and state statutes and regulations that contain requirements that nursing homes must satisfy for the purposes of Medicare and Medicaid participation and facility licensure may increase the potential future malpractice liability exposure of nursing homes. Patients could thus receive a double protection, in terms of both economic recovery for injuries and improvement in the quality of care, from the combination of strengthened administrative and tort standards and remedies.

First, as noted,\textsuperscript{148} under OBRA 90 state Medicare and Medicaid survey results must be released to the public within fourteen days of

\textsuperscript{142} 42 C.F.R. § 483.20(f) (1990). (This is referred to as the PASSAR requirement, for Preadmission Screening and Annual Resident Review).
\textsuperscript{143} 55 Fed. Reg. 10256.
\textsuperscript{144} 55 Fed. Reg. 10938.
\textsuperscript{147} Ohio Amended Substitute House Bill 822, approved by the Governor on December 13, 1990 (codified at OHIO REV. CODE § 3721.13).
\textsuperscript{148} See supra note 124 and accompanying text.
their transmittal to the surveyed nursing home. State licensure inspection reports usually are public records under specific state law.\textsuperscript{149} Additionally, HCFA issues an annual multi-volume compilation of Medicare/Medicaid survey results for all participating nursing homes in the United States. All of this information may facilitate potential plaintiffs and their attorneys in deciding to initiate legal action against a particular nursing home.

Second, the information generated by and publicly accessible through federal and state inspection processes may assist plaintiffs in proving their claims during litigation. As explained earlier,\textsuperscript{150} statutes and regulations may be introduced into evidence either as probative or prima facie on the issue of applicable tort or contract standards, or to establish negligence per se solely on the basis of their violation. At the least, deficiency reports issued by surveying agencies may be introduced at trial as proof that the facility had been placed on actual notice of its deficiencies that should have been corrected.\textsuperscript{151} Statutes and regulations may also be interpreted as creating implied warranties of habitability and due care under the circumstances.\textsuperscript{152}

Perhaps most important, OBRA 87 and its implementing regulations arguably create a clear private right of civil action against the nursing home where violation of the standard directly causes a patient injury. Protection of patient health and welfare was the undeniable intent of Congress in enacting the legislation and commanding administrative implementation by HHS.\textsuperscript{153} Many state acts specifically authorize a private right of action for money damages to enforce their provisions,\textsuperscript{154} and some provide for recovery of greater than actual damages to deter substandard practice by facilities.\textsuperscript{155}

CONCLUSION

A confluence of contemporary social forces are acting to alter fundamentally the character of long-term care services, including

\begin{itemize}
  \item \textsuperscript{150} See supra note 123 and accompanying text.
  \item \textsuperscript{151} Montgomery Health Care Facility, Inc. v. Ballard, 565 So. 2d 221, 224 (Ala. 1990).
  \item \textsuperscript{152} See supra notes 93-94 and accompanying text.
  \item \textsuperscript{153} See Edelman, 24 CLEARINGHOUSE REV. at 549.
  \item \textsuperscript{154} See, e.g., CAL. HEALTH AND SAFETY CODE § 1430 (1990); ILL. ANN. STAT. ch. 111 1/2, para. 4153.601 (Smith-Hurd 1988).
  \item \textsuperscript{155} See, e.g., ILL. ANN. STAT. ch. 111 1/2, para. 4153.602 (allowing for treble damages).
\end{itemize}
nursing home care, in the United States. These forces and the changes in practice that they inspire shape the legal environment within which long-term care providers deliver their services to patients in need. While it is difficult to predict with confidence, the dynamic legal environment of long-term care may well facilitate significantly increased malpractice liability exposure as patients and their families and attorneys discover and pursue nursing homes and non-institutional long-term care providers as a fertile source of financial recovery in the future.