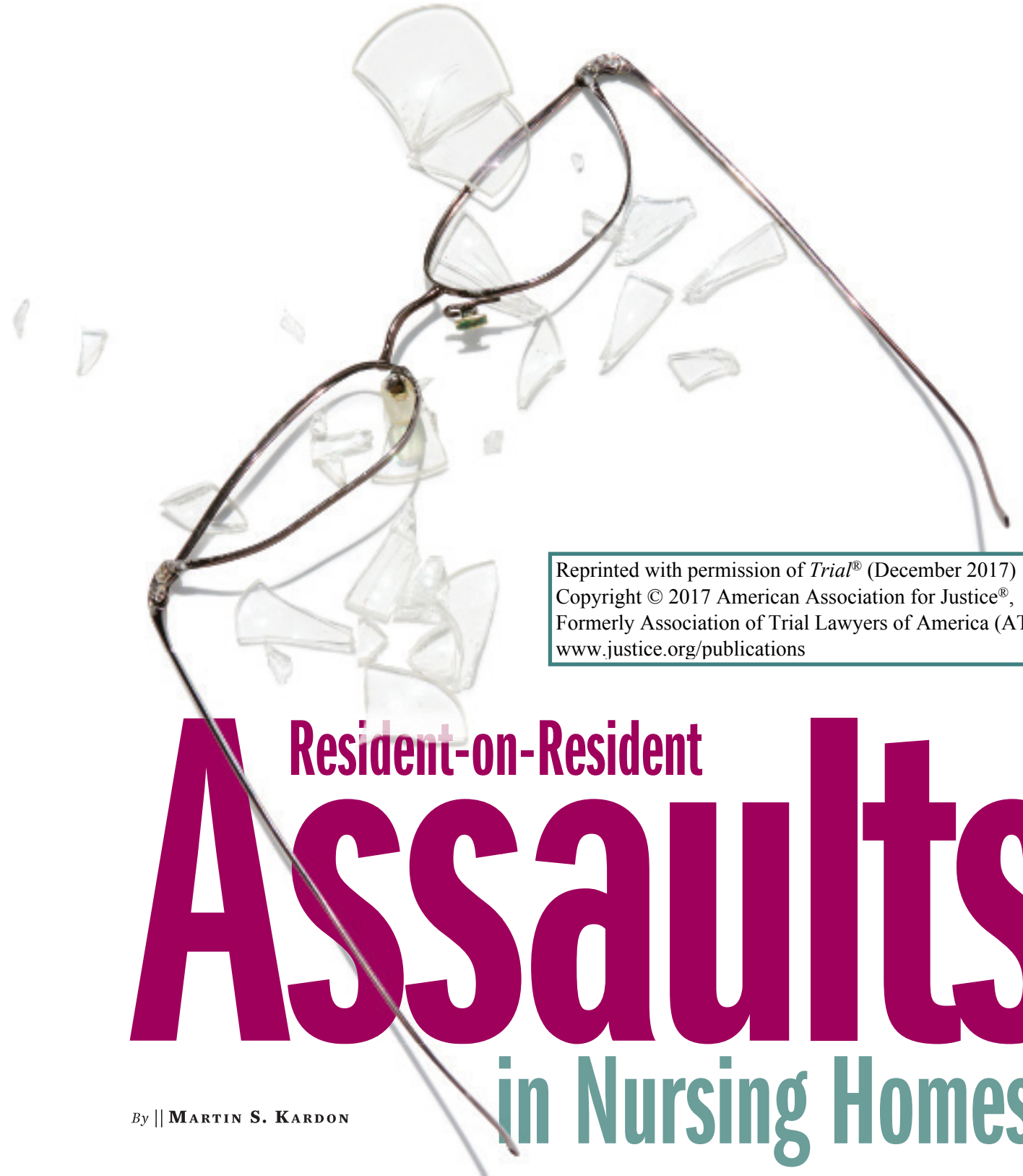

Resident-on-Resident Assaults in Nursing Homes

By || **Martin S. Kardon**

When a nursing home resident injures another resident, the facility should be held responsible for failing to prevent the attack. It is essential to comb through records and depose staff to uncover shortcomings in how violent residents are handled.

PM IMAGES/GETTY IMAGES

John had lived in the nursing home for five years. He was 86, tall, thin, and frail. His Alzheimer's had steadily advanced until the formerly gentle and universally loved man became verbally aggressive. He was, however, easily calmed with a word or two from staff.

Jane lived in the same wing and was 13 years younger than John. Except for her dementia, she was in excellent physical condition. Jane's dementia manifested in frequent outbursts, aggressive behavior, and altercations with the staff and residents that had twice become physical.

During a shift change one afternoon, Jane shoved John from behind, and he fell to the hallway floor. He suffered serious injuries, including multiple facial and spinal fractures and a subdural hematoma. He died several days later.

Regrettably, this scenario is not unusual. At times, people with long histories of aggressive behavior are moved from long-term placements in mental health institutions to skilled nursing facilities. When screening prospective residents, facilities rely on referral sources such as hospitals, doctors, and family for information about violent tendencies. As part of the initial and ongoing assessments, the entire care team must be aware of and appropriately respond to indications of aggressive behavior.

In contrast to when a facility employee commits an assault, there is generally no viable civil claim against the assailant in the majority of cases involving an assault by a resident with cognitive deficits. There is lack of legal capacity and probable lack of assets. Instead, consider whether a viable action exists against the nursing home for failing to provide a safe place to live and to prevent abuse or injury.[1]

In the absence of willful intent—due to the assailant's incapacity—federal regulations classify the assault as an "accident," from which nursing homes are required to protect their residents.[2] In framing the issues in John's case, for example, the claim against the facility is for allowing the assault/abuse and failing to protect him from injury. The key fact to prove is that the facility knew or should have known about the assailant's violent tendencies and the risk to fellow residents. Thorough investigation and discovery is crucial in these cases.

Get the Records

Review your client's facility records first. It's even more important, however, to obtain the assailant's records from the facility, including prior incident reports, especially ones that involved violence.

Under HIPAA guidelines, you typically wouldn't be able to obtain the assailant's protected health information, even with a subpoena.[3] However, in judicial proceedings once suit is filed, HIPAA regulations provide a mechanism to obtain a court order directing the defendant facility to release the assailant's records through a discovery order or a stipulation once specific requirements are met and within certain limitations.[4]

Initially, there must be notice or a reasonable attempt to notify the person whose records are at issue.[5] The qualified protective order, or the stipulation, must prohibit all parties from disclosing the person's private health information outside the litigation.[6] Once the litigation has ended, the records must be destroyed or returned to the facility.[7] Consider using this type of language in your stipulation or proposed order:

> Any party receiving said materials pursuant to this order shall not use or disclose any portions thereof for any purpose other than for this litigation, for which such information was requested. Plaintiff shall return to Defendants, or destroy, said materials (including copies) at the conclusion of the litigation.

The seminal case discussing production of protected health information is *United States v. Jong Hi Bek*.[8] Only four state cases address disclosure of protected health information,[9] but the principle is discussed in all of the federal circuits except the Second Circuit.[10]

Review the assailant's facility charts for any tendencies toward violent behavior similar to the type manifested in the assault. For example, in John's case, there may have been nursing note entries or incident reports about Jane acting out against staff, verbally or physically; abusive language or behavior short of physical violence against other residents; and earlier altercations between John and Jane. These instances could support legal action against the facility.

Keep in mind possible third-party data, including ambulance and hospital emergency department records. There may even be records from a police investigation that doctors, emergency medical technicians, or the family initiated. The facility itself rarely takes the step of triggering a police investigation. These documents can contain key post-assault staff interviews. Also, when a resident is injured, most states require reports to be filed with the agency that supervises long-term skilled nursing facilities.

Liability Theories

Subject to the specific facts of your case, there are two approaches to liability.

Negligence. The facility could be liable because of its negligent admission or retention of a resident who puts the safety of other residents at risk. Even if the injured resident also has a known propensity for harmful behavior, this could support rather than hinder your case. Such behavior often is an outgrowth of a resident's underlying illness, and the nursing home must implement a plan to protect that resident and others. This could include, in the most intractable cases, discharge and transfer to another facility designed to care for people exhibiting violent behavior, such as an inpatient geropsychology unit specializing in the mental health needs of older adults.

Understaffing. The second approach to liability is based on the nursing home's failure to provide sufficient staff to supervise residents with potentially dangerous behavioral issues. When there are residents with behavioral issues, the facility must provide adequate staff, often at staff-resident ratios higher than state minimums. The staff also must be sufficiently trained and monitored to

What Lies Ahead in the Forced Arbitration Battle

By Gabe Lezra

With a rulemaking to end forced arbitration in nursing homes in question, see what may be next as the fight for residents' rights continues.

After years of careful research and dialogue with industry members and patients' rights advocates, the Centers for Medicare and Medicaid Services (CMS) issued a comprehensive overhaul of the federal regulations governing conduct in nursing homes in October 2016. Importantly, the new rule had a provision prohibiting many nursing homes from including mandatory pre-dispute ("forced") arbitration clauses in contracts. For years, nursing homes used these clauses to strip residents and their families of their rights to hold facilities legally accountable when residents suffer harm—no matter how egregious the conduct.

The rule would have put an end to the use of forced arbitration by certain facilities that receive federal funding. When CMS originally promulgated the proposed rule, a vast array of organizations representing almost every element of the nursing home experience submitted comments supporting CMS' interest in banning forced arbitration. These organizations included patients' advocacy organizations such as the National Consumer Voice for Quality Long-Term Care,[1] the Center for Medicare Advocacy,[2] AARP,[3] New Yorkers for Patient & Family Empowerment,[4] and the Center for Independence of the Disabled[5]; consumer advocacy organizations such as Public Citizen's 21,000 consumer activists[6] and the Empire State Consumer Project[7]; unions representing health care employees such as the Service Employees International Union (SEIU)[8]; and the attorneys general of 16 states.[9]

In fact, the only entities that submitted comments supporting continued use of forced arbitration clauses were nursing home corporations and their insurers.[10] Patients, their families, and health care employees also submitted voluminous comments in support of the ban.

But almost immediately after CMS issued the final regulation, the American Health Care Association, the nation's largest nursing home- and hospital-lobbying organization, sued to enjoin implementation of the ban, arguing that CMS had exceeded its statutory authority.

On Nov. 7, 2016, Judge Michael Mills agreed and issued a preliminary injunction.[11] While the Obama administration appealed the ruling to the Fifth Circuit in January, the current administration directed CMS to drop its appeal—which it did in June. The decision to abandon the appeal effectively prevents CMS from implementing the rule as written.

While recent public scandals have shed light on the negative consequences of forced arbitration clauses, the Trump administration's continued refusal to address these issues does not bode well for nursing home reform advocates. The administration's newest proposal, a rule that would lift the ban on forced arbitration clauses, is even worse than existing law for

The facility could be liable because of its negligent admission or retention of a resident who puts the safety of other residents at risk.

provide appropriate care for residents with inappropriate behavior. Often, at the root of the problem is a facility's profit motive to maximize the number of residents while minimizing the number of staff, which is the greatest expense in long-term care.

What to Request in Discovery

Aside from the charts for the residents involved in the assault, your first discovery requests should focus on the incident itself, including:

- reports on the internal investigation of the incident (some state laws consider these privileged under "peer review" or "quality assurance" exemptions, making them more difficult to obtain)

patients and their families.[12] CMS will now review the proposed rule—to which AAJ has submitted comments—and fashion it into a final rule that will likely override the previous administration's efforts to protect nursing home residents and continue to allow nursing homes to include forced arbitration clauses in their admission contracts.

These contracts, signed by patients and families during one of the most emotionally challenging times in their lives, stack the deck against injured parties and deny justice to those most in need. AAJ will continue to fight for the rights of patients and their families to hold bad actors publicly accountable for their misconduct. Justice demands no less.

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Notes

1. Nat'l Consumer Voice for Quality Long-Term Care, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Oct. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-8992.
2. Ctr. for Medicare Advocacy, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Oct. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-8377.
3. AARP, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Sep. 28, 2015), www.regulations.gov/document?D=CMS-2015-0083-4472.
4. New Yorkers for Patient & Family Empowerment, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Sep. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-5465.
5. Ctr. for Independence of the Disabled in New York, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Sep. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-5465.
6. Public Citizen, Letter to CMS re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Oct. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-8427.
7. Empire State Consumer Project, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Sep. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-9761.
8. SEIU, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Oct. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-9181.
9. Letter From 16 State Attorneys General, Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Oct. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-8382.
10. *See, e.g.*, Physician Insurers Ass'n of Am., Comment re: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 (Sept. 14, 2015), www.regulations.gov/document?D=CMS-2015-0083-5492.
11. *Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921 (N.D. Miss. Nov. 7, 2016).
12. Ctrs. for Medicare & Medicaid Servs., *CMS Issues Proposed Revision Requirements for Long-Term Care Facilities' Arbitration Agreements* (June 5, 2017), www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-06-05.html.

TOA55/THINKSTOCK

The defense will likely focus on the facility's lack of knowledge of the risk and inability to predict or prevent the assault. Thus, the records for and testimony of prior incidents or behavior are extremely important.

- reports of other incidents involving the assailant
- reports from government authorities, notably the state surveyors' deficiency findings (CMS 2567), and any mandatory reports of abuse or neglect under state elder abuse laws.[11]

Next, discovery should focus on areas that apply to most long-term care cases, such as:

- admission and discharge procedures
- assessments and care plans specifically including information about the reassessment process when a resident's condition worsens
- written policies and procedures for assessments, incident prevention, and care for dementia-afflicted residents
- staff job descriptions, schedules, and reports of staff attendance
- emails regarding the plaintiff, prior resident-on-resident assaults, and substantially similar events
- a floor plan and photos of the location where the assault occurred, including any video that may have been taken[12]
- facility cost reports, which will include reported staffing numbers. If the defendant is a nonprofit, IRS 990 tax returns will yield a trove of financial data on upper management salaries, related entities to whom funds are payed, and other facilities owned by the same entities.[13]

Staff Depositions

Once paper discovery is substantially completed, depose the care staff—including those involved in caring for the assailant—to establish the staff's knowledge of dangerous propensities. Closely examine resident care plans and minimum data set forms[14] from each chart for interventions staff took to protect the residents from harm.

Interventions may include psychiatric and medication consults, ordering frequent checks to monitor behavior, and moving the resident away from people he or she has had conflict with. If all else failed and the facility could not have kept others safe from harm, it should have transferred the resident to another facility.

When deposing staff to support the failure to provide appropriate care plans, supervision, and staff, focus on the day of the assault and the conditions inside the facility. Ask how many staff and residents were present, where in the facility staff was deployed, whether enough people were there to implement care plans, and whether those plans were consistent with facility policies.

For example, deposition testimony could yield the following information as evidence of understaffing: The plaintiff's wing was staffed with one licensed practical nurse (LPN) and a couple of certified nurse assistants (CNAs). Many residents were living in that wing. At the time of the assault, the LPN was receiving shift change information from the departing nurse inside the nurse's office with the door closed. One of the CNAs was in the shower room cleaning a resident. The other was in the lounge supervising eight residents. The rest of the residents were in their rooms or walking in the hall, leaving 18 residents, all with varying stages of dementia, unsupervised.

Question the facility's management, such as the director of nursing and the administrator, about admission policies, the management of resident-on-resident risks, their actions after the assault, policy enforcement, budgeting, and staffing decisions.

The defense likely will focus on the facility's lack of knowledge of the risk and inability to predict or prevent the assault. Thus, the records for and testimony of prior incidents or behavior are extremely important. In the event that the staff didn't see the assault—even though residents may say otherwise—the defense will impugn the credibility of any witness statements from impaired residents. To counter this, point to incident reports, staff statements, or deposition testimony of what was observed when staff arrived, or any statements residents made to staff at the time.

By properly narrowing the issues and conducting thorough discovery, you can prove the facility knew about the clear risks of a harmful altercation.

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Notes

1. 42 C.F.R. §483.12 (2017).
2. The Centers for Medicare and Medicaid Services publishes a facility guide to the regulations that comments on resident-on-resident assaults: "An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance at F223. 'Willful' means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under this tag, F323." Ctrs. for Medicare & Medicaid Servs., *State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP*, 358–59 (Mar. 8, 2017).
3. The assailant's representative can authorize disclosure of the records, but a direct request to the assailant's family, assuming his or her name is even known, is rarely successful because of privacy concerns and potential exposure in any litigation.
4. 45 C.F.R. §164.512(e) (2017).
5. 45 C.F.R. §164.512(e)(1)(ii)(A).
6. 45 C.F.R. §164.512(e)(1)(v)(A).
7. 45 C.F.R. §164.512(e)(1)(v)(B).
8. 493 F. 3d 790, 802 (7th Cir. 2007) (holding that HIPAA does not create a privilege against disclosure of protected health information without authorization but rather procedures for disclosure).
9. *People v. Bauer*, 931 N.E.2d 1283 (Ill. Ct. App. 2010); *Fusco v. Shannon*, 63 A.3d 145 (Md. Ct. Spec. App. 2013); *People v. Carrier*, 867 N.W.2d 463 (Mich. Ct. App. 2015); *T.M. v. Elwyn, Inc.*, 950 A.2d 1050 (Pa. Super. Ct. 2008).
10. *See, e.g.*, *United States v. Pellmann*, 668 F. 3d 918 (7th Cir. 2012); *United States v. Smith*, 573 F. 3d 639 (8th Cir. 2009); *United States v. Jafari*, 648. F. App'x 226 (3d. Cir. 2016).
11. CMS 2567 forms report state surveyors' findings of regulatory violations at a facility during periodic inspections or those triggered by complaints. For state elder abuse laws, see www.justice.gov/elderjustice/elder-justice-statutes-0.
12. Since such videos would not be considered part of the resident's medical file, the facility may erase or discard them, so you should immediately send a letter admonishing management to preserve this evidence.
13. These reports are also publicly available through Freedom of Information Act requests to the state agency. Medicare cost reports for every facility in the country can be downloaded from www.snfdata.com. IRS 990 tax returns for nonprofits can be obtained from www.guidestar.org.
14. Minimum data sets standardize data submitted to Medicare and Medicaid of each resident's condition and any changes as they are found. These reports form the basis for facility reimbursement and, therefore, are faithfully filed.