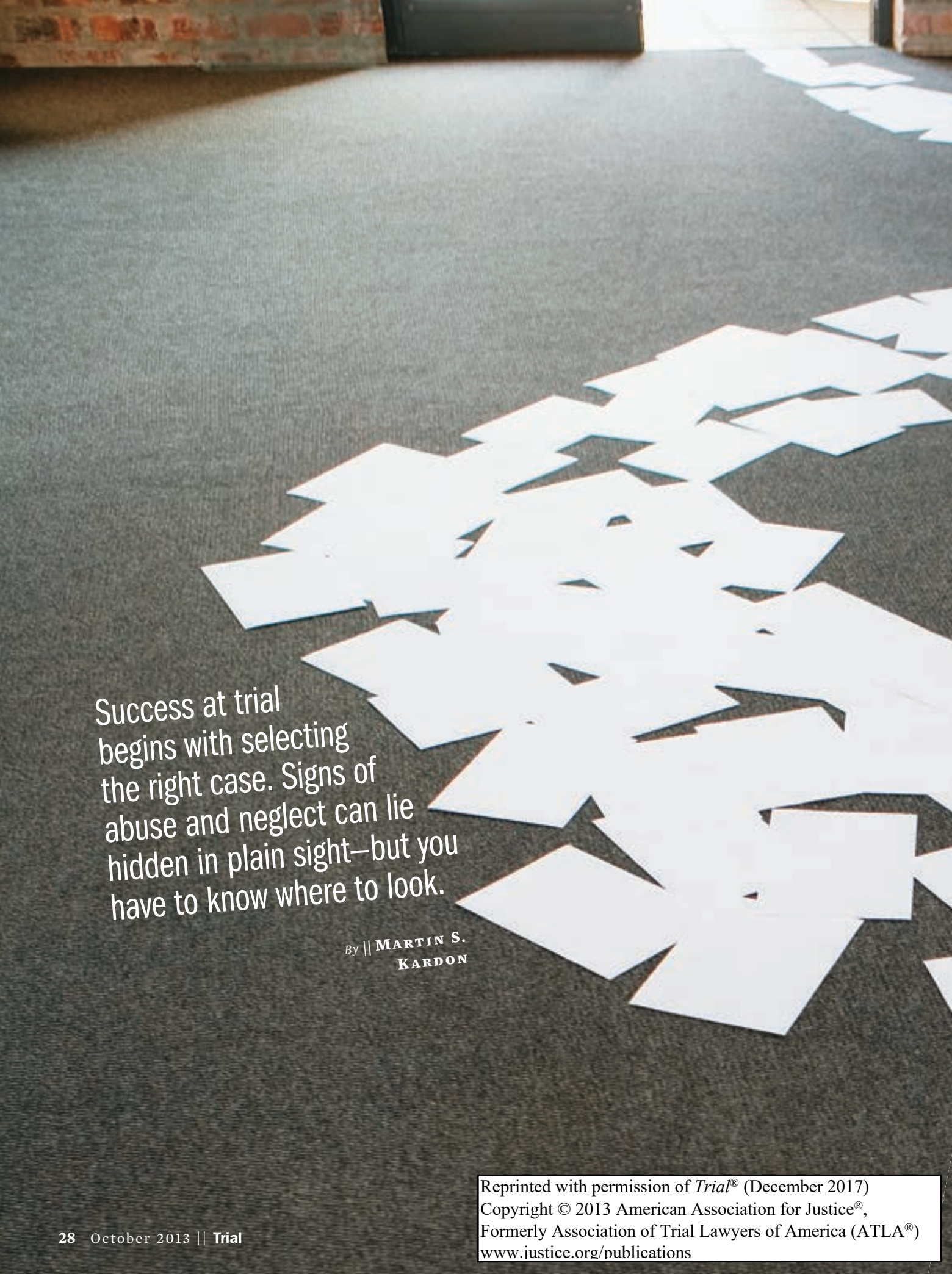

Success at trial begins with selecting the right case. Signs of abuse and neglect can lie hidden in plain sight—but you have to know where to look.

By || Martin S. Kardon

Use the RESIDENT'S RECORDS as a Road Map

Your success in a case of nursing home abuse or neglect depends on making the right decision when you select the case. The nature of the defendant's misconduct, corporate liability, and regulatory deficiencies may occupy center stage, but unless there is an underlying failure in caring for or protecting the nursing home resident, your case may never get off the ground.

Learning what to look for and where in the client's nursing home records can help ensure that you take on the right cases and guide them in the right direction.

You will need an expert to participate in the case selection process, and the first expert to consult generally should be a nurse with long-term care experience. Once a potential case presents enough bare facts to warrant review of medical records, this expert can help you fully understand the medical records, enabling you to give the final go-ahead to take the case to the next level.

Obtaining the nursing home records should be your first order of business. Most nursing home charts are remarkably similar because of Medicare and Medicaid requirements, and my firm has learned where to locate what we need to proceed. Our policy is to have clients obtain the facility records with our assurance that this is the only expenditure they will incur if the firm elects to proceed. We make exceptions when there is obvious liability, or when the family in a likely meritorious case is financially unable to obtain the records.

All nursing homes are required under federal regulations to provide requested copies of records to the resident or family within 24 hours.[1] If there are delays in getting the materials, a complaint to the state department that oversees nursing homes will shake loose the required records in most instances.

Once the nursing home resident's records are in hand, you may want to have a paralegal or assistant organize them before delving into an analysis. My practice is to scan and number the records for ease in referencing important parts of the chart going forward. (See the box on p. 30.)

Hospital records. In most instances, a nursing home resident is admitted to the facility following a hospitalization. While it

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is exceedingly rare for the entire hospital chart to be forwarded with the newly admitted resident, certain materials are usually provided before or at the time of the transfer. They may include transfer orders, medication lists, and laboratory or imaging studies. For hospital admissions or outpatient visits during the residency, similar materials exist. All these help provide a nonparty perspective on client care and issues.

Admission evaluations. The federal nursing home regulations require that a comprehensive plan of care be developed for residents within 14 days of admission to the facility and, thus, one of the facility's first orders of business is evaluating the resident's needs.[2] The format varies by facility and nursing home chain, but they always contain valuable information regarding the resident's condition on admission and the risks seen as requiring preventive interventions in the plan of care.[3] Of particular interest in these evaluations are the determined risks of falls, nutritional compromise, and pressure ulcers, because these factors constitute a significant percentage of nursing home injury cases.

Plans of care. These records set forth the particular services and care that the facility is to provide the resident, based on the problems identified during the evaluation. Because a nursing home resident's health condition is dynamic, care interventions must evolve with any changes in condition, as well as following reevaluations of the efficacy of the planned care. The plan of care reflects such changes, or the lack thereof, and sets forth the particular care mandates for which the facility is responsible.

Interdisciplinary and nursing notes. This part of the chart contains the narrative that reflects how the care, changes, and harm to the resident unfolded. It must be read thoroughly and chronologically to get a sense of what happened and why. The health care professionals who write in this section of the chart may include nurses, dieticians, therapists (physical, occupational, and speech) and, in some instances, staff members who conduct investigations into resident complications or harms.[4] Depending on facility and regulatory requirements, there may be daily entries. Sometimes the lack of such entries is as significant as the entries made. While many of the entries are routine and repetitive, these notes in the chart become key in deposing witnesses and determining the "what, when, and why" of the case.

Physician entries. The majority of care for nursing home residents is provided by the nursing staff, but federal regulations require that physicians supervise medical care.[5] There must always be an admitting physician examination, admitting orders, and ongoing updated doctors' orders either during regularly scheduled examinations (required every 30 days for the first 90 days of admission) or through verbal orders obtained and documented by the nursing staff in telephone calls to the attending or on-call physician. There may also be periodic consultations by psychiatrists, dentists, podiatrists, and other health care professionals.

Although the vast majority of nursing home litigation involves failures by the facility in its custodial care obligations, you should thoroughly scrutinize physician interactions, because the attending doctor is an important member of the care team.

Records of therapy. Residents who need assistance with self-care typically receive a blend of physical therapy (for balance, mobility, and ambulation) and occupational therapy for activities of daily living (ADLs) such as dressing, washing, eating, and toileting. These services are provided by licensed therapists and usually occur several days a week or daily. These therapists are either employed by the facility or work there

ORGANIZING RECORDS

I categorize nursing home records based on the following organizational scheme. Numbering the records this way makes it easier to refer to them later.

1. Admitting documents and business office records
2. Preadmission records from other sources
3. Discharge summary
4. Physician admission history and physical
5. Nursing admission evaluation
6. Interdisciplinary plan of care
7. Interdisciplinary/nursing team notes
8. Physician notes
9. Physician consults
10. Physician orders
11. Medication/treatment administration records
12. Certified nursing assistant/activities of daily living flow charts
13. Pressure ulcer risk evaluation and treatment
14. Nutritional/dietary risk evaluation and treatment
15. Fall risk evaluation
16. Minimum data set (MDS 3.0)
17. Resident assessment profile (RAP)
18. Physical therapy
19. Occupational therapy
20. Speech therapy
21. Social services
22. Vital signs
23. Input/output records
24. Imaging studies
25. Labs
26. Billing

through third-party contracts with the nursing home.

The documents generated from these caregivers are fairly uniform. They include admission and discharge summaries, therapists' evaluations, treatment plans, and summaries of each therapy session. These documents are of particular interest in cases involving fall injuries because they demonstrate the resident's balance and walking strength (physical therapy), and safety awareness (occupational therapy).

Speech therapy records pertain mainly to evaluation and treatment of residents' swallowing abilities. Residents who receive speech therapy also have an elevated risk of aspiration and subsequent pneumonia. These issues are typically treated through a combination of speech therapy (determining ability to swallow) and staff nutritionists who determine the proper texture of food, balancing safety needs against taste and resident preferences.

Medication and treatment administration records. These records, commonly referred to as MARs and TARs, are monthly charts completed by the licensed nursing staff. They set forth medications and care ordered by the doctor and how it was provided to the resident. Typically completed in a grid formation, the charts contain medications or treatments on the left side of the page with blocks for checking off when during each day's shift (day, evening, night) medications and therapy were provided to the resident. Caregivers may include their initials for each shift so they can be identified.

You can argue that numerous blank spaces in pressure ulcer treatments, for example, establish that such care was not given. You also may find days and times initialed when the resident was not even in the nursing home. While this can be ascribed to scrivener's errors if the entries are rare and isolated, multiple instances of these errors may show false or inattentive charting, undermining the veracity of the entire chart and the care it reflects.

ADL flow sheets. The basics of custodial care for help with ADLs are supplied by certified nursing assistants (CNAs). These activities include help with eating, walking, cleaning, and moving in bed—all of which are crucial to prevent falls, pressure ulcers, and malnutrition. The ADL flow sheets are typically in the form of grids with various activities of daily living in the horizontal and particular days and shifts in the vertical. The CNAs are required to initial the grid each time a particular care service is provided for a resident. Failure to complete these forms implies that the care was not provided.

Minimum data sets (MDS). This section of the chart consists of a federally mandated form that is completed as part of both the Medicare and Medicaid payment processes and data gathering by the federal government. The format was recently updated, but both versions (MDS 2.0 and MDS 3.0) likely will appear for some time in all but the newest facility charts. In both versions, the forms contain details of residents' underlying medical conditions, functional capacity, care needs, and many other factors. They are completed at regular intervals and provide numerous details of the resident's evolving conditions and needs.

Investigation reports. In cases of traumatic injuries, the facility reports the event to the supervising state office, such as the state department of health, and prepares written investigations containing witness statements and narrative detail. In some instances, these materials may be included in the chart and contain information that is valuable in considering whether to proceed with a case. If they are not in the chart, many states allow plaintiff counsel to access them during discovery. Defense counsel frequently object to producing them, arguing that they are protected "peer review" documents.

Laboratory and imaging studies. Imaging studies are key when a resident has suffered a fracture from a fall, because they can help rule out fractures due solely to bone density loss (osteoporosis) and because they help establish the fracture's traumatic cause. I recommend in any fall case that the imaging reports, as well as the images themselves, be forwarded to a radiologist for review. The images, while a part of the chart, are often taken by a hospital or third party, such as an in-house medical imaging vendor. The vendor obtains and interprets imaging studies when ordered by facility physicians, so the images usually have to come directly from the vendor.

Laboratory tests such as periodic blood and urine screens are kept in the chart. These can help identify chronic urinary tract infections (often caused by indwelling urinary catheters), malnutrition (identifiable by low albumin, prealbumin, and total protein blood scores), dehydration (identifiable by blood urea nitrogen and creatinine measure of kidney function), and facility-acquired infections of skin wounds, bowel, or lungs.

Photographs. For many years, it was common practice for nursing homes to take photographs of resident pressure ulcers because they were helpful in

MORE ON NURSING HOME RECORDS

Visit the Web pages below for additional information.

AAJ SECTION

Professional Negligence
www.justice.org/sections

AAJ LITIGATION GROUP

Nursing Home
www.justice.org/litgroups

LITIGATION PACKET

Nursing Home Litigation: Regulations, Discovery, and Damages
www.justice.org/litigationpackets

identifying the size, location, and healing status of the wounds. These photographs can be potent exhibits for juries to consider in pressure ulcer cases, and most facilities have instituted policies to no longer routinely take such pictures. If you see them in the chart, you should make every effort to get the color photographs. Hospitals generally take these photos, so you should request color copies for review.

Electronic charts and computer audit trails. Patient charts are increasingly updated electronically by mobile computers. This is a positive step to the extent that such records are "everywhere" in a facility and thus available to everyone. A post facto review of the printed electronic chart, in which illegible handwriting is replaced by typed entries, presents new challenges because the information typically appears as a series of computerized data entries.[6]

With the loss of handwriting and signatures, fraudulent charting can become harder to immediately detect. Document examiners and handwriting experts are giving way to computer forensic analysts. If there is any hint of inconsistent, delayed, or questionable charting, you should request the audit trail from the corporate defendants to identify the dates, times, and locations of changes or updates to the resident's medical chart.

When you are considering a new case, a review of the road map contained in a nursing home resident's chart is an essential part of the decision-making process. Your effort and diligence reviewing the chart will help you distinguish a good case from one you should decline.

Martin S. Kardon *is a partner with Kanter, Bernstein & Kardon in Philadelphia. He can be reached at kardon@kbklaw.com.*

Notes

1. *See* 42 C.F.R. §483.10(b)(ii) (2013).
2. *See* 42 C.F.R. §483.20(2)(i),(ii) (2013).
3. Business office admission records are not generally part of the resident chart, but they can and should be obtained if for no other reason than to determine whether there is a valid arbitration agreement in effect that affects the potential case.
4. In other instances, investigations are intentionally left out of the resident chart and can be obtained only after suit is filed.
5. *See* 42 C.F.R. §483.40.
6. It is particularly challenging to review MAR/TARs and ADL flow sheets that are not in grid format but are presented as long strings of repetitive data.