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Nursing Home Malpractice Cases: Key Differences

Elliot Kolodny

Elliot Kolodny, who has worked both as a plaintiff and defense attorney, currently focuses on nursing home litigation. As an LNC, you have a strong chance of becoming involved in a nursing home case. By listening to this podcast, you will get true benefit from learning the differences between medical malpractice and nursing home litigation cases and the specifics of why so many nursing home malpractice cases occur.

- What is a critical difference in focus between medical malpractice cases and nursing home cases?
- How does the jury's perspective change in nursing home cases?
- What causes many instances of nursing home litigation cases?
- Why do LNCs play a critical role in nursing home cases?

Patricia: Hi. This is Pat Iyer with Legal Nurse Podcast. And I have with me, today, Elliot Kolodny who is a plaintiff attorney who has experience both as a defense and a plaintiff attorney, who has worked on both sides of cases, including personal injury, and nursing home, and medical malpractice cases. He is partners with David Cohen in a law firm that's based in Pennsylvania. Elliott has extensive recent experience now working on nursing home cases. And I wanted to bring him to the show because I know some of you listening to this will have an opportunity or are working in the area of nursing home litigation, either screening cases, or being an expert witness, or being approached by attorneys who are looking for experts. Elliot, welcome to the show.

Elliot: Thank you, Pat. My partner wouldn't forgive me if I failed to point out that a significant, probably a majority of our practice is in New Jersey, as well. So, we cover both Pennsylvania and New Jersey extensively.

Patricia: Perfect. Thank you.

Elliot: You're welcome.

Patricia: I know that the first time a legal nurse consultant sees a nursing home chart, they are immediately struck with the fact that there's less

volume, there are some new forms they haven't seen, and there's a whole set of regulations that are behind nursing home care that do not exist in hospital care. Can you give us, from your perspective, some of the differences between nursing home cases and medical malpractice cases?

Elliot: Sure. And I had that transition to make myself as primarily a plaintiff's medical malpractice attorney just prior to getting involved in nursing home work. It's a common mistake to assume nursing home cases are a subset of medical malpractice. There are some similarities, so let's just start with that. Obviously, they both deal with medicine and sick people. They both ask the same question: Was the patient—or in nursing home cases the resident—injured because of something that was done or not done to or for them? And the basic question is was proper care delivered?

There are many differences, frankly. First of all, nursing home cases tend to be more about the institution than the patient. Medical malpractice cases are almost always about the patient, their medical condition. Was the standard of care met for that medical condition, and if not, was that violation of the standard of care causative of damages to the plaintiff? Nursing home cases, by contrast, rarely are about medical standards of care, rarely about causation, and most often focus on the delivery of what everybody can agree was the treatment or therapies that should have been delivered to the resident. Now, there are always exceptions to the rule.

One of the most common types of nursing home cases are pressure sore cases. They used to call them bed sores. We think that really diminishes what they're about, pressure wounds or pressure ulcers, or pressure sores sometimes had a significant medical component relating to causation. We can agree, perhaps, that this patient should have been turned every two hours, and they weren't. Occasionally, we will see defendants making the argument that, wait, there's a medical reason, independent of pressure, that's causing this. But yeah, peripheral vascular disease, some cancer patients who are incapable of maintaining proper nutrition. Sometimes, those types of wounds are clinically unavoidable.

But that's, really, a small subset. Most of the nursing home cases rise and fall on was the actual care delivered. You talked about the

regulatory framework, and that's what these cases are about, most often. In a medical malpractice case, we fight about how should this particular condition have been treated, and did the failure to treat it that way cause the problem? In nursing home cases, as I said, we rarely argue about those things; the focus is on was the care delivered.

And the regulatory framework, perhaps the audience has heard about this watermelon book. I just brought it to show you, people hear about this. It's called the watermelon book because the color looks like the inside of a watermelon. So, every nursing home in the United States that takes any money from Medicare or Medicaid, which is close to 100% of them, voluntarily subjects themselves to federal regulation. And the federal government, through CMS, has established rules and regulations that are set forth in the long-term care survey, which is a guidance to the surveyors or inspectors.

And it establishes certain things that must be maintained in the chart. And that is probably the single biggest difference. I often say to people, nursing home cases are often about a failure to communicate. And what we like to see in a chart is that everything that should be done is in the chart, whether or not it was done, it should be in the chart. And we should be charting certain things about every single patient. The reason that's important, is, because unlike a medical malpractice situation, these people are in facilities for a long period of time. That means lots and lots of healthcare providers are involved. But they're not all around the bedside at the same time.

So, how does a medical director communicate with the director of nursing, and the RN, and the LPN, and the CNAs in a consistent way so everybody can know what the resident is experiencing and what needs to be done? That's a big part of long-term care survey, the watermelon book. If things are not properly documented, meaning are they in the chart, and are they in the chart in the right place? That's a recipe for disaster, because you might have a medical director or a DON who's reviewing what's going on with a resident by looking at the chart, but they've got lots of residents to look at. So, they're just going to flip through certain things in the chart, what were the physician's orders, what do the nursing notes say? And if things aren't properly documented or they aren't in the proper place, that's how the kind of neglect that we most often see in nursing home cases occurs.

So, that's why the regulatory framework is so important. A couple of other difference are, in a medical malpractice case, from a legal perspective, there's a real jury bias against plaintiffs and plaintiffs' attorneys. People are skeptical sitting on juries when a medical malpractice case is brought. They feel that their own care may suffer if there is an award. It's almost the exact opposite in nursing home cases; we're wearing the white hats. People sitting on juries understand that really bad things happen in nursing homes. And it's much easier to bring them along to tell our story.

And finally, this is a really big difference that I see as a strength now, but as a medical malpractice attorney making the transition, it's a little bit counterintuitive. In a medical malpractice case, you're focusing on one condition, and was that one condition properly taken care of. And it's almost always acute. Even if you're dealing with a chronic condition that the patient is experiencing over a long period of time, the patient interfaces with the system in an acute way. They're not there for a long period of time.

Contrast that with the nursing home resident. Most often, people who are residents of nursing homes are medically very complex. They've got a lot going on. There are the exceptions to the rule, if somebody who's in a persistent vegetative state, maybe they're there with no other problems, at least initially. But certainly, in our elderly population, the typical nursing home resident has a bunch of things going on. Some of them may be life-threatening, some of them may be more chronic conditions. And that would appear, at first blush, to make these cases more difficult to try. But the reality shifts when you realize the nursing home has voluntarily accepted these patients, these residents precisely because they are medically complicated, and they're getting paid a significant amount of money.

The Medicaid reimbursement rates in Pennsylvania, and it changes from state to state, is over $8,000 a month for a nursing home resident. And that's the worst-case scenario. Obviously, private pays patients get paid a lot. These nursing homes are voluntarily accepting people who are medically complicated, and that usually works in our favor. All of these things, though, really highlight an important difference that I think is particularly pertinent today. And that is, A, a nursing expert is absolutely required in 100% of the nursing home cases. And in the vast, vast majority of them, they are our most

important expert, and we need to be able to rely on our nursing experts.

In the med mal case, I can identify that this is a failure to diagnose a ruptured appendix, and I don't need a nurse to go through the records and tell me all the other things. I can do that. I then go out and find a general surgeon or appropriate expert who can talk about that. There may be nursing issues in those cases, but in a nursing home case, it's all about working with your nursing home expert hand in glove, that somebody may come to us with a specific problem. And with a good expert going through these pretty voluminous charts, we, very frequently, identify other problems. So, we like to hire nursing experts early and rely on them much more than we would in med mal case. So those are some of the differences.

Patricia: Yes. And I can see that there can be a lot more. I have a memory of sitting down with David, your partner, when we were presenting some programs together for attorneys, and him showing me a medical record that was clearly fabricated, with identical handwriting, that claimed that there was a meeting on January 1 to go through the MDS, having a group meeting to talk about the Minimum Data Set. I would think that there are challenges with documentation. It is voluminous, but there is also, from what I understand, a very large temptation to alter medical records after the fact. Have you run into that with the cases that you handle?

Elliot: Absolutely. In the med mal world, I've run into it, too. It's very difficult to prove that, even when you suspect that's true. I'll tell you a little story. Early on, in my nursing home career, I found a very clear example of false charting. And I think I called David on this; we weren't at the same firm at that time. One of the things that the regulations require you to keep track of is food intake. And there are, occasionally, cases where that's medically important. But even if it's not, you're required to track that. So, you'll see in a nursing home chart, a breakfast, lunch, and dinner, and 70%, 70%, 70%. It's rarely 100%, meaning that they ate 70% of their meals.

And I called David up and I said, “Oh my God, I just found a case where somebody ate 70% of their meals four days after they died.” My recollection is, and he's not here to defend himself, was that he chuckled. And he said, “Take the deposition, you're going to find that

there was a charting party." And sure enough, in that case, a nurse, I think it was a nurse, might have been a CNA, admitted to me that they are so busy, because of understaffing, which I believe is really the root cause of all of the neglect cases, the staff just can't keep up with the paperwork. There just aren't enough of them.

And in this particular facility, at the end of every month, there would be a pizza party, where they would spend their lunch hour filling out charts. Now we're seeing more and more electronic medical records, and that's happening less, but it still does happen. Somebody might come home for Easter, or they might be in the hospital, and there are still entries in the chart.

Now, that may not translate directly into evidence that they weren't turned with the appropriate frequency. And as we allege in a hypothetical case, this caused a stage four pressure sore. But it's damning evidence that their chart is credible and should be relied upon. I'm sure most of the people listening to this were taught in nursing school, that if it's in the chart, it happened, if it's not in the chart, it didn't happen. And that's a mantra that we hear a lot in med mal.

In nursing home cases, with a high degree of frequency, we can find false or inaccurate charting. Many times, it's not the nurse doing something nefarious. And I want to disabuse people of the notion that what's happening, that the real problem in nursing homes is the kind of abuse that we read about in the highly sensationalized cases. Most of our cases are cases of neglect. Most of the time, virtually all of the time, that's a result of understaffing, too few warm bodies to do the job. And CNAs, and LPNs, and RNs being asked to do things that they're just not trained to do all in the name, we believe, of profits, even the nonprofit nursing homes.

I know that sounds cynical, but it happens time and time again. And it's not rare, it's fairly frequent, that when we take the deposition of nursing staff, that they are almost relieved to share with somebody that they have been complaining to management that they need more help, that they need more staff. And that's when problems occur. The vast majority of nurses are there. They're not getting paid big bucks.

Patricia: No, they're not.

Elliot: The vast majority are there because they care. And I believe, I don't have any data to support it, that they remain in warlike conditions, where they're underappreciated, they're one-armed paper hangers, knowing that they're not delivering the kind of care that they really like to, but they remain because they really care and worry about what's going to happen to their residents if they're not there.

Patricia: I've had nurses tell me when I've taught programs in nursing homes that they are very attached to the residents and protective of them. And I think about the job of the CNA, which is poorly paid and hard, hard work, and how difficult it is to maintain that type of job with that payment. And many of them don't have their own transportation, they're dependent upon bus lines. It's a really hard job. And you've got them delivering the majority of the care and hoping that they are going to be skilled enough to be able to pick up a significant change and report it to whoever is in charge of that unit, an LPN, who herself or himself has to have enough knowledge to recognize that there is a change occurring and then to carry it forward. It's a difficult environment in which to work.

Elliot: It really is. Imagine a CNA who's working at two o'clock in the morning, and they've got 16 people with call bells. And, very often, they're being asked to roll silverware for breakfast, lunch, and dinner, or to do some other tasks unrelated to resident care. Even if they weren't tasked that way, how does one person answer three call bells? And they're really, really tough conditions. And my heart does go out to them. They are not the enemy. And that's what I mean, when I say, and I think most nursing home attorneys would agree with this, the key difference is it's not really about the patient, or the resident. Meaning it's not that we don't care about them, right? It's about the institution, and the decisions the institution has made that prevent the caregivers from doing what we all know is necessary. I can't turn four patients at two o'clock in the morning if I also have to answer three call bells.

And nobody disputes that somebody who's at a high risk for pressure sores needs to be turned on a regular basis. It's frustrating, and my heart goes out to them. And sometimes, I can see it in a deposition, they're almost unburdened by being able to say, “Hey, I know this is a problem. I've tried to bring this to the attention of administration.” And when you see these big nursing home verdicts, these eye-popping

numbers come because the full story is told to a jury, that really what is happening here is that nursing facilities are putting profits over patients. That's the theme in virtually all of our cases. And caught there is the nurse nursing staff. Rarely are they the enemy. I say rarely, because there are cases of real abuse. But they're a relatively small subset of what we do.

Patricia: What are the most common reasons why families come to you looking to see if there is a claim? What are the common allegations? And then the other part of that question, in the last time that we have together, is what would cause you to reject a case when that family member walks in the door?

Elliot: So, let's start with this observation, there's a lot of self-selection that goes on in nursing home cases. We accept a high percentage of them, which is another big difference between medical malpractice cases. And the reason we accept a high percentage of them is, think about this, it's sad but true, death is not an uncommon outcome for somebody who is in a nursing home. Everybody understands it's going to be the last place somebody comes to live. So, death is not going to be a suspicious event, most of the time. So, something, I believe, has to be egregious for a family to come an attorney and say, “Hey, wait a minute. We think something wrong happened here.”

The two most common things that we see are pressure sores and falls with fractures. There are lots of falls in nursing homes, where there are no injuries. But fractured hips, as most of the audience understands, in this population, often leads to death. I mean, the complications are very significant. But we see falls and pressure sores, by far and away, are the most common reasons why people come to see us. And that makes sense. There may be other things, once we roll up our sleeves and get into the chart; medication errors are a good example. But a family member is probably not going to know that there was a medication error, even if that medication error caused a death. Death due to an infection, influenza, for example, is not something somebody is going to come to us about, even though we now know, in the COVID cases, that there's often a failure to follow appropriate infection protocols.

Patricia: Yes.

Elliot: So, it's pressure sores, it is falls, and then there's actual abuse. Those are the things that are obvious, that's what brings people to us. And if they're coming to us, and they already suspect something, 90% of the time the chart will bear that out. We reject cases, occasionally, because the medicine doesn't hang together, but that's relatively rare. The most common reason we will reject a case is this; there are some family members that just don't care about their loved ones. They've warehoused Mom or Dad while they fly off to Aspen, or they go to Florida, and they don't visit. And it's very clear that the only reason that they're here is they want to monetize this. And if it's obvious to us that the family doesn't care, we'll reject the case.

We reject it for two reasons. Number one, that's not what we're about. At the end of the day, David and I believe that we do this for a couple of reasons. We want to stand up for our clients and their families, we want to give them a voice. We want to give them answers to what really happened to their loved one. And we want to join them in their mission of doing what they can to make sure this doesn't happen to the next person. Nothing is going to bring back Mom or Dad.

Occasionally, there might be a victim of nursing home neglect that is still alive, and now because of the neglect has a real need for that money. But most of the time, the money in a lawsuit serves the purpose of changing behavior. And that's a real motivating factor for our clients, and a real motivating factor for David and me. So, if somebody comes in the door, and it appears to us that all they really care about isn't their mom, isn't making this a better place, we know a jury is going to think that way, and we're not going to take that case.

Patricia: Are you aware of instances where facilities did change their behavior as a result of being hit with a large settlement or verdict?

Elliot: I'd like to think so. My first nursing home case was actually a restraint death case against a hospital, somebody was strangled to death in a Posey vest when they were left unattended. There were 91 restraint use violations in that particular case. We got the US Attorney's Office involved. I think there was an indictment. And part of the resolution, on the criminal side of that case, was an agreement to change their policies to bring in a third-party overseer. So, in that case, I can tell you, absolutely yes.

There are other cases of specific abuse. I had a case where a woman was being sexually assaulted by the head of groundskeeping, in what was supposed to be a locked dementia wing. We know that they changed their access policies. But, by and large, the real issue is understaffing. And nursing homes make, I believe, a business decision, that in order to change, we're going to have to increase our staffing for everybody. That is very, very expensive. And I think, very often, they do not do it unless they are really incentivized to do it. And I think we do play a role in incentivizing them by holding them accountable for bad behavior.

Patricia: Well, there are so many complexities to what we've been talking about. And we've just scratched the surface.

Elliot: Yeah.

Patricia: And I can think of about 20 other questions I would like to ask you, but the question I'll ask you now is how can our listeners find out more about you and about your firm?

Elliot: Well, on the website, you can go to AbuseAnalytics, with an S, A-N-A-L-Y-T-I-C-S, and that'll give you a bio about David and I, it'll give you some information about what we do, but, most importantly, it will give you our contact information. And I mean this sincerely, one of the really great things about being a nursing home attorney is that it's a generous community that's on a mission.

And I think that mission coincides with the mission of caregivers, and that's do everything we can to make sure that the residents in skilled nursing facilities get better treatment. So, if you have a real issue, just call us. We're happy to give you our time and answer specific questions, and if we can't answer them, we've got a network of people like you, Pat, and all sorts of other people that we can connect the audience with. But that's the single best, shoot us an email, at EKolodny@abuseanalytics.com, go to our website, and don't hesitate to reach out to us, and we'll hook you up.

Patricia: All right. And for the people who are listening to the program, can you spell your last name for them?

Elliot: Yeah. Yes, it's Elliott, E-L-L-I-O-T. My last name is Kolodny, K-O-L-O-D, as in David, N-Y@abuseanalytics, with an S, dot com.

Patricia: Okay, perfect. And your email was EKolodny@abuseanalytics.com?

Elliot: Correct.

Patricia: Okay, perfect.

Elliot: All right.

Patricia: Well, thank you so much, Elliot, for being on the show. And thank you to you who is listening to this program. Be sure to come back next week when we have a new guest. Subscribe to this show on our YouTube channel. Leave a comment, tell us whether you like it or don't like it. Give us some feedback. And we are so appreciative of the fact that you are one of our listeners. Legal Nurse Podcast is now in its fifth year of production, and it is because of the feedback we've gotten from people who said how much they appreciate these shows that I continue. Thanks so much.