Marquette Elder's Advisor

Volume 2
Issue 2 *Fall*

Article 3

From the Guest Editors: Nursing Home Litigation: An Overview

Julie A. Braun

Jane M.R. Mulcahy

From the Guest Editors Nursing Home Litigation: An Overview

This overview of the most common fact patterns involved in the litigation of neglect or abuse of the elderly provides essential definitions and statistics from which the remaining articles in this issue expand.

By Julie A. Braun and Jane M.R. Mulcahy

The average award in nursing home negligence cases nearly doubled between 1987 and 1994, from $238,285 to $525,853.[1] Approximately twenty percent of all cases against nursing homes result in punitive damages, compared with 5 percent in other types of personal injury cases.[2] Civil litigation brought by or on behalf of a resident against a nursing home may involve a number of different fact patterns that support one or more legal theories.[3] This *Elder's Advisor* issue concentrates on tort cases involving chemical restraint (Julie A. Braun and Lawrence A. Frolik), pressure sores (Jeffrey M. Levine), sexual abuse (Elizabeth A. Capezuti and Deborah J. Swedlow), and wandering (Janice F. Mulligan and Steven M. Levin) delivered from legal, medical, academic, and consultant perspectives. Each article provides a generous overview of the subject accompanied by valuable practice tips. In addition, this *Elder's Advisor* issue instructs on gathering and analyzing the nursing home record (Deborah D. D'Andrea). Moreover, it evaluates options for the distribution of funds received as a result of winning or settling a personal injury claim on behalf of the nursing home resident (Cheryl C. Mitchell and Ferd H. Mitchell). Finally, Jane M.R. Mulcahy reviews an essential reference book for every nursing home case. This guest editorial overview encompasses the varied fact patterns that may arise in the nursing home environment and trigger a lawsuit as a result.[4]

Julie A. Braun, J.D., L.L.M, is a Chicago-based attorney and writer. She chairs the American Bar Association Tort and Insurance Practice Section, Medicine and Law Committee.
Jane M.R. Mulcahy practices law at Brusky & Sjostrom SC in Wauwatosa, Wisconsin. Her practice focuses on elder law and estate planing.

Commom Fact Patterns

Choking and Feeding Tube Cases

Swallowing impairment or dysphagia[5] increases with advancing age and accompanies a variety of conditions (such as cerebral vascular accidents, dementia, poor dentition, Parkinson's disease, and Sjogren's syndrome).[6] Experts estimate that forty to sixty percent of institutionalized older adults have identifiable signs and symptoms of a swallowing disorder.[7] "Dysphagia is an uncomfortable, frightening, and potentially life-threatening condition" that represents a major healthcare problem for nursing homes.[8] Federal regulations addressing dietary services usually are referenced in allegations

involving choking or aspiration as a result of swallowing[9] or chewing disorders.[10] In *Beverly Enterprises-Virginia, Inc. v. Nichols*, for example, a nursing home was held liable after an unattended resident suffering from Alzheimer's choked to death on some food that she could neither chew nor swallow properly.[11] The case was tried, without the need for an expert witness, on the theory that the home was negligent in allowing the resident to eat without assistance.[12]

Some nursing homes find it easier (and cheaper) to tube feed a resident than to assist the resident who has difficulty eating.[13] Federal regulation prohibits this practice.[14] If tube feeding is appropriate, the nursing home must ensure that the resident "receives the appropriate treatment and services to prevent aspiration[,] pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers[,] and to restore, if possible, normal eating skills."[15] In *Crowne Investments Inc. and Crowne Management Corp. v. Reid*, the Alabama Supreme Court upheld a $750,000 verdict rendered in an asphyxiation death case against the defendant owner-operator of a nursing home and its management company, a co-defendant.[16] The estate's medical malpractice-based complaint alleged that the nursing home had negligently caused or allowed the decedent's wife to feed him although she was not medically trained to feed someone in his condition.

Wandering Cases

Many different types of problematic behaviors are encountered among the nursing home population, including wandering. In this issue's article, *Litigating Nursing Home Wandering Cases*, Janice F. Mulligan and Steven Levin consider the recurrent scenarios encountered with residents who wander and the standard of care applicable to wandering cases. They name exposure to the elements and being struck by a moving vehicle as the most prevalent injuries sustained as a result of wandering. They advise that because of the potential dangers, wandering is a behavior for which the nursing home should make accommodations. Mulligan and Levin estimate that more than thirty-one percent of ambulatory, demented nursing home residents demonstrate this intriguing, yet potentially hazardous, behavior. Suggested causative factors of wandering include overstimulation, boredom, restlessness, loneliness, stress, the desire to feel useful, and prior life patterns. To protect the wanderer from harm, the authors recommend that the nursing home identify wanderers, develop prevention programs, secure the facility from wandering hazards, and implement procedures to deal with wandering behavior when it occurs. To deal with potential wandering hazards, they propose that the nursing home alter the environment, secure the environment, or implement behavior modification. Mulligan and Levin also present case law and share practice tips for successful litigation of wandering cases.

Falls and Fall-Related Injuries

Falls and fall-related injuries are a leading cause of lawsuits against nursing homes.[17] Nearly one third of people sixty-five years of age or older fall each year.[18] Dr. Rein Tideiksaar, a recognized authority on the topic of falls, estimates that more than fifty percent of nursing home residents fall annually; over forty percent experience repeat fall occurrences.[19] About eleven percent of falls result in significant injury (such as hip fractures), often leading to hospitalization and further physical deterioration.[20] Falls are a major cause of death among older adults.[21] About twenty percent of all fall-related deaths occur in the five percent of elderly persons residing in nursing homes.[22] A facility's alleged failure to protect a resident from falling has been considered negligence[23] in some cases, and health care malpractice[24] in others.[25]

Physical and Chemical Restraints

A major issue in nursing homes is the use of chemical and physical restraints.[26] Federal law and regulation prohibit using chemical or physical restraints for discipline or convenience.[27] Restraints may be used only when necessary to treat medical symptoms or to ensure the physical safety of the resident or other nursing home residents.[28] Except in emergencies, physical and chemical restraints may be used only with the informed consent of the resident (or the resident's legal representative) and under a physician's written order specifying the duration and circumstances for their use.[29]

Physical restraints include any manual method or physical or mechanical device, material, or equipment attached or adjacent to the nursing home resident's body that physically restricts the resident's freedom of movement, physical activity, or normal access to the resident's body.[30] Types of physical restraints include, but are not limited to,

leg and arm straps, hand mitts, soft ties or vests, wheelchair safety bars, as well as lap cushions and lap trays the resident cannot remove.[31] Certain nursing home practices satisfy the definition of a restraint. For example, tucking in a sheet so tightly that a bed-bound resident cannot move or placing a wheelchair-bound resident so close to a wall that the resident is prevented from rising.[32] Seclusion, the involuntary confinement of a nursing home resident alone in a unit or room that the person is physically prevented from leaving, may be characterized as another form of restraint.[33] "Depending on their purpose, side rails may or may not be restraints."[34] Side rails are restraints if used to keep a resident from climbing out of bed "and that resident wants to get out of bed."[35] Side rails are not restraints if they "facilitate mobility in and out of bed."[36] If used for both purposes, they must be evaluated as restraints.[37]

In *Legal Aspects of Chemical Restraint Use in Nursing Homes*, Julie A. Braun and Lawrence A. Frolik define chemical restraints as any drug used for discipline or convenience rather than to treat medical symptoms. The authors discuss the consequences of chemical restraint including its impact on resident autonomy, consciousness of self or environment, and functional decline as well as its relationship to fall risk and a variety of other medical problems. Braun and Frolik cite the 1987 Nursing Home Bill of Rights as landmark legislation that changed the way nursing homes use chemical restraints. Under this law, the nursing home resident's care plan must reflect the utility of any drug employed by the nursing home. If it does not, the use of the drug is unacceptable. Another safeguard that protects against chemical restraint is the requirement that the informed consent of the resident, or the resident's legal health care decision-maker, must be obtained by the facility, with the resident made aware of the right to refuse such treatment. As with all nursing home tort investigation, Braun and Frolik suggest that a thorough investigation of the nursing home record be made and compared against the applicable standard of care.

Scalding Suits

In practice, scalding suits arise when residents are left unattended in a bath or shower. In *Ivy Manor Nursing Home v. Brown*, the Colorado Court of Appeals reversed a directed verdict in favor of the nursing home where a resident was scalded while being placed in a bathtub.[38] In *Starling v. MetroHealth Center Skilled Nursing*, employees at a county-run facility allegedly improperly set the temperature of a resident's bath, improperly transferred her into the bath, and failed to monitor her.[39] The complaint asserted that their negligence caused severe injuries. The county unsuccessfully moved for dismissal on the basis of sovereign immunity.

Burn Cases[40]

Poor posture control, hand dexterity, or confusion can increase the chances of an accident among restrained nursing home residents who smoke.[41] Also, visitors and other residents unaware of a potential fire hazard may give smoking materials to the resident without staff knowledge.[42] Further, many residents use oxygen, or are in close proximity to other residents who use oxygen, thereby increasing the danger of fire.[43] The deliberate or accidental igniting of restraints may result in death or injury.[44] For example,

> A 76-year-old nursing home resident diagnosed with dementia died two days after suffering third degree burns over 56 percent of his body when his clothing caught fire. Allegedly, the resident was found standing and ablaze from the waist up after facility staff responded to screams. In a subsequent negligence lawsuit, the decedent's surviving heir claimed that the resident had been placed in a vest restraint without a physician's order in violation of federal and state regulatory rules and procedures. She also claimed that the facility administrator had instructed employees to restrain the resident when his family members left the premises after visiting. The plaintiff also alleged that the facility had an ineffective smoking policy despite knowledge that some residents had cigarettes and lighters. She theorized that the resident's roommate, who also suffered from dementia, either lit a cigarette for the decedent or tried to help him use a cigarette lighter to burn off the restraining vest's straps. The resident's room was cleaned and painted at night immediately after the fire. A fire investigator allegedly found a trash bag in a dumpster containing the decedent's clothing and the remains of the vest. The administrator denied the allegations. A Texas Department of Human Services investigation prompted the establishment of an involuntary trusteeship to operate the facility and return it to compliance with federal and state regulations. A $1,350,000 settlement ended the negligence suit.[45]

It is important for every nursing home to have a smoking policy or risk a similarly large settlement following resident death from self-inflicted burns. Risk managers are advised to review their facility's smoking policy and compare it to actual smoking practices within the facility.

There have been reports of physical restraints with ash and cigarette burns in them, indicating a safety problem with flammable materials.[46] Although the Food and Drug Administration does not require flame-resistant materials for all restraints, the agency recommends that health care institutions, including nursing homes, develop and implement policies using flame-retardant restraints for residents who smoke while restrained.[47]

Malnutrition and Dehydration

Proper nutrition care is vital to the health and well-being of nursing home residents. The most common nutrition-related problems are unintended weight loss,[48] dehydration, pressure ulcers, and complications from tube feeding. Dehydration is the most common fluid and electrolyte disorder in long-term care settings.[49] Inadequate fluid intake in older adults "may lead to rapid dehydration and precipitate hypotension, fever, constipation, vomiting, mucosal tissue dryness, and confusion."[50] Federal regulations require that the nursing home provide each resident with sufficient fluid intake to maintain proper hydration and health.[51] Providing nursing home residents "an adequate amount of fluid is a basic, universal physiological need. It is not sophisticated, highly technological, costly care. If we do not provide an adequate amount of fluid to nursing home residents, we have seriously failed" America's nursing home residents.[52]

"While malnutrition and dehydration are frequently the result of nursing home negligence, it can be extremely difficult to prove that they were the actual cause of death, and it is even more difficult to prove that a death was due to improper feeding."[53]

Pressure Sore Cases

Pressure sores, also known as pressure ulcers, decubitis ulcers, or bedsores, are among the most common adverse events that occur among nursing home residents.[54] The incidence of pressure sore development among residents seems to increase arithmetically with the length of stay in a facility, with more than twenty percent of residents developing a pressure sore after two years in a nursing home.[55] The development of pressure sores has long been equated with poor quality nursing care.[56] Consequently, the risk of litigation for negligent care involving pressure ulcers has increased.[57] Less than ten percent of cases reviewed by outside medical experts go to trial.[58] "Most claims are settled before a case is filed, and many settlements are confidential and unreported. Thus, the total number of cases annually is now assumed to be many thousands."[59]

Plaintiffs prove negligence by looking for patterns of behavior because pressure ulcers develop over time and time is required to treat and heal their occurrence.[60] Such evidence is found in the resident's medical record; through careful examination of federal and state nursing home survey results; and in federal regulations[61] and interpretive guidance[62] governing pressure sores.[63]

However, not every pressure sore that develops results in litigation, and not every pressure sore case commands a win for the plaintiff. Common factors that produce decisions favoring the defendant nursing homes include the following:[64]

- supporting documentation in the medical record reflects rigorous adherence to the standard of care for pressure ulcers;
- verifying underlying disease and complications that made bedsore development inevitable;
- developing and implementing aggressive and comprehensive bedsore prevention and treatment programs;
- demonstrating the resident's preexisting weakness or frailty;
- alleging contributory negligence (the resident refuses to comply with a care plan, for example); and
- highlighting contributing medical conditions (such as a resident who is unable to lie in a position to alleviate pressure on her skin because emphysema requires that the resident maintain a sitting position).

In *The Pressure Sore Case: A Medical Perspective*, Dr. Jeffrey M. Levine, defines the pressure sore as a skin lesion that is usually on a bony prominence that is caused by unrelieved pressure and results in damage to the underlying tissue. Alarmingly, Dr. Levine states that residents with

pressure sores have a two to six times greater mortality risk than residents without the sores. The 1987 Nursing Home Bill of Rights is once again cited as the law that changed the prevalent practices in this area. Dr. Levine discusses preventive measures, appropriate care, proper documentation, nutrition and rehabilitation, avoidability, expert review, survey reports, and complaint files in the context of evaluating the pressure sore case. Then, Dr. Levine outlines the best defense against litigation including establishing a pressure sore program, detecting and preventing risk factors, training and educating staff, and fostering job satisfaction for caregivers.

Medication Errors

Some of the most successful litigation against nursing homes concerns medication administration errors.[65] Approximately ninety-five percent of all nursing home residents receive medication.[66] Overuse or underuse of a drug, administration of the wrong medication, or failure to properly monitor the resident for side effects may result in serious injury or death.

Sexual Abuse

In *Sexual Abuse in Nursing Homes*, Elizabeth A. Capezuti and Deborah J. Swedlow discuss the disturbing occurrence of the rape of nursing home residents. The authors remark that older residents with physical disabilities, residents with cognitive impairments, and younger residents with severe physical impairments are the three most common categories of nursing home rape victims. Additionally, the victim's age, assault history, physical status, cognitive ability, generational influence, socioeconomic status, and race are cited as potential barriers to the victim's ability to report the rape. Once again, the Nursing Home Bill of Rights is cited as the instrument that brought the problem of sexual abuse in the nursing home to the forefront and prompted investigation of the problem and treatment of the victims. Capezuti and Swedlow then explore the difficulties in investigating the rape case where the victim has diminished capacity. Also discussed are the increased injuries that are more likely to occur in the older rape victim. The authors suggest that traditional negligence, negligent hiring and supervision, and vicarious liability or respondeat superior are tort remedies that the victim's attorney should consider in the nursing home rape case.

Miscellaneous Cases

Other injuries that may be the basis of a lawsuit include physical abuse, improper insertion of catheters and feeding tubes, injuries resulting from medical negligence, illness due to improper ventilation control (that is, a facility maintains excessively hot or cold temperatures that cause dehydration or discomfort),[67] gangrene, emotional trauma and distress, or injuries caused by rodents[68] or other vermin (for example, a resident is attacked by fire ants while in bed or develops maggots in a wound because of the presence of flies).[69]

This *Elder's Advisor* Issue

Since 1987 and the passage of the Omnibus Budget Reconciliation Act, which encompasses the Nursing Home Bill of Rights, advocates for injured nursing home residents have a new tool in seeking justice for their clients. This legislation constructed a new standard of care that allowed civil litigation in this area to expand its legal theories and more ably administer justice for the injured nursing home resident. This issue explores these expanded theories and provides the practitioner with a reference source for litigating the nursing home tort case.

Endnotes

1. *See* Thomas D. Begley, Jr., *Nursing Home Law and Litigation*, 156 N.J. L. J. 120 (Apr. 12, 1999).
2. *See id.*
3. *See generally* Annotation, *Patient Tort Liability of Rest, Convalescent, or Nursing Homes*, 83 A.L.R. 3d 871, 879–902 (1978 & Supp. 1990).
4. *See generally* Julie A. Braun, *Resident Abuse and Neglect: What to Look for When Visiting a Client in a Nursing Home*, 12 NAELA Q. 3 (Fall 1999).
5. *See* TABER'S CYCLOPEDIC MEDICAL DICTIONARY 593 (17th ed. 1993) (defining dysphagia) [hereinafter TABER'S].
6. *See* Jeanie Kayser-Jones, *Dysphagia Among Nursing Home Residents*, 20 GERIATRIC NURSING

77, 78 (1999) [hereinafter *Dysphagia Among Nursing Home Residents*].

7. *See id.* at 78.

8. *Id.* at 82.

9. *See generally id.*

10. *See* 42 C.F.R. § 483.25.

11. 441 S.E.2d 1 (Va. 1994).

12. *See id.* at 3; Ralph Gerstein, *Nursing Home Litigation, in* THE ELDER LAW PORTFOLIO SERIES 13-1, 13-28, 13-35 through 13-39 (Harry S. Margolis ed., Feb. 1996) (discussing *Beverly Enters.-Virginia, Inc. v. Nichols* and presenting sample testimony in a wrongful death case fact pattern based upon this case).

13. *See* ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 2.11[2] (1999) (discussing nutrition taken through a tube).

14. *See* 42 C.F.R. § 483.25(g)(1) (referencing use of a naso-gastric tube although the regulation presumably applies to other types of feeding tubes as well).

15. 42 C.F.R. § 483.25(g)(2). Another regulation obligates a nursing home to provide "proper treatment and care" for tube feeding. *See* 42 C.F.R. § 483.25(k)(2).

16. 740 So. 2d 400 (Ala. 1999).

17. *See* Laurence Z. Rubenstein, *Preventing Falls in the Nursing Home*, 278 J. AM. MED. ASS'N 595, 596 (1997).

18. *See* Steven R. Cummings & Michael C. Nevitt, Editorial, *Falls*, 331 N. ENG. J. MED. 872, 872 (1994). For additional reference to nursing home fall injury rates see Purushottam B. Thapa et al., *Injurious Falls in Nonambulatory Nursing Home Residents: A Comparative Study of Circumstances, Incidence, and Risk Factors*, 44 J. AM. GERIATRICS SOC'Y 273, 273–78 (1996); Clorinda M. Cali & Douglas P. Kiel, *An Epidemiologic Study of Fall-Related Fractures Among Institutionalized Older People*, 43 J. AM. GERIATRICS SOC'Y 1336, 1336–40 (1995).

19. *See* REIN TIDEIKSAAR, FALLS IN OLDER PERSONS: PREVENTION AND MANAGEMENT 1 (Health Professions Press 2d ed. 1998). This book discusses the consequences of falls (mortality, morbidity, family concerns, and institutional effects); reviews the intrinsic and extrinsic causes of falls and identifies risk factors for falls and injury; considers environmental modifications (such as lighting, floor surfaces, hallways, beds, seating, bathroom, tables and nightstands, and storage areas); details the clinical assessment and evaluation of fall risk and fall history; describes interventions that reduce fall risk including medical, rehabilitative, and environmental strategies as well as fall prevention programs; and evaluates reducing physical and chemical restraint use while decreasing fall risk. The appendix offers a performance-oriented environmental mobility screen; ambulation device measurement; ambulation device utilization; home fall prevention handouts; and case studies for self-study or training.

20. *See* Rubenstein, *supra* note 17, at 596.

21. *See* TABER'S *supra* note 5, at 708.

22. *See* Rubenstein, *supra* note 17, at 596.

23. *See, e.g.*, Parker v. Illinois Masonic Warren Barr Pavilion, 701 N.E.2d 190, 194–96 (Ill. App. Ct. 1998) (determining that ordinary negligence had been alleged, and accordingly reversing a verdict based in part on an expert physician's testimony); McLeod v. Plymouth Court Nursing Home, 957 F. Supp. 113 (E.D. Mich. 1997) (finding that the resident alleged ordinary negligence involving a fall due to the facility's failure to obtain a wheelchair for the resident); Owens v. Manor Health Care Corp., 512 N.E.2d 820, 823–24 (Ill. App. Ct. 1987) (ruling ordinary negligence had been alleged where resident had fallen because the facility had negligently restrained him in his wheelchair); Kujawski v. Arbor View Health Care Ctr., 407 N.W.2d 249, 254–55 (Wis. 1987) (failing to use restraining belt in wheelchair would be ordinary negligence); Brodie v. Gardner Pierce Nursing & Rest Home, Inc. 403 N.E.2d 1184, 1186 (Mass. App. Ct. 1980) (concluding no health care malpractice involved in nursing home's failure to maintain stairway in safe condition).

24. *See e.g.*, Dunagan v. Shalom Geriatric Ctr., 967 S.W.2d 285, 288–89 (Mo. Ct. App. 1998) (applying the statute of limitations for health care malpractice to allegations that a nursing home's negligence on five separate occasions had allowed a resident to fall and break bones); Sexton v. St. Paul

Fire & Marine Ins. Co., 631 S.W.2d 270, 272 (Ark. 1982) (citing that health care malpractice was alleged in a case involving a resident's fall due to the facility's failure to restrain the resident); Husby v. South Alabama Nursing Home, 712 So. 2d 750 (Ala. 1998) (assuming without discussion that health care malpractice had been alleged in a case involving allegations that a nursing home resident fell four times despite facility efforts to restrain her in bed).

25. *See* CARLSON, *supra* note 13, at § 10.09[2][a].

26. *See generally* Julie A. Braun & Elizabeth Capezuti, *The Legal and Medical Aspects of Physical Restraints and Bed Siderails and Their Relationship to Falls and Fall-Related Injuries in Nursing Homes*, 3 DEPAUL J. HEALTH CARE L. ___ (forthcoming Fall 2000) (copy on file with authors) [hereinafter *The Legal and Medical Aspects of Restraints and Siderails*]; Julie A. Braun & Elizabeth Capezuti, *Siderail Use and Legal Liability in Illinois Nursing Homes*, 88 ILL. B.J. 324, 324–34 (2000) (copy on file with authors); Julie A. Braun, *Legal Aspects of Physical Restraint Use in Nursing* Homes, 10 THE HEALTH LAWYER (ABA Health Law Section Jan. 1998).

27. *See* 42 U.S.C. §§ 1395i-3(c)(1)(A)(ii), 1396r(c)(1)(A)(ii); 42 C.F.R. § 483.13(a).

28. *See id.*

29. *See id.*

30. *See* U.S. DEP'T HEALTH & HUMAN SERVS., HEALTH CARE FIN. ADMIN., GUIDANCE TO SURVEYORS—LONG-TERM CARE FACILITIES (Transmittal 274, June 1995), 44.

31. *See id.* at 45.

32. *See id.*

33. *See generally* Frieda H. Outlaw & Barbara J. Lowery, *An Attributional Study of Seclusion and Restraint of Psychiatric Patients*, 8 ARCHIVES PSYCHIATRIC NURSING 69, 69–77 (1994); U.S. Gen. Accounting Office, Health, Educ. & Human Servs. Div., *Improper Restraint or Seclusion Places People at Risk* (GAO/HEHS-99-176, Sept. 7, 1999); Leslie G. Aronovitz, *Extent of Risk from Improper Restraint or Seclusion Is Unknown*, U.S. Gen. Accounting Office, Testimony before the U.S. Senate Committee on Finance (GAO/T-HEHS-00-26, Oct. 26, 1999); New York State Comm'n on Quality of Care for the Mentally Disabled, *Restraint and Seclusion Practices in New York State Psychiatric Facilities* (1994); Elaine Carmen et al., *Report of the Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused* (Mass. Dep't of Mental Health Jan. 25, 1996); Chadwick v. Al-Basha, 692 N.E.2d 390 (Ill. App. Ct. 1998) (alleging unlawful restraint and seclusion).

34. U.S. DEP'T HEALTH & HUMAN SERVS., HEALTH CARE FIN. ADMIN., SIDE RAILS INTERIM POL'Y (Feb. 4, 1997); Beth A. Klitch, *HCFA's Side Rails Update*, 46 NURSING HOMES 10, 10 (1997).

35. *Id.*

36. *Id.*

37. *See id.*

38. Ivy Manor Nursing Home, Inc. v. Brown, 488 P.2d 246, 248 (Colo. Ct. App. 1971).

39. Starling v. MetroHealth Ctr. Skilled Nursing et al., No. 75554, 1999 WL 685641 (Ohio Ct. App. Sept. 2, 1999), *appeal denied*, 722 N.E.2d 527 (Ohio 2000) (Table, No. 99-1931).

40. This section was adapted from Braun & Capezuti, *The Legal and Medical Aspects of Restraints and Siderails*, *supra* note 26.

41. *See* 61 Fed. Reg. 8432, 8438 (1996).

42. *See id.*

43. *See id.*

44. *See id.* at 8432, 8437

45. *Restraints: Resident Death from Burns*, 5 ISSUES IN CONTINUING CARE RISK MGMT. 15, 15–16 (ECRI June 1999) (citing 15 MED. MALPRACTICE 29 (1999)).

46. *See* 61 Fed. Reg. 8432, 8437 (1996).

47. *See id.*

48. A national repository of best practices guidelines for care of nursing home residents at risk for weight loss and dehydration has been included on the Health Care Financing Administration Web site at <http://www.hcfa.gov/medicaid/siq/siqhmpg.htm>

(viewed April 11, 2000) (Select "professional standards/guidelines," next choose "agree," and finally select "nutrition/hydration.") A special section has been added to the State Operations Manual to address weight loss and dehydration.

49. *See* Jeanie Kayser-Jones et al., *Factors Contributing to Dehydration in Nursing Homes: Inadequate Staffing and Lack of Professional Supervision*, 47 J. AM. GERIATRICS SOC'Y 1187, 1187 (Oct. 1999).

50. *Id.* at 1193.

51. 42 C.F.R. § 483.25(j) ("The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health"); *see generally* Sarah Burger et al., NURSING HOMES: GETTING GOOD CARE THERE 63 (1996) (reviewing dehydration in nursing homes).

52. *See id.* at 1193.

53. Janet Shafer Boyanton, *Nursing Home Litigation: An Emerging Field for Elder Law*, THE ELDERLAW REPORT 1, 5 (Harry S. Margolis & Neil V. Golden eds., Apr. 1999).

54. *See* Patricia S. Goode & Richard M. Allman, *Pressure Ulcers, in* DUTHIE: PRACTICE OF GERIATRICS 228, 228 (3rd ed. 1998).

55. *See* Gary H. Brandeis et al., *The Epidemiology and Natural History of Pressure Sores in Elderly Nursing Home Residents* 264 J. AM. MED. ASS'N 2905, 2905–09 (1990).

56. *See* Dan R. Berlowitz et al., *Are We Improving the Quality of Nursing Home Care: The Case of Pressure Ulcers*, 48 J. AM. GERIATRICS SOC'Y 59, 59 (Jan. 2000) ("Pressure ulcers are an ideal measure of quality").

57. *See* Richard G. Bennett, *The Increasing Medical Malpractice Risk Related to Pressure Ulcers in the United States*, 48 J. AM. GERIATRICS SOC'Y 73, 75, 78 (Jan. 2000) (documenting an increase in the number of cases involving pressure ulcers since the 1987 passage of landmark nursing home reform law and another increase in 1992 with publication of companion regulations).

58. *See id.* at 76.

59. *See id.*

60. *See id.* at 77.

61. *See* 42 C.F.R. § 483.25(c) (1998).

62. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH CARE FIN. ADMIN., STATE OPERATIONS MANUAL, Transmittal No. 250 at 122–125 (1992).

63. *See* Bennett, *supra* note 57, at 77

64. *See id.* at 78.

65. *See* Patricia W. Iyer, *Nursing Liability Issues, in* NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 151, 184–86 (Patricia W. Iyer ed., 1999).

66. *See* Begley, *supra* note 1, at 120.

67. *See* 42 C.F.R. § 483.20(h)(6) (stating that the facility must provide "[c]omfortable and safe temperature levels" ranging from 71°–81° F).

68. *See* 42 C.F.R. § 483.70 (describing facility responsibilities with regard to its physical environment).

69. *See* Boyanton, *supra* note 53, at 5.