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## **CIVIL PROSECUTION OF A NURSING HOME CASE- PLAINTIFF'S PERSPECTIVE**

### **A PRIMER FOR THE PLAINTIFF'S ATTORNEY**

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# I. OVERVIEW OF THE NURSING HOME INDUSTRY

### Litigation Trends

We have been litigating nursing home claims for the past three years and have had an interest in it for longer and have lobbied for and supported nursing home safety. We observed that settlements and verdicts continue to rise. For instance, in a wrongful death case in Texas, in a particularly egregious bed sore case, there was a verdict of \$312 million dollars that was ultimately settled for \$20 million. In 2002 there was a jury verdict of \$50,000,000 in West Virginia that was ultimately reduced to \$5,000,000 because of a high-low agreement. Two years ago a Florida jury awarded a family \$15 million for a nursing home resident's pain and suffering. In New York, Parson v. Interfaith, 267 A.D.2d 367, 700 N.Y.S. 2d 224 (2d Dept. 1999) there was a jury verdict of \$1,000,000 for past pain and suffering.

According to the National Law Journal (7/8/03), citing the American Health Care Association, "lawsuits per nursing home bed have been increasing at an annual rate of 14% since 1995, with 14.5 claims for every 1,000 occupied beds last year."

Compensation in nursing home cases is growing particularly in the area of pressure ulcer a/k/a pressure sore or decubitus ulcer cases. According to the February 2001 edition of the Medical Malpractice Law & Strategy journal in the period from 1987 to 1994, the average award in a nursing home negligence case increased from \$238,285 to \$525,853. According to the National Law Journal (7/8/03), in 2001 the average jury award was \$406,000 and 46% of verdicts were for plaintiff. In addition, while personal injury litigation produced punitive damages in only 5% of cases, the figure was 10% for nursing home lawsuits, according to the recent National Law Journal article. Furthermore, in 28 of 30 plaintiff verdicts/settlements in pressure sore cases, awards averaged \$973,340.

Through these verdicts, juries are sending a clear message to nursing home corporations that they will no longer tolerate them putting profits before people. On the other hand, State legislatures and the US Senate are, at this moment, being heavily lobbied by the insurance industry and health care companies, to limit nursing home liability to \$250,000.00 for *pain and suffering claims*, which in New York, is essentially all one may claim. The future is unknown, except that by the year 2020, the population of "the aged 85 and older will increase by almost 60%!" (National Law Journal (7/8/03). Now that we have hopefully sparked your interest in nursing home litigation, let us discuss the reality of prosecuting these claims.

**In our offices, we join the National Citizen's Coalition for Nursing Home Reform (NCCNHR) for every family or victim that retains us. This organization is worthy of your support. It lobbies and educates in favor of better nursing home care. An application to join is in our materials. (Exhibit "A")**

## **II      STATUTORY AND REGULATORY PROTECTIONS OF RESIDENTS**

Following is a list of some of the Federal and State Statutes and regulations involved in regulating care and protecting residents. Resident's rights and standards for resident's care are detailed in the regulations.

### **A.      FEDERAL**

#### **1.      FEDERAL STATUTE**

**Omnibus Reconciliation Act (OBRA) of 1987 (42 U.S.C. 1396r; 42 U.S.C. 1395I-3) is the comprehensive federal statute that imposes far reaching reform on the nursing home industry. (OBRA of 1990 amended the Medicaid Act to include personal care services by home health providers (Federal regulations at 42 CFR Part 440 and NY State regulations at 18 NYCRR 505))**

#### **2.      FEDERAL REGULATIONS**

##### **1.      Code of Federal Regulations (42 CFR Part 483)**

Federal regulations under the statute which create specific standards of care the nursing homes must follow in order to collect Medicare and Medicaid moneys.

##### **2.      Guidance to Surveyors**

Interpretive guidelines which explain the regulations.

### **B.      NEW YORK STATE**

#### **1.      NEW YORK STATUTES**

##### **1.      PUBLIC HEALTH LAW ARTICLE 28 - HOSPITALS**

**§2801. Definitions – Nursing Home is a hospital.**

**§2801-d. “Private actions by patients of residential health care facilities”**

- **New York statute which creates a private cause of action for nursing home neglect or abuse or violation of “any right or benefit...”. Special advantages conferred by PHL 2801-d:**
- **creates a private statutory right of action if a right or benefit granted by contract, regulation or statute**

is taken away from a resident

- elements of claim: deprivation of a right or benefit and causation
- establishes minimum amounts of damages (at least 25% of the daily rate the nursing home charges)
- expressly authorizes punitive damages (if deprivations of any right or benefit was willful or in reckless disregard of the patient's rights)(d)(2)
- attorney fees can be awarded in discretion of court to victorious resident's attorney (d)(6)
- 3 year statute of limitations
- damages recovered are not Medicaid liens and are exempt for purposes of determining continuing eligibility for Medicaid, if your injured client is still alive and in need of nursing home care.(d)(5)

§2803-c "Rights of patients in certain medical facilities"

§2803-d "Reporting abuses of persons receiving care or services in residential health care facilities"

§2803-e "Reporting incidents of possible professional misconduct"

§2805-d "Limitation of medical, dental or podiatric malpractice action based on lack of informed consent"

§2805-e "Reports of residential health care facilities"

§2805-l "Incident Reporting"

- b. PUBLIC HEALTH LAW ARTICLE 28A – NURSING HOME COMPANIES
- c. PUBLIC HEALTH LAW ARTICLE 36-HOME CARE SERVICES

## 2. NEW YORK REGULATIONS

Title 10 – DOH – Nursing Homes – Part 415

Title 18 – DSS – Adult Homes – Parts 487 - 490

Title 18 – DSS - Adult Day Care –Parts 485 and 492

**Title 18 – DSS – Home Health Care Agencies - Part 505**

**Title 18 – DSS – Adult Care-Family Type Facilities – Part 489**

**Title 18 – DSS-Adult Care-Group Homes – see all of the above**

### **III. THE INITIAL CLIENT INTAKE and SCREENING**

#### **A. Initial Conversation and client intake**

1.           The first thing we want to know is the relationship between the caller and the resident. Was the caller involved in the resident's life? Did they visit? Are they familiar with resident's medical conditions? Do they have health care proxy or power of attorney? If they were not involved and the victim is deceased, was anyone involved (and speak with them)? *If it turns out the family was not involved and did not visit then be really sure you want to handle the case-would the jury care more about the victim than the family did? Maybe-if egregious enough.*  
Find out the family dynamics. Find out if all siblings are speaking. Is the spouse alive? If there is no spouse, will they understand that they will have to share the settlement with their siblings? You may hear, "but my brother was not involved, he never visited, why should he get anything?" Resolve this issue up front. Tell them that you cannot take the case unless they accept this. This dynamic is present in MANY cases. You must investigate and resolve these issues up front.
2.           Meet all potential family members who can legally pursue the intestate's claim, if applicable. Select the most compelling, reliable and knowledgeable individual to act as the estate representative.  
  
*If it's a great case, and no family members are sympathetic or likeable, yet they want to go forward, you can get a retired judge or doctor or advocacy group-NCCNHR- to serve as plaintiff or administrator of the estate of the injured.*
3.           Discuss the existence of Medicare/Medicaid status in that first conversation. (Detail the lien ramifications) and PHL 2801-d for Medicaid.
4.           Fact sheet/intake----sample as Exhibit (B)

#### **B. Possible Presuit Discovery**

1.           Investigation sometimes requires pre-suit discovery pursuant to CPLR 3102(c)
  - a.           CPLR 3102(c) allows a party to obtain disclosure prior to commencing an action but only by Court Order. To obtain the Order, the applicant must show existence of prima facie cause of action.
  - b.           This may be a useful discovery tool if you need to preserve evidence, the entire chart, or to identify proper parties (only permissible purposes of pre-action



disclosure)

#### **IV. PRESUIT CONSIDERATIONS IN NURSING HOME LITIGATION**

Prosecuting a nursing home case is a very expensive proposition. Typically, you have to set up an estate and have an estate representative appointed, at some point. In the context of a large family this can be very expensive and time consuming. The records can be voluminous as the victim may have lived in the nursing home for a long period and has been in and out of the hospital. The initial pre-suit investment will cost several thousands of dollars. Litigation expenses can quickly mount and easily exceed \$25,000 in a nursing home case. In some cases you will have to, or want to, conduct as many depositions on issues of liability as well as damages. Many of the depositions will be to establish damages witnesses on the pain and suffering issues. Many witnesses will be former employees of the facilities, and need to be subpoenaed.

##### **A. WHO IS YOUR CLIENT AND HOW TO GET STARTED**

##### **WHO HAS STANDING TO BE THE PLAINTIFF? (for RECORDS or LITIGATION)**

In order to even secure records to evaluate if you have a case, one needs standing.

**Injured person is alive and competent** – injured person is named as the plaintiff.

**Injured person is alive but incapacitated/incompetent** – unless you are fortunate enough that a “power of attorney” or “guardianship” was previously completed, a guardian ad litem procedure or Article 81 guardianship must be commenced for a person to appear on behalf of the injured person.

In the absence of a power of attorney, the appointment of a Guardian Ad Litem (CPLR 1202) is easier and less expensive than appointing an Article 81 Guardian.

a. Procedure for Guardian ad Litem is outlined in CPLR 1202 - sample petition (Exhibit “C”)

b. Guardian Ad Litem may gather records and conduct the lawsuit but does not have the authority to obtain a court approved settlement or accept settlement funds. Article 81 Guardian must be appointed for that purpose. *Tudorov v Collazo*, 215 AD 2d 750, 627 N.Y.S.2d 419 (2d Dept. 1995). (obviously if the victim is deceased by

the time of settlement, the process will proceed as an Estate in Surrogate's Court)

The plaintiff is named as "Jane Doe, as guardian ad litem for (the injured person)". There should be an allegation in the Complaint stating that Jane Doe applied for guardianship and setting forth when, where, and how such guardianship was granted.

**Injured person is deceased-** Letters of administration or letters testamentary should be applied for immediately upon taking the case.

**If there is a will,** a Executor of the Estate of the injured person must be appointed by applying to the Surrogate's Court where the deceased resided at the time of his or her death for letters testamentary. If there are already letters testamentary or after such letters are issued, the plaintiff in the cause of action is named as "Jane Doe, as Executor of the Estate of the injured person". There should be an allegation in the Complaint regarding the date and Court where the petition was made for and issuance of the letters testamentary.

**If there is no will,** an Administrator of the Estate must be appointed by applying to the Surrogate's Court for letters of administration. If there are already letters of administration or after such letters are issued, the plaintiff is named as "Jane Doe, as Administrator of the Estate of the injured person".

**PRACTICE POINT:** *You might want to associate with a Trusts and Estates attorney who will do the guardianship papers and applications for letters on a contingency pending the success of the case and they will do the compromise order at the end of the case!*

**B. WHO WILL BE YOUR CLIENT, LIKEABLE? – see III (A) above.**

Who should be the "authorized representative" of the incompetent or deceased resident? see III(A)(1) above

**C. TYPES OF RECORDS AND HOW TO SECURE RECORDS**

Once you have someone with legal capacity in order to secure records (see IV (A) above), you have to obtain all records from the nursing home and all health care providers in order to fully evaluate liability and damages.

If the resident had a long stay in the nursing home this can be very expensive because every facility will charge \$ .75 cents per page.

A few years in a nursing home can generate thousands of pages. Once you have the records YOU MUST HAVE an expert review them immediately and in some cases you may need more than one expert. Once again this is very costly. Some of us use a nurse with nursing home expertise for the first pass through the case. After a nurse affirms deviations and negligence, a doctor is consulted on similar issues as well as causation issues.

How many years of records are needed to get? This is not an easy answer as there may be many degrading and dehumanizing events in the nursing home that are actionable and a lot of poor care that contributed to the “fall” or the “ulcer” or the “death”. We suggest securing the records for three months before the incident, for the first view of the case, and secure the care plans on MDS forms going back further.

The attorney can ask the family to pay for the records and we then review them to determine if they should be forwarded to an expert. In ordering the records you can save money by requesting only some of the records. For example, in a “fall” case you may only want the initial assessment and the incident reports if you can get them. Your expert can help you identify the records that you want to request. When you request the records from the nursing home advise them that you are requesting the records pursuant to Federal and New York State Law as follows:

**48 CFR 483.75 (l)(1)**

The facility must maintain clinical records on each patient

**42 CFR 483.10(a)(2)(i) and (ii)**

Facility must give access to records within 24 hours of request, and facility must provide copies of the records to the resident or his authorized representative within 2 business days

**10 NYCRR 415.22 and 10NYCRR 415.3(c) (1) (iv)**

Facility must turn over the records to the resident or his authorized representative within 24 hours and copy said record within 2 days, for its own cost or .75 cents per page, whichever is less.

1. **NURSING HOME CHART** – Looks like a hospital chart but be aware of special types of records in a nursing home chart and

what to look for. Plans of Care---duty to update.... RAPS, MDS (Exhibit “D” MDS form - note that you must secure this form “in color” by color copying) records showing “turning and repositioning”,... .

2. **HOSPITAL CHARTS** - In addition to obtaining the nursing home chart, it is important to obtain all relevant medical records, especially hospital records. Hospital records will often evidence signs of inadequate care that are not necessarily illustrated in the nursing home chart. Obtaining complete copies of all the records from the hospitals that treated your client before, during and after his or her residency at the nursing home will help you rebut this argument and get a more complete understanding of the care, or lack thereof, provided by the nursing home.

The need to obtain all of your client’s hospital records is best illustrated in the context of a bedsore case. You should review the hospital records immediately prior to your client entering the nursing home and immediately after leaving the home. By doing so you can determine whether your client developed bedsores prior to his admission to the nursing home, and if so, how severe they were. Often the nursing home records will suggest the bedsores were healed at the time of discharge to the hospital, but the hospital records will suggest otherwise. At the time of admission, the hospital will assess the severity of the bedsore by charting its length, depth and overall appearance. Often they will take photographs. *Don’t be surprised if the nursing home or hospital that admitted the patient with pressure ulcers, took photographs in order to protect themselves.*

Of course the hospital records may indicate the opposite, that the hospital is primarily responsible, and accordingly you will add them as a defendant.

3. **STATE SURVEYS, LAW ENFORCEMENT INVESTIGATION REPORTS AND OTHER STATE AGENCY INVESTIGATIONS**

If a family member of a nursing home resident calls you after the occurrence of suspected abuse, *you should encourage them to report the abuse to the New York State Department of Health hotline for nursing home abuse.* The number is 888-201-4563. It is suggested that the attorney do a written complaint or draft it for the victim’s family and include records (if already received) or photos (pressure ulcers). The attorney can attach records to encourage easy investigation and the attorney can get the client to call and keep after the DOH- they are overworked, understaffed and will more likely pursue and survey cases in which the family is more involved.

The Department of Health is required to investigate and

survey every allegation of neglect and/or abuse. Furthermore, they will investigate complaints of a suspicious death even if there is not an allegation of neglect and/or abuse.

If the case warrants it, the investigators will interview witnesses and review the records to determine if there was abuse and/or neglect. *A report will be generated that will be made available to you and your client once it is completed. While there is rarely a finding of neglect, when there is, the report is invaluable.* In any case, the investigators will “find facts” and interview witnesses.

**Law Enforcement Investigation:** If your client was involved in a case of potential abuse or there is a suspicious death there may be an investigation performed by a New York State law enforcement agency. Again, these reports provide immediate, frontline investigation of such incidents which will serve as a valuable discovery tool in your case. Law enforcement agencies sometimes are eager to discuss an abuse case with you and advise you “off the record”, as to what they have found.

**Ombudsman:** You should also ask your client whether the Neglect and abuse was reported to the local ombudsman. The ombudsman acts as an advocate for the resident in the facility.

#### 4. DEPARTMENT OF HEALTH SURVEYS & PLANS OF CORRECTION

Nursing homes must submit to *annual* surveys conducted by The New York State Department of Health in order to participate in Medicare and Medicaid programs. You should obtain the survey reports for the period of your client’s residency to determine whether there were any systemic problems at the facility (e.g., pressure ulcers), which are relevant to your client’s case. The key to using these surveys is evaluating the “scope and severity” of the deficiencies cited by the inspectors and relating the deficiencies to the issues of neglect/abuse in your case. For example, if you have a pressure ulcer case, you should look for citations relating to the lack of pressure ulcer prevention measures and pressure ulcer development at the facility. (These citations are highly relevant to your case, should be discovered in depth in depositions and should be presented by your expert

**when testifying about systemic failures at the facility which caused or contributed to your client's injuries).**

**Obtain the nursing home surveys by making a FOIL request to:**

**New York State Department of Health  
Office of Continuing Care  
Bureau of Administrative Services  
161 Delaware Avenue  
Delmar, NY 12054**

**Obtain summaries of nursing home surveys on line at:**

**<http://www.health.state.ny.us/nysdoh/nursing/kings.htm>**

**<http://www.health.state.ny.us/nydoh/consumer/nursing/homenurs.htm>**

**On occasion you will locate a survey report which identifies your client's problems at the facility. Of course, this is a grand slam because an independent group of inspectors has discovered that your client was neglected and/or abused in violation of the OBRA standards.**

#### **4. OTHER PRE-SUIT INVESTIGATIONS**

1. Investigate whether you have to file a notice of claim.
2. Arrange for photographs to be taken of your client by family? By a professional? By you?
3. Review any website that the facility may have and find out if your client relied on the website in choosing this nursing home.
4. Obtain and review all of the brochures and pamphlets that were given to your client upon admission if the family has them. Often they contain invaluable information such as bold statements that they specialize in caring for Alzheimer's residents. Get someone to go or you go, to the nursing home for a tour and secure brochures.
5. Call the nursing home, get put on hold- do they have "music on hold" where the magical voice tells you how wonderful the nursing home company is? Consider taping it and get this tape in disclosure.
6. Secure the incident reports if the nursing home omitted them from the chart.

- a. The Court of Appeals in Subpoena Duces Tecum to Jane Doe, 99 NY2d 434, 757 NYS2d 507 (2003) provides an excellent discussion of what constitutes privileged quality assurance materials and what does not.
  - b. Defendant will always argue that all documents such as infection control reports and accident/incident reports constitute quality assurance documents - the Court of Appeals disagrees where records kept pursuant to statutory or regulatory mandate. Even though this case came up in the course of a Grand Jury investigation of Medicaid fraud in nursing homes, I think it may be used to successfully argue that all these documents are discoverable in a civil negligence/malpractice case.
7. Are there other defendants besides the Nursing Home. Were incompetent nurses assigned as “temps” by a staffing company? Are the individual nurses insured? (Discussion of case history - 3 and how defendant nursing home received contribution from insurance carrier for individual nurse)

## **V. TYPICAL NURSING HOME CASE SCENARIOS AND THEORIES OF LIABILITY AND NECESSARY DISCLOSURE**

### **A. GENERAL REQUIREMENTS and REGULATIONS**

The NYS Dept of Health surveys all nursing homes each year.

In general 5% of all State surveys must be done by the federal

government as oversight on the State's surveyor performance. The Feds are out there to see that the State surveyors are doing their jobs. Surveyors are supposed to interview staff, residents, resident's families and review charts (both "active" and "closed").

In addition, the Federal regulations and New York State require that:

The facility must be safe:

42 CFR 483.70 and 10NYCRR§415.29 (the facility- (the physical environment) must be designed and maintained to protect the health and safety of residents.)

The residents must be provided good and necessary care.

Under 10NYCRR§415.12 (Quality of Care) and 42CFR

483.25:

shall

attain

mental

with

care

determination."

"Each resident shall receive and the facility provide the necessary care and services to or maintain the highest practicable physical, and psychosocial well-being, in accordance the comprehensive assessment and plan of subject to the resident's right of self-

In the federal regulation (42 CFR 483.25) and the State regulation (10NYCRR§415.12): there is a list of required treatments that the nursing home "ensures" will

care and happen relating to:

1. Activities of daily living (ADL)
2. Vision and hearing
3. Pressure sores
4. Urinary incontinence
5. Range of motion
6. Mental and psychosocial functioning
7. Enterol feeding tubes
8. Accidents



9. Nutrition
10. Hydration
11. Special needs
12. Drug therapy
13. Medication errors

This list of Quality of Care issues is not complete. In 10NYCRR§415.12 and 42CFR§483.25 (F309)(PP-83)(citations hereinafter to “PP-page #” are to the pages of “Guidance To Surveyors-Long Term Care Facilities” in “The Long Term Care Survey” by American Health Care Association, May 2001) *is a general “catchall” to “ensure” all other safe care that is not included in the above list.* In the regulation listing all “quality of care” requirements, the opening general paragraph of 10NYCRR§415.12 is a “catch all” for requiring good care. In the “Guidance to Surveyors” (PP-83) they are told to “*use Tag F309 to cite (the nursing home for) quality of care deficiencies that are not explicit in the quality of care regulations.*” For instance: avoiding “pain” and avoiding “fecal impaction” are covered by F309. A violation of F309 would be at least a “G” level- serious-violation.

When the Department of Health survey occurs, the nursing home must present a “Roster/Sample Matrix” listing every patient and all their “resident characteristics”. (Exhibit “E”) - form (Exhibit 90 from AHCA “the Long Term Care Enforcement Procedures”) Each patient’s data and problems are listed, including “pain”, “fecal impaction” and items listed in the regulations, such as “pressure sores” and “falls” (accidents). (form HCFA 802 and Exhibit 265 of “The Long Term Care Survey” by AHCA (5/01))

**PRACTICE POINT:** *In disclosure, get this form from defendant and from DOH with other patient’s names redacted - gives you full view of the patient on a particular day. It also gives characteristics of other patients (redacted names) so you can explore whether staffing levels were appropriate for these types of residents.*

The list of Quality of Care issues includes many items whose violation may cause an accident (falls) or other liability inducing changes in the plaintiff.

As for *incidents* involving residents:

42 CFR §483.13 and 10NYCRR§415.4 (Resident behavior and facility practices) state that:

- Alleged violations including neglect must be thoroughly

*investigated* 42CFR §483.13( c )(3); 10 NYCRR§415.4(b)(3)

- The facility must ensure that all violations involving mistreatment and neglect are *reported* immediately to the administrator of the facility and to the (State Department of Health) 42CFR §483.12( c )(2); 10 NYCRR§415.4(b)(2) (pursuant also to PHL§2803-d)
- Injuries of unknown origin must be investigated and reported to the facility administrator and to the (State Department of Health) 42CFR§483.12( c )(2); 10NYCRR§415.4(b)(2)

When the New York State Department of Health receives the report of an “alleged violation” it is to generate a survey/investigation. A survey can also be initiated from the complaint made by family, the attorney or an honest employee (whistle blower), *but the facility is required* to report all “alleged violations involving neglect, including injuries of unknown source, to the Department of Health”.

**PRACTICE POINT:** *If an incident or alleged violation was not reported to DOH, depose the home. Why was it not reported? Who discussed it? Who made the decision not to report?*

**PRACTICE POINT:** *If your client’s case was surveyed by the annual routine surveys or in response to a complaint, question the nursing home on the factual findings, did they agree or disagree with the surveyor’s findings? Did they write in response? Did they submit “plan of correction”? (By not disputing the DOH findings and merely putting in a “plan of correction”, weren’t they admitting the finding?)*

Finally, note that

**42 CFR 483.20 (b)(2) requires that**

**-within 14 days of admission, the facility must perform a comprehensive assessment of the resident, including consideration of risk for falls** (complete an MDS)(F273)(PP-72) ( Exhibit “D”)

and that

**-7 days thereafter must establish a plan of care.**

Therefore, a completed comprehensive care plan is to be done by day 21. (F280)(PP-82.2)

**PRACTICE POINT:** (PP-72) §483.20, Resident Assessment, (b) (2), “requires comprehensive assessment of resident within 14 days of admission” but also Guidance to §483.20 (b) (PP-69) provides that “the

*facility is responsible for addressing the resident's needs from the moment of admission". (initial care plan)*

*Therefore, good practice requires an assessment of real risks (i.e.: falls) with **any** assessment and with admission.*

## **B. FALLS (FALL INJURIES)**

**The elderly fall with alarming regularity. So much of the Federal regulations and State regulations deal with "falls" due to the proclivity of falls as well as the danger to the remaining health of the elderly that a severe fracture represents. Typical results include the permanent loss of mobility and permanent decrease in the quality of life as well as the dangers of a severe downturn in health and quality of life, for the elderly and infirm from undergoing anesthesia in surgery for fractures from falls. Cases involving "falls" center upon issues of poor quality of care and neglect.**

**Falls are extremely common in nursing homes. In surveys of nursing home resident the percentage of residents reported to fall each year ranges from 16-75% with a mean of 43%. See chapter 12, Medical Legal Aspects of Long-Term Care, compiled and edited by Dr. Jeffrey M. Levine, MD, Lawyers & Judges Publishing Company, Inc. citing a study.**

**Because of the prevalence of falls, many of the cases that you evaluate will involve falls. The defense will typically be that falls are inevitable, especially since nursing homes have been forced to move away from physical and**

**chemical restraints. *In fact, a recent Texas study indicated that as restraint use has decreased, prevalence of falls did not increase and that the injuries, without using restraints, due to falls, were actually less severe. (i.e.: climbing over side rails instead of falling out of a lowered bed).*** In Texas the residents had been restrained" in order to avoid falls or wandering. In the study it was determined **that less restraints was better** for preserving the resident's function and to actually decrease injuries. The "MYTHS" that restraints protect residents, decrease staff time, decrease the cost of care or that it allows for less medication use

**and decrease liability were proved false. In fact, "The Texas Department of**

Insurance recognizes restraint use as a key facility liability risk - management issue because of liability claims arising from the use of restraints.” The study concluded that *nursing homes should evaluate and care for residents and seek restraint - free environments.* (Exhibit “F” - copy of the Texas study)

A fall in a nursing home should not be viewed as in anyway similar to a fall that occurs in any other setting. The “falls case” centers around the physical plant , the medical condition of the resident and how the resident was evaluated, what safeguards of care were taken and how aware and committed the staff was in dealing with the individual care of the victim.

a. STATUTE AND REGULATIONS IN THE “FALLS” CASE

A review of the Federal and State regulations is needed in order to analyze a case involving FALLS.

In 42 CFR Section 483.25(h) (Accidents) & 10 NYCRR §415.12(h); the regulation is that: (also see F323 (PP-104) and F324 (PP-105))

- (1) Facility must ensure that the resident environment remains as free of accident hazards as is possible; and
- (2) Each resident must receive adequate supervision and assistance devices to *prevent accidents.*

“Accidents” are situations like “falls”, “burns” in a hot tub not checked by the CNA or where a picture frame falls off a wall and hits the resident.

In the “Guidance To Surveyors” under 42 CFR §483.25(h) (PP-105), the federal administrators state what the regulation means and how to test that the home is complying with the regulation.

Intent §483.25 (h) (2) (What does regulation mean?)

The intent of this provision is that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.

An “accident” is an unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care, (e.g., drug side effects or reactions).

Procedures: §483.25 (h)(2) (these “procedures” walk the surveyors

through how this regulation is in compliance or is violated by the nursing home)

- If a resident(s) selected for a comprehensive or focused review has had an accident, *review the facility's investigation of that accident and their response to prevent the accident from recurring.*

**PRACTICE POINT:***In DISCLOSURE, get the facility's investigation. (It should exist because it must be "reviewable" and therefore "written") Did the supervisor of the investigation make findings? Was the Care Plan followed before the accident? Was the Care Plan's faulty in the first place? Did the Care plan need modification after the accident? (If the Care Plan was not followed, it was due to neglect by staff.) Was it modified? How?*

- Identify if the resident triggers any RAPs for falls, cognitive loss/dementia, physical restraints, and psychotropic drug use and whether the RAPs were used to assess causal factors for decline or lack of improvement.

**PRACTICE POINT:***If a RAP is triggered in the MDS form, (Exhibit "D") the form dictates what to do. On the top of the last page of the MDS form, it states the nursing home is to "use the RAP guidelines to identify areas needing further assessment", from the MDS training guidelines. The RAP guidelines for "falls" is attached as Exhibit "G". This document is a deposition handbook in itself. Each "assessment area" is a treasure trove of areas of inquiry.*

*On the second page of the RAP guideline for "falls", the Nursing Home is told that "Falls are the most common cause of accidents in people over 65 "and "Falls cause more deaths than pneumonia or diabetes and all other types of accidents combined". Ask the Director of Nursing if she knew that? Ask them if they knew that "hip fracture is the most common fall - related injury that leads to hospitalization and that approximately 25% of these patients die within 6 months of injury and 60% have decreased mobility after a hip fracture".*

**PRACTICE POINT:***the surveyor (and therefore the plaintiff's attorney) has to have all the MDS' done by the home and use the last full MDS done on the resident (must be completed by day 14 of the stay at the home).*

*At the EBT- question the nursing home witness: was the MDS form completed? Take the witness through the answers in the MDS and the content of the chart. Were the answers consistent with the chart? If MDS*

was

it

*completed contrary to the history, and what the home knows in the chart, is a violation.*

*Did a RAP get triggered? (anything in “red” and answered “yes” triggers a RAP (Resident Assessment Protocol) which is a full assessment of that issue. (Last page of MDS form – the # corresponds to the red # on the questionnaire.) Did the nursing home use the RAP guidelines (to identify factors contributing to the risk of falls)? Take the nurse through the RAP guideline for falls and how they went through the “assessment”. Did you write on page 10 of the MDS form, (Exhibit “D”) under #11, how the assessment was done?*

*Case History I-MDS §J(4) on accidents (page 6): “a “ should have been checked, since the patient had a fall that hospitalized the resident before the transfer to the deft nursing home. This should have triggered a RAP for falls (#11 and #17) and see MDS final page for #11 and #17. RAPs being triggered requires use of the “RAP guideline” for that issue or those issues.*

- The survey team identifies a number of or pattern of accidents, in Phase II sampling, review the quality assurance activities of the facility to determine the facility’s response to accidents.

**PRACTICE POINT:** *Were a number or pattern of accidents identified? What actions did the nursing home take to avoid the accidents – before and after?*

**Probes: §483.25 (h)(2)** (probes are questions to ask, and items or ideas to look for)

1. Are there a number of accidents or injures of a specific type or on any specific shift (e.g., falls, skin injuries)?
2. Are residents who smoke properly supervised and monitored?
3. If the survey team identifies residents repeatedly involved in accidents or sampled residents who have had an accident:

(i.e.: case history - I - prior accidents)

(a) Is the resident assessed for being at risk for falls?

**PRACTICE POINT:** *Did they do a “Falls Risk Assessment” upon admission? (before the MDS was done)*

(b) What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk?

**PRACTICE POINT:** *What did they do to prevent falls? Did they develop a “care plan” to prevent falls?*

(c) How did the facility fit, and monitor, the use of that resident’s assistive devices?

**PRACTICE POINT:** *i.e.: wheelchairs with and without non-tippers, walkers, cane, ...-the therapist (PT/OT) usually determines how much assistance a resident needs. Examine the PT and OT charts and evaluations done on day 1 or day 2.*

(d) How were drugs that may cause postural hypotension, (stand up and blood pressure drops), dizziness, or visual changes monitored?

**PRACTICE POINT:** *Was the resident’s medical status or medications contributing to the risks of accidents? If “dizziness” was occurring, MDS page 5§J(f) should have been checked off and #11 and #17 would have been triggered RAPs and RAP guidelines would have questioned the “falls” and “medication” issues.*

**b. INVESTIGATING THE “FALLS” CASE:**

When doing the initial intake ask the family members whether there was a pattern of falls.

Find out from the family whether they advised the facility upon intake that the resident had a history of falls in

their home and if that is the

reason the resident was brought to the facility. If a resident with a history of falls is accepted into the facility, and the facility assured family members that the resident would be carefully watched to avoid falls, this is evidence of express promise.

Since nursing homes are required by federal law to report all falls and to prepare a report regarding the same, you should not be surprised to find out that the family is well aware that there was a long history of falls.

Secure the State DOH surveys concerning the nursing home and any incidents.

Review the federally mandated initial assessment and falls risk assessment and care plan that was developed as a result of the assessment, (F279)(PP-77) (42CFR§483.20(d)), and “use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care”.

Also review follow up comprehensive assessments that are also mandated by federal law to first determine whether the resident was at risk for falls when he entered the facility, and second, what precautions were recommended as a result of that initial evaluation.

**1. Did the care plan include precautions?**

For example: Exhibit “H”- the nursing home noticed significant risks for falls upon admission, in its initial assessments and classified the patient as “HR” (High Risk) for falls, yet put in no precautions. (Case history - II case) She fell the next day, out of a wheelchair, without “non tippers”, on her way to the bathroom.

**2. Determine whether the facility implemented the care plan.**

For example:  
a care plan called for a bed alarm and one was not being used.

**3. Were adjustments made in the care plan to prevent falls as circumstances dictated?**

For example:  
if no bed alarm was recommended as a result of the initial assessment, was one provided after the first fall?

In the Case History - 2, what was the prima facie case? No bed rails



were ordered, (frowned upon), but did they lower the bed to the floor or use alarms, or since she was in a wheelchair and non ambulatory by herself and not toileted sufficiently, should she have had non-tippers on the wheel chair (at \$60 apiece!).

c. **OTHER FACTORS, SCENARIOS AND THEORIES OF LIABILITY IN NURSING HOME “FALLS” CASES:**

1. **TOILETING SCHEDULE-** was the schedule appropriate in order to serve the resident safely? Was it modified as changes in diet or medication occurred (i.e.: diuretics) ?
2. **COGNITIVE LOSS-** some precautions: alarms, buzzers will not work; esp. high risk in conjunction with incontinence this patient will not use the call bell! A pressure sensitive alarm, in bed, is a better alarm and the call bell rings at nurses station alerting to particular patient.
3. **PRIOR FALLS-** as in Case History - I, the falls kept happening, especially in the early morning. Did they modify the toileting schedule or otherwise study why he was getting up then and whether that could be avoided?
4. **DEATH WITH OR SHORTLY AFTER THE FALL-** be wary of the case where there has been a fall followed by unconsciousness and then death. There is a problem with this type of case in that the resident would have had no conscious pain and suffering. Find out from family whether the resident showed any visible signs of consciousness and pain and suffering. If you have consciousness at any level following the fall, you can make out a case for pain and suffering. Review the records for pain and suffering. Was the resident found on the floor moaning? *Clearly this is evidence of pain and suffering.*

**PRACTICE POINT:** *damages typically can be established through depositions of employees and former employees.*

5. **MEDICATIONS and POLYPHARMACY-** may contribute to “falls”.

**42 CFR 483.25** - residents must not be administered unnecessary drugs or excessive doses of drugs

6. **FALLS OF UNKNOWN CAUSE - Lorber v. Prospect Nursing Home, 289 A.D.2d 303, 734 N.Y.S.2d 865 (2d Dept. 2001).**  
 This case was dismissed after plaintiff was found in bed with a fractured leg . How did the injury occur? Did he fall from bed and was put back in bed? Was he able to get himself back into bed?

7. **RESTRAINTS - The federal regulation (42 CFR 483.13(a) that states“residents have the right to be free of physical or chemical restraints imposed for discipline or convenience”. The New York State regulation on restraints (10NYCCR§415.4) is more detailed and constantly tests the nursing home to see if they are used “only to protect the resident”, but also “to assist the resident to attain and maintain optimum levels of physical and emotional functioning”.**

**PRACTICE POINT:** *Challenge them on the use and lack of use of restraints. Did they justify the “use” or “non use”? Serious falls may occur due to restraints (high bed rails), yet falls may occur due to lack of restraints. The defense may argue that the fall occurred because they could not use restraints due to the above law. That is a MYTH and studies show that wise and judicious care, without restraints, actually reduces injuries. (Exhibit “F”)*

### **C. PRESSURE SORES/ULCERS**

(PRESSURE SORES, PRESSURE ULCERS, BED SORES, SKIN ULCERS)

In my forty-five minute presentation, you will get up or shift position three to five times. Imagine not moving your rear end for all that time! Cross your legs for twenty minutes and take a look at the red marks on your legs. Can you imagine that the red marks did not disappear after the next half hour? Imagine being in a wheelchair, possibly mentally or physically unable to shift your position. In a few hours you would begin to develop a pressure ulcer. Imagine a blister on the bottom of a toe and continue walking in those same shoes. Wouldn't you take off those shoes and put your feet up, massage them, ice them...?

What is a pressure ulcer? Have you seen photographs of a pressure ulcer? A pressure ulcer is defined in the Guideline to 42 CFR §483.25 (c). The stages, I through IV are defined and described in these regulations.

**The Federal regulation (42 CFR § 483.25(c) (1) and (2) )(F314 at PP-93 and PP-95) in this area was strengthened by the more stringent New York regulation 10 NYCRR§415.12(c)(1) and (2) which states that:**

**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 despite every reasonable effort to prevent them; and**
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.**

**PRACTICE POINT: *If the pressure sores develop from not***

*having any, or they do not improve, is it not defendant's burden to explain why or why not? The New York Regulation requires "every reasonable effort to prevent" pressure ulcers from developing. Your expert will provide a litany of care that was not done, unless the home was not at all liable.*

**Is this a case to take?** (The following are factors to look for when screening a pressure ulcer case):

a. Was the resident ambulatory?

**PRACTICE POINT:** *If the resident was confined to a wheel chair and/or bed there is a much greater likelihood of developing pressure ulcers. What preventive measures were put into place to relieve pressure? (i.e.: wheelchair cushions, special mattresses, heel booties, heel protectors, turning and positioning,...)*

b. What stage were the bedsores?

1. Stage I - redness not disappearing and over a bony prominence. Appearing like diaper rash.
2. Stage II - superficial break in skin, "cut", "blister".
3. Stage III - significant break in skin with *depth* of layers exposed.
4. Stage IV - is right down to the bone, or any ulcer with necrotic, "black", tissue (even without a break in the skin).

c. Was the resident incontinent?

**PRACTICE POINT:** *Incontinence is a significant risk factor for pressure ulcers. Was the initial assessment done? Was the MDS done by day 14? Was the MDS done so that RAP 16 was triggered? Was the RAP guideline for "ulcer" followed?*

*If no pressure ulcer has yet formed, but the RAP was triggered by the risks being presented: §G(1)(a) Bed Mobility. Was this filled out on the MDS using "A" or "B" criteria? For "A" - 2 or 3 or 4 or 8 will trigger RAP 16 for pressure ulcers and therefore trigger the RAP Guideline for "ulcers" before the ulcers appear!*

*If the resident already has pressure ulcers, MDS §M(2)(a) will trigger RAP 16 for ulcers and require the RAP guideline to be followed.*

*The RAP Guideline for "ulcer" is attached as Exhibit "I". Once again, as in the RAP Guideline for "falls", the areas listed that must be assessed are varied, numerous and significant. Depositions in each*

*area can be detailed directly from the Guideline and questions will center on how the nursing home did or did not do each assessment owed to the resident under the regulations.*

*Was a Plan of Care put into effect? How often was the resident “toileted”? How often was the resident given perineal care (getting cleaned, lotion, new diaper, ...)*

- d. Ask the family whether the resident often sat in urine for long periods of time. Ask them whether on their visits they often discovered that their loved ones needed to be changed, or did the family smell urine? If you smell someone, it has been a long time since the person was changed.
- e. Dehydration and/or Malnutrition
  1. There is a direct medical link between bedsores and dehydration and malnutrition.
  2. Inquire of the family members whether the resident suffered from dehydration and/or malnutrition.
  3. Review records to see if there were hospitalizations for dehydration and/or malnutrition.
  4. Does the Care Plan address poor intake or weight loss, with corresponding interventions and nutritional supplements, such as “ensure” (a high protein shake)? Was the Care Plan for nutrition followed?

**PRACTICE POINT:** *Your expert will analyze the labs in the chart. Low albumen (a protein breakdown product) may indicate malnutrition and is a risk factor for ulcers and will inhibit healing of existing ulcers. High BUN indicates dehydration. With less fluid, or a fluid imbalance, the skin gets rigid and increases the risk of breakdown of the skin. Is your client getting diuretics? Increasing the urine may contribute to a loss of fluid and fluid imbalance.*

- f. Was the resident properly assessed when first admitted as being at risk for bedsores? If so, what measures were taken to avoid bedsores?

**PRACTICE POINT:** *For example, was a special mattress provided? Was the resident turned and repositioned every two hours? Were there any doctor’s orders that facility failed to follow? How often were skin assessments done? If the resident has a high risk for bedsores, skin checks should be done daily by a direct care giver (CNA) and assessed weekly by the nurse.*

- g. Review the “turn and repositioning records” in the Nursing Home chart..
- h. Does the resident have any circulatory diseases? ie: peripheral vascular disease, diabetes, ...) This would be another risk factor that should have been assessed from the beginning as an indication that your client was at risk for pressure ulcers.

- i. Cognitive Loss -The resident may not think to change positions
- 10. Medications - can make the victim lethargic and therefore not change position.
- 11. Restraints - restrict movement and therefore increases risk for pressure ulcers.
- 12. Disclosure-EBT of Plaintiff's family- Defense counsel may ask whether the family ever noticed the bedsores. Often counsel is implying that they should have noticed. A typical response you hear from children of resident is that they did not remove the diaper and look at their mother's buttocks. They respected her right to privacy.  
-EBT of Defendant- Who were the hourly and daily care givers? Who changed the diapers? Discover the schedule of the care givers on the unit.
- m. ATLA article-"Wound care and nursing home liability-(Trial, Nov. 2002 -pages 42-47)(Exhibit "J")

**PRACTICE POINT:** *Defenses to a pressure sore case may include that: It's not a pressure ulcer, its a stasis ulcer and not an indication of any neglect. Stasis ulcer is a non-healing medical condition caused by poor circulation and not over a bony prominence and generally lower extremities.*

## **D. POSITIONAL ASPHYXIATION**

- a. Generally, this is death by strangulation. In other words the resident dies from asphyxiation as a result of being caught between the bed rails and mattress. In some cases the resident gets trapped between the bed rails. These deaths are the result of chest compression or airway covering.
- b. While not nearly as common as falls, they are almost always avoidable.
- c. The division within the Department of Health and Human Services that implements laws for federally regulated health care facilities has closely tracked bedrail issues. It publishes a regular newsletter addressing restraints and rails. In August, 2000 it advised that, used improperly, restraints, including side rails, can pose a serious health and safety risk to nursing home residents. See [www.hcfa.gov/medicaid/lcsp/q&a/t18-8100.htm](http://www.hcfa.gov/medicaid/lcsp/q&a/t18-8100.htm).
- d. The Department of Health and Human Services has further stated that, "The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical systems. The potential for serious injury is more likely from a fall from a bed with raised side

rails then from a fall from a bed where side rails are not used.” See Health Care Financing Administration. Medicare State Operations Manual, Provider Certification, September 7, 2000.

e. Considerations in pre-suit investigation:

1. Ask the family and review the records to determine if there were prior incidents of the resident getting tangled in the rails. Dr. Steven Miles from Minneapolis, who has studied bedrail deaths for the previous decade, advised me that in over 80% of the strangulation deaths you will find that there were several prior incidents of the resident getting tangled in the rails.
2. If there were prior incidents, then check the care plan to determine whether any effort was made to revise the care plan to address this problem.
3. File a motion for pre-action disclosure to locate and preserve the bed and mattress as evidence, or at a minimum, record the make and model number.
4. Another important consideration is whether the staff has been trained in the use of bed rails and the risks associated with their use.
5. Review records and interview the family members to determine whether the resident had several of the risk factors associated with positional asphyxiation such as cognitive impairment, active agitation in bed and a history of slipping through bed rails.
6. Dr. Miles is urging attorneys to bring products liability law suits against bed manufacturers because they have been aware of the problem for many years and have failed to warn the facilities purchasing their beds or to inform their engineering departments so they can develop a safer design.

**E. DEHYDRATION AND MALNUTRITION CASE**

Under 42 CFR§483.25(1) and the New York regulation:

The facility must ensure that the resident maintains acceptable parameters of nutritional status, body weight and protein levels unless the resident’s clinical condition demonstrates this is not possible.

**F. PHYSICAL ABUSE AND NEGLECT CASES**

Singer v. Friedman, 220 A.D.2d 574, 632 N.Y.S.2d 802 (2d Dept. 1995) 42 CFR 483.13 states that:

The facility must develop and implement written policies that prohibit mistreatment, neglect and abuse of residents.

The facility is prohibited from permitting verbal, mental, sexual or physical abuse or involuntary seclusion.

The facility must immediately investigate all allegations of alleged abused and the result of the investigation must be reported to the facility administrator and state authorities as required by law.

## **G. MEDICATION ERRORS AND POLYPHARMACY CASES**

42 CFR 483.25 (l) and (m) and 10 NYCRR§415.12 (l) and (m)

Each resident's drug regimen must be free from *unnecessary drugs*.

Each resident's drug regimen must be free of *excessive doses* of drugs.

The facility has the responsibility to avoid significant *medication errors*.

Discussion of case history - 3 (Exhibit "K")

## **VI. STATUTE OF LIMITATIONS CONCERNS**

### **A. ALTERNATE PERIODS OF LIMITATION**

1. Intentional Tort (1 year under CPLR §215(3)) - If the victim was intentionally harmed, as may be the case in an abuse situation and/or assault and/or battery, the statute of limitations may be as short as one year.
2. Wrongful Death (2 years under EPTL) - In any case, including a nursing home litigation type case, where the injured person is dead and there may be a causal link between wrongdoing and the death, one must consider a wrongful death cause of action and its two year statute of limitations from the date of death.

However, from a practical point of view, and as important as any statute of limitation concern, one must also consider whether the lack of wrongful death type damages (i.e.; pecuniary damages), warrant such a cause of action.

3. Death of Claimant and less than one year remains on the subject statute of limitations (1 year from death under CPLR §210(a)) - If the injured person dies and less than a year remains on the subject statute of limitations, CPLR Section 210(a) allows for the decedent's representative to bring suit within a



year after the death. This is an alternative period of limitations as opposed to an extension or toll and is needed only if there is less than a year remaining on the limitations period when the injured person dies.

**B. MEDICAL MALPRACTICE (2 year 6 month) vs. NEGLIGENCE (3YEAR)**

1. Be aware of the distinction between negligence and malpractice. This is an important issue because of the *differing statutes of limitations, different attorney's fees, and different expert requirements*, including a certificate of merit, with the Complaint, in the medical malpractice case. From a practical standpoint and to be safer than sorry, it can be argued that one should include medical malpractice causes of action and negligence causes of action in the complaint. Note that by pleading malpractice and negligence, since the fee chargeable by counsel differs, the Court will probably have to decide the fee. As many of these cases result in deceased plaintiffs, the Surrogate Court will apportion between negligence and malpractice. Finally, as a doctor is needed early in the case to consider the causation between the nurse's opinions on negligence and the damages, the doctor can easily opine on the "malpractice".

4. A claim sounds in malpractice when the challenged conduct constitutes medical treatment or bears a "substantial relationship" to the rendition of medical treatment by a licensed physician. A claim sounds in negligence only if "gravamen of complaint is not negligence in delivering medical treatment but the failure in fulfilling a different duty". Weiner v. Lenox Hill Hospital, 88 N.Y. 2d 784, 787, 650 N.Y.S. 2d 629. The "malpractice" may be by a doctor or by a nurse!

5. The issue of whether a particular cause of action sounds in medical malpractice or negligence is fact specific. See e.g., Reardon v. Presbyterian Hospital, 739 NYS2d 65 (1<sup>st</sup> Dept. 2002)(fall while being helped down from the examining table sounds in negligence, as there was no claim that an improper assessment of plaintiff's medical condition played any role in determining how or even to help her off the table); Fields v. Sisters of Charity Hospital, 714 NYS2d 176 (4<sup>th</sup> Dept. 2000)(decedent who had suffered a seizure and was brought to the emergency room was placed on examining table where he had another seizure and struck his head on the CT equipment and fell from the table; "allegations that defendant failed to provide a safe and adequate examining table and that table was not installed, maintained or secured in a safe and proper manner " sounds in ordinary negligence"); Rey v. Park View Nursing Home, 262 AD 2d 624, 692 N.Y.S. 2d 686 (2<sup>nd</sup> Dept. 1999)(where assessment of mental or physical condition or degree of supervision is questioned, allegations sound in malpractice); Weiner v. Lennox Hill Hospital, 650 NYS2d 629 (1996) (contamination of blood with HIV is ordinary negligence); Toepp v. Myers Community Hospital, 721 NYS2d 177 (use of bandage containing needle constituted integral part of medical treatment and thus, was malpractice rather than negligence); Bleiler v. Bodnar, 489 NYS2d 885 (failure to take proper medical history is malpractice, but failure to provide proper personnel or to set forth and implement appropriate rules is negligence); DeLeon v. Albert Einstein College of Medicine, 566 NYS2d 213 (negligent hiring is negligence); Rice v. Vandenebossche, 586 NYS2d 303 (burning plaintiff on forehead with lamp while doctor treated forehead laceration was malpractice). See also memoranda of law in Pierce and

