

A MEDICO-LEGAL EVALUATION OF DEHYDRATION AND MALNUTRITION AMONG NURSING HOME RESIDENTS

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Our nation's 1.6 million elderly and disabled nursing home residents are a highly vulnerable population. In this article, Julie Braun and Elizabeth Capezuti draw on their legal and medical backgrounds to highlight a growing area of nursing home litigation: dehydration and malnutrition. The authors write in detail about the

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disorders and choking. Each of these topics is entertained with medical precision and clarity, thanks to Dr. Capezuti's in-depth knowledge of gerontology. This medical discussion is complemented by a skillful review of the legal aspects of these conditions conveyed from Ms. Braun's extensive nursing home litigation experience. The result of their combined efforts is an informative article that elucidates the issue of dehydration and malnutrition for all concerned with elder law.

I. Introduction

This article presents a medico-legal evaluation of common nutrition-related problems presented in nursing homes.¹ Among the larger problems are weight loss and concomitant protein energy undernutrition,² complications from tube feeding, dehydration, malnutrition, swallowing disorders, and choking. The article begins by considering the nutritional assessment and care planning process. This discussion is accompanied by a review of nutritional services department staff and their responsibilities. The article then shifts its attention to common liability fact patterns involving weight loss, tube feeding, dehydration, malnutrition, swallowing disorders, and choking. In each instance, the authors

Both authors are members of the federal Food and Drug Administration's (FDA) hospital bed work safety group, a national task force considering bed rail safety in nursing home, hospital, and home health care environments, and co-investigators in an FDA-funded grant exploring the medical and legal liability issues surrounding bed side rail use. The authors thank Shirley A. Hoth and Joy G. Rodman for their administrative and skilled research efforts, respectively.

1. As used herein, the term *nursing home* refers to a "[f]acility that fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that (i) [a]re above the level of room and board; and (ii) [c]an be made available only through institutional facilities[.]" 42 C.F.R. § 440.155(a)(i)(1999). As used herein, *nursing home* encompasses facilities that are freestanding or hospital based. In addition, their ownership may be proprietary, nonprofit, or governmental.

2. See generally Adil A. Abbasi & Daniel Rudman, *Observations on the Prevalence of Protein-Calorie Undernutrition in VA Nursing Homes*, 41 J. AM. GERIATRICS SOC'Y 117 (1993) (showing a high prevalence of calorie and protein undernutrition in the nursing home residents of Department of Veterans Affairs (VA) nursing homes, wide variation in the prevalence across nursing homes, and frequent lack of documentation of these nutritional deficiencies by physicians and nurses); Adil A. Abbasi & Daniel Rudman, *Undernutrition in Nursing Homes: Prevalence, Consequences, Causes and Prevention in Nursing Homes*, 52 NUTRITION REV. 113 (1994).

offer definitions, prevalence estimates, and risk factors associated with the clinical condition along with relevant federal law and regulation on the subject, punctuated with case illustrations. Next, the article highlights the standard of care used in nutrition-related cases through federal statutes and companion regulations, interpretive guidance to federal regulations, state statutes and regulations, nursing home industry standards of practice, facility policy and procedure, voluntary accreditation standards, and standards promulgated by professional organizations. The article concludes with the medico-legal aspects of nursing home records. These records include hospital discharge summaries; nursing home admission notes and physical examination forms; physician orders and progress notes; daily nursing notes; nutritional reviews, meal forms, and dietician/ nutritional consultant forms; medication records; subspecialty records, intake and output (I & O) records; weight records, and dental/oral health records.

II. Nutritional Assessment and Care Planning

Each nursing home resident³ “must receive[,] and the facility must provide[,] the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being[] in accordance with the comprehensive assessment and plan of care.”⁴ The nursing home may be cited for non-compliance with federal requirements if the assessment is not undertaken and the care plan not created.

A. Nutritional Assessment

According to federal regulation, nursing homes “must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.”⁵ These regulations explicitly reference a resident’s “[d]ental and nutritional status” as a component of this assessment.⁶ In addition, state law may

3. Following the terminology used in federal regulations, 42 C.F.R. § 483.10, the authors refer to individuals who have been admitted to nursing homes as *residents* rather than *patients*.

4. 42 C.F.R. § 483.25.

5. *Id.* § 483.20.

6. *Id.* § 483.20(b)(1)(XI).

delineate resident assessment and care requirements.⁷ Further, the Joint Commission on Accreditation of Healthcare Organizations

7. See, e.g., ALA. ADMIN. CODE r. 420-5-10 (1999) (following the federal regulations); ALASKA ADMIN. CODE tit. 7, § 12.270(a) (2000) (requiring an assessment and care plan be prepared within 14 days after a resident's admission, and at least quarterly thereafter); ARIZ. ADMIN. CODE R9-10-905(C) (2000) (demanding completion of an assessment by a registered nurse within two weeks after a resident's admission); ARIZ. ADMIN. CODE R9-10-905(E) (2000) (noting resident or resident representative participation in care plan developed by an interdisciplinary team); CAL. CODE REGS. tit. 22, § 72311(a)(1) (2000) (stating that the facility's nursing service prepares the assessment and care plan for each resident and that the care plan must be reviewed viewed at least quarterly); CONN. AGENCIES REGS. § 19-13-D8t(o)(2)(H)-(I) (2000) (requiring that all residents have an assessment and care plan with the care plan reviewed at least once every 90 days); D.C. MUN. REGS. tit. 22, § 3200.2 (2000) (adopting by reference federal regulations); FLA. ADMIN. CODE ANN. r. 59A-4.109(1)-(2) (2000) (assessing a resident within 14 days of admission and preparing a care plan within seven days thereafter); *id.* r. 59A.4.109(3) (including the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, maintenance, and evaluation of the resident care plan); IND. ADMIN. CODE tit. 410, r. 16.2-3.1-31 (2000) (assessing the resident's condition at admission and at least yearly thereafter); *id.* tit. 410, r. 16.2-3.1-35(c)(2)(C) (requiring, to the extent practicable, resident and family participation in care plan development); KAN. ADMIN. REGS. 28-39-151 (tracking federal requirements at 42 C.F.R. § 483.20 regarding resident assessments and care planning); CODE ME. R. § 10-144-110, 12.B.2, 12.B.3, 12.B.4 (2000) (completing resident assessment process within 14 days of admission and at least quarterly thereafter, with a complete reassessment undertaken at least once a year); *id.* § 10-144-110, 12.C.3 (considering care plans prepared by a team that includes at least the resident's physician and a registered nurse as well as the resident and/or resident's legal representative); *id.* § 10-144-110, 12.C.4 (completing care plan within seven days after completing the initial assessment process); MICH. ADMIN. CODE r. 325.20709(1) (2000) (basing nursing care on the resident assessment and a care plan on that assessment); *id.* r. 325.20709(5) ("The nursing home shall make reasonable efforts to discuss the [resident] care plan with the [resident], next of kin, guardian, or designated representative so that such parties can contribute to the plan's development and implementation."); MINN. R. 4658.0400 (2000) (stating that facility must complete comprehensive assessment of a resident within 14 days after admission, and at least once every 12 months thereafter); *id.* 4658.0405(2) (relating that care plan "must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs"); *id.* 4658.0405(1) (using an interdisciplinary team composed of the resident's physician, a registered nurse, and, if possible, the resident or resident's representative to create the resident's care plan); N.J. ADMIN. CODE tit. 8, § 8:39-11.2 (1997) (completing an assessment and care plan within 14 days and 21 days, respectively, following resident admission); *id.* tit. 8, § 8:39-12.1 (describing composition of interdisciplinary team to include professional and/or ancillary staff from each service providing care to the resident); N.Y. COMP. CODES R. & REGS. tit. 10, § 415.11(a)(3)(i) (2001) (completing a comprehensive assessment within 14 days of resident admission); *id.* tit. 10, § 415.11(c)(2)(i) (developing a care plan within seven days of assessment completion), *id.* tit. 10, § 415.11(c)(2)(ii) (designing a care plan with input from an interdisciplinary team composed of the resident's "attending physician, a registered professional nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by" resident needs, and, to the extent practicable, "the resident and resident's family or the resident's legal

(JCAHO),⁸ an independent organization of health care professionals that promulgates national standards for health care facilities, including nursing homes,⁹ develops care standards for the initial, ongoing, and annual assessment of resident nutritional and hydration needs.¹⁰

representative”); N.C. ADMIN. CODE tit. 10, r. 03H.2301(b), (c) (July 2000) (basing resident care upon an assessment and care plan as well as requiring, where possible, participation by the resident or resident’s representative in preparing the care plan); N.D. ADMIN. CODE § 33-07-03.2-15(1) (1999) (relying on federally developed assessment documents to perform resident assessments); *id.* § 33-07-03.2-15(2) (shaping care plan with assistance of resident or resident’s representative); *id.* § 33-07-03.2-15(3) (tailoring care plan “to meet the needs of the resident” and requiring that the plan “must include problem and strength identification, measurable resident-centered goals, plans of action, and which professional service is responsible for each element of care. Goals must be measurable, behavior-oriented, time-limited, and achievable.”); OR. ADMIN. R. 411-86-0060 (2000) (requiring assessment and care plan preparation for each resident as well as participation by the resident and resident’s legal representative in care plan creation); 28 PA. CODE § 211.11(c) (2000) (shaping of resident care plan by a registered nurse from the facility); *id.* § 211.11(d) (2000) (reviewing, evaluating, and updating the care plan, as necessary, by professionals involved in caring for the resident); S.D. ADMIN. R. 44:04:06:15, :16 (2000) (requiring resident assessment completion within seven days after admission, and quarterly review thereafter); *id.* 44:04:06:05 (using the assessment, an interdisciplinary team which includes the resident or resident’s representative prepares a care plan within seven days of the assessment completion that describes “the services necessary to meet the resident’s medical, physical, mental or cognitive, nursing, and psychosocial needs” and contains “objectives and timetables to attain and maintain the highest level of functioning of the resident.”); 40 TEX. ADMIN. CODE §§ 19.801, 19.802 (West 2000) (corresponding closely to federal requirements for assessment and care plans appearing in 42 C.F.R. § 483.20); UTAH ADMIN. CODE 432-150-17 (2000) (presenting resident assessment provisions similar to federal requirements of 42 C.F.R. § 483.20); VT. CODE R. 13-11-005, § 5 (featuring resident assessment requirements similar to federal regulations located at 42 C.F.R. § 483.20(b), (c) (2000)); *id.* 13-11-005, § 6 (tracking federal requirements for care plans noted at 42 C.F.R. § 483.20(d)); WASH. ADMIN. CODE § 388-97-060(1), (3)(a) (2000) (obtaining informed consent in the development of a care plan); WIS. ADMIN. CODE § 132.60(8)(a), (d) (2000) (noting use of the federal minimum data set in preparing care plan developed within four weeks following resident admission); *id.* § 132.60(8)(b) (updating care plans as required).

8. See Joint Comm’n on Accreditation of Healthcare Orgs., *The Joint Commission on Accreditation of Healthcare Organizations* (visited Nov. 11, 2000) <http://www.jcaho.org/whatwedo_frm.html> (relating JCAHO’s mission statement, describing JCAHO accreditation process generally and conveying organization history); see also *infra* notes 330–32 and accompanying text (discussing voluntary accreditation standards).

9. See generally U.S. GEN. ACCOUNTING OFFICE, MEDICARE: HCFA’S APPROVAL AND OVERSIGHT OF PRIVATE ACCREDITATION ORGANIZATIONS 1, 10–17 (1999) (discussing accreditation by a recognized private organization such as JCAHO). See also *Report to Congress: Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System* (last modified July 21, 1998) <<http://www.hcfa.gov/medicaid/exectv2.htm>> (examining the three issues identified in the title); 42 C.F.R. § 488.4 (1999) (addressing application and reapplication procedures that apply to private accreditation organizations requesting deeming authority to

nursing homes); *Facts About the Joint Commission on Accreditation of Healthcare Organizations* (visited Sept. 18, 2000) <http://www.jcaho.org/aboutjc/m_and_h.html> (providing JCAHO mission statement, relating organization history, and describing accreditation process generally); 55 Fed. Reg. 51434 (1990) (proposing JCAHO nursing home accreditation).

10. See generally JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS. 2000-2001 STANDARDS FOR LONG TERM CARE (2000) (relaying nutrition and hydration, among other, care standards) [hereinafter JCAHO MANUAL]. The following standards are of particular relevance: Standard PE.2 (assessing each resident's physical, functional, psychosocial, and nutritional status); Standard PE.2.1 (describing initial resident assessment process to include, among other subjects, nutritional status); Standard PE.2.1.1 (examining the resident's past medical history and medical status, including current diagnosis, medications, allergies, treatments, results of diagnostic or laboratory studies, prognosis, limitations, and precautions as part of the initial assessment); Standard PE.2.1.4 (incorporating swallowing ability into resident's initial assessment); Standard PE.2.1.8 (considering the resident's nutritional and hydration status; potential nutritional risk and deficiencies; cultural, religious, or ethnic food preferences; special dietary requirements; and nutrient intake patterns); Standard PE.2.1.9 (reviewing the resident's dental status and oral health, including the condition of oral cavity, teeth and tooth-supporting structures; the presence or absence of natural teeth or dentures and the ability to function with or without natural teeth or dentures); Standard PE.3 (reassessing resident at regularly scheduled intervals related to the course of treatment or when the resident's physical, psychosocial, functional or nutritional status significantly changes); Standard TX.1 (ensuring that care and treatment planning (e.g., dietetic) is systematic and comprehensive); Standard TX.1.1.1 (including representatives from the following departments in the interdisciplinary care planning process: activities; dental; dietetic; medical; nursing; pharmacy; rehabilitation; and social services); Standard TX.1.4.2 (making oral health services available to meet resident needs); Standard TX.2 (emphasizing that qualified individuals should provide the planned care in a collaborative and interdisciplinary manner that involves the following disciplines or services activities: dental, dietetic, medical, nursing, pharmacy, rehabilitation, social services and other appropriate disciplines or services); Standard TX.2.3 (assisting residents with self-care, as appropriate, including eating and oral hygiene); Standard TX.2.3.2 (helping residents with dining activities and providing adaptive self-help devices that assist residents with independent eating); Standard TX.2.5 (using nutrition and hydration interventions to prevent and treat complications of immobility); Standard TX.5 (noting that an interdisciplinary care plan must include a plan for nutrition care); Standard TX.5.1 (requiring a therapeutic diet or nutrition product(s) to achieve a resident's optimal nutritional status); Standard TX.5.2 (allowing authorized individuals to prescribe or order food and nutrition products); Standard TX.5.2.1 (posting menus in areas accessible to residents); Standard TX.5.2.2 (rotating cycled menus to cover a three-week period); Standard TX.5.3 (detailing responsibilities for preparing and distributing food and nutrition products); Standard TX.5.4 (administering food and nutrition products); Standard TX.5.5 (storing and preparing food under proper conditions of sanitation, temperature, light, moisture, ventilation, and security); Standard TX.5.6 (distributing and serving or administering food and nutrition products in a safe, accurate, timely, and acceptable manner); Standard TX.5.7 (monitoring each resident's nutrition and hydration status); Standard TX.5.8 (developing and maintaining a method for providing food or nutrition products when diets or diet schedules change); Standard TX.5.9 (standardizing nutrition care approaches and processes and communicating same throughout the facility); Standards TX.6.1-6.2 (highlighting rehabilitation services appropriate to resident needs; for example, using a speech language pathologist to assist a resident with swallowing tech-

The assessment occurs “[w]ithin 14 calendar days after [the resident’s] admission [to the facility], excluding readmissions,” such as a return to the facility following hospitalization, “in which there is no significant change in the resident’s physical or mental condition[.]”¹¹ and quarterly thereafter¹² unless the resident experiences “a significant change in . . . physical or mental condition.”¹³

Each facility uses a “Resident Assessment Instrument” (RAI)¹⁴ specified by the state and approved by the Health Care Financing Administration (HCFA)¹⁵ to describe a resident’s functional capabili-

niques); Standard PF.3.4 (educating the resident about nutrition and hydration intervention, modified diets, and oral health, where applicable); Standard PF.3.7 (instructing the resident and family members in independent eating activities); Standards PF.5–.6 (monitoring the effectiveness of the interdisciplinary educational process (e.g., counseling the resident about nutrition interventions)); Standard LD.2.2.5 (communicating that facility leaders are accountable for providing services to meet resident needs, including, among other contracted care or services, consultant dietitians, dental services, dietetic services and nursing care or services); Standard LD.4.2 (relating that long-term care policies and procedures are approved by facility leadership (e.g., nursing procedures specific to hydration or feeding)); Standard HR.2.1.2 (identifying facility performance expectations for staff to satisfy resident nutritional needs); Standards HR.2.2.1, .2, .7 (checking staff qualifications to meet resident nursing care, nutritional, and oral health needs); Standard H.R.3.2 (requiring ongoing education, including in-service training and other activities that address, among other areas, oral health and nutrition to maintain and improve staff competence); Standard IM.7.3.2 (documenting the provision of and resident response to nutrition care services on a quarterly basis, including the resident’s acceptance of any prescribed diets; the resident’s food and fluid consumption; significant weight loss or gain; hydration status; the resident’s ability to eat independently; the resident’s ability to use adaptive devices for eating and the extent to which nutritional goals included in the resident’s interdisciplinary care plan are achieved). *See id.*

11. 42 C.F.R. § 483.20(b)(2)(i) (1999).

12. *See id.* § 483.20(c).

13. *Id.* § 483.20(b)(2)(ii). The term “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.

Id.

14. *See generally* Brant E. Fries et al., *Effect of the National Resident Assessment Instrument on Selected Health Conditions and Problems*, 45 J. AM. GERIATRICS SOC’Y 994 (1997); Catherine Hawes et al., *The OBRA-87 Nursing Home Regulations and Implementation of the Resident Assessment Instrument: Effects on Process Quality*, 45 J. AM. GERIATRICS SOC’Y 977 (1997); John N. Morris et al., *A Commitment to Change: Revision of HCFA’s RAI*, 45 J. AM. GERIATRICS SOC’Y 1011 (1997); Charles D. Phillips et al., *Association of the Resident Assessment Instrument (RAI) with Changes in Function, Cognition, and Psychosocial Status*, 45 J. AM. GERIATRICS SOC’Y 986 (1997).

15. *See* U.S. DEP’T OF HEALTH & HUMAN SERVS., GUIDANCE TO SURVEYORS—LONG-TERM CARE FACILITIES (1995) [hereinafter HCFA GUIDANCE].

ties.¹⁶ The RAI consists of the “Minimum Data Set” (MDS),¹⁷ a core set of screening, clinical, and functional status elements that serve as the foundation of the resident’s comprehensive assessment;¹⁸ the “Resident Assessment Protocols” (RAPs)¹⁹ which “provide a structured, problem-oriented framework for organizing MDS information and studying additional clinically relevant information about a resident”²⁰ and “[u]tilization guidelines [offering] instructions about how and when to use the RAI.”²¹

A typical nutritional assessment evaluates resident positioning needs; environmental and social considerations; ability to self-feed; ability to chew, drink, and swallow; weight; signs of dehydration (such as dry mouth, poor skin turgor); and lifelong food habits.²²

16. See 42 C.F.R. § 483.20(b)(1). The resident assessment instrument must include at least the following: identification and demographic information, customary routine, cognitive patterns, communication, vision, mood, and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health conditions, *dental and nutritional status*, skin condition, activity pursuit, medications, special treatments and procedures, discharge potential, documentation of summary information regarding the additional assessment performed through the resident assessment protocols and documentation of resident participation in the assessment. See *id.* § 483.20(b)(1)(i)–(xviii).

17. See generally PETER J. BUTTARO, PRINCIPLES OF LONG-TERM HEALTH CARE ADMINISTRATION (1999) (providing sample Minimum Data Set (Version 2.0) used for nursing home resident assessment and care screening that includes information on resident eating patterns (Section AC—Customary Routine); how the resident eats and drinks as well as nourishment intake by other means, such as tube feeding or total parenteral nutrition (Section G—Physical Functioning and Structural Problems); any nutrition-related disease diagnoses (Section I—Disease Diagnoses); problems with the resident’s weight and fluid input/output (Section J—Health Conditions); oral/nutritional status (Section K—Oral/Nutritional Status); oral/dental status (Section L—Oral/Dental Status); special treatment and procedures the resident requires involving, for example, fluid input/output accompanied by nursing rehabilitation with resident eating or swallowing (Section P—Special Treatments and Procedures); and a resident assessment protocol summary concerning nutritional status, feeding tubes, dehydration/fluid maintenance and oral/dental care (Section V—Resident Assessment Protocol Summary); JANET I. FELDMAN & R.W. BAKER, A STEP-BY-STEP GUIDE TO COMPLETING THE MDS (Jane Colilla ed., 1999) (offering definitions, explanations, and examples that assist in completing the Minimum Data Set (Version 2.0)); LONG-TERM CARE COMPLIANCE RESOURCE MANUAL 11:17–11:23 (Jennifer C. Forsyth et al. eds., 2000) (reproducing the Minimum Data Set (Version 2.0)) [hereinafter COMPLIANCE RESOURCE MANUAL]; Catherine Hawes et al., *Reliability Estimates for the MDS for Nursing Home Resident Assessment and Care Screening (MDS)*, 35 GERONTOLOGIST 172 (1995).

18. See COMPLIANCE RESOURCE MANUAL, *supra* note 17, at 11:4.

19. See *id.*

20. *Id.*

21. *Id.*

22. See OSNAT ALICE LESHEM & DOROTHY M. VARHOLAK, LONG-TERM CARE: NURSING STANDARDS, POLICIES, AND PROCEDURES 13:27 (1999); James S. Goodwin,

Properly performing a nutritional assessment is critical to a resident's (and the facility's legal) health. In *Fagan v. A Dade County Nursing Home*,²³ a twenty-four-year-old victim entered a nursing home after suffering a gunshot wound which left him quadriplegic, in a persistent vegetative state and completely dependent upon others.²⁴ "Plaintiff's height was inaccurately documented and his nutritional assessment was prepared for a resident five inches shorter."²⁵ His "nutritional status as a result of Defendant's [alleged] neglect and failure to adhere to applicable state and federal laws and regulations resulted in multiple infections, pneumonia, development of new decubitus ulcers, and infection to existing ulcers, sepsis [a life-threatening blood borne infection], *dehydration*, and *nutritional marasmus*."²⁶ Mediation produced a \$275,000 settlement accompanied by a confidentiality provision that prohibits revealing the nursing home's identity.²⁷

B. Nutritional Care Plan

An interdisciplinary team develops a comprehensive care plan within seven days after completion of the resident's assessment.²⁸ The team is composed of "the [resident's] attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,"²⁹ and, where practicable, "the resident, and the resident's family or the resident's legal representative."³⁰ The care plan offers "measurable objectives

Social, Psychological, and Physical Factors Affecting the Nutritional Status of Elderly Subjects: Separating Cause and Effect, 50 AM. J. CLINICAL NUTRITION 1201 (1989); see also Yves Guigoz et al., *Assessing the Nutritional Status of the Elderly: The Mini Nutrition Assessment as Part of the Geriatric Evaluation*, 54 NUTRITION REVIEWS 559-565 (1996).

23. No. 97-11862 CA 15, 1998 WL 775509 (Dade County Ct. Apr. 22, 1998).

24. See *Settlement in Suit Against Nursing Home*, 18 VERDICTS, SETTLEMENTS & TACTICS 398 (1998) (discussing *Fagan v. A Dade County Nursing Home*).

25. *Fagan*, 1998 WL 775509, at *1.

26. *Id.* (emphasis added). See STEDMAN'S MEDICAL DICTIONARY 1064 (27th ed. 2000) (defining nutritional marasmus as "extreme weakness and wasting secondary to malnutrition"). This condition is a result of "prolonged dietary deficiency of protein and calories." *Id.*; see also INSTITUTE OF MED., THE ROLE OF NUTRITION IN MAINTAINING HEALTH IN THE NATION'S ELDERLY: EVALUATING COVERAGE OF NUTRITION SERVICES FOR THE MEDICARE POPULATION 48-49 (2000) (discussing adult marasmus).

27. See *Fagan*, 1998 WL 775509, at *1.

28. See 42 C.F.R. § 483.20(k)(2)(i) (1999).

29. *Id.* § 483.20(k)(2)(ii).

30. *Id.*

and timetables to meet a resident's medical, nursing, and mental and psychosocial needs" identified in the resident's assessment.³¹ The plan must be updated at least annually pursuant to federal requirements.³²

A resident's nutritional care plan is developed following a nutritional assessment,³³ usually completed by a dietician.³⁴ The dietician gathers diet history, physical examination information, laboratory test results (low serum-albumin levels, for example, are strong evidence of malnutrition and dehydration) and anthropomorphic measurements (such as height, weight, and mid-arm muscle circumference).³⁵ The data is used to formulate an individualized nutritional care plan for the resident.³⁶ The resident's response to the nutritional plan must be monitored and documented.³⁷ Plan results are measured and evaluated.³⁸ As the resident's eating³⁹ patterns change for psychosocial, medical or environmental reasons, the individualized nutritional care plan should also change.⁴⁰

Consider, for example, developing a care plan for the depressed underweight resident with loose-fitting dentures who refuses to eat.⁴¹ Addressing only the loose-fitting dentures is ineffective.⁴² There will be no weight gain because the resident is still depressed and refusing

31. *Id.* § 483.20(k)(1).

32. *See id.* § 483.20(b)(2)(iii).

33. *See* R. BEHRENS & A. BLOCKER, CONTINUOUS QUALITY IMPROVEMENT & NUTRITIONAL CARE PLANNING: A MANUAL FOR LONG-TERM CARE FACILITIES § 3, at 9 (1993); K. Boyle & R. Collinsworth, *Nutritional Assessment of the Elderly*, 15 J. GERONTOLOGICAL NURSING 18-19 (1991).

34. *See* George A. Balko III, *Risk Management for Nursing Homes: A Primer*, in LONG-TERM CARE ADMINISTRATION HANDBOOK 331-32 (Seth B. Goldsmith ed., 1993) [hereinafter *Risk Management Primer*].

35. *See generally id.*

36. *See id.* at 332.

37. *See* 42 C.F.R. § 483.20(b)(1) (1999) ("the assessment process must include direct observation and communication with the resident").

38. *See generally* Susan Saffel-Shrier & Bonnie N. Athas, *Effective Provision of Comprehensive Nutrition Case Management for the Elderly*, 93 J. AM. DIETETIC ASS'N 439-44 (1993).

39. *See* HCFA GUIDANCE, *supra* note 15, at PP-88 (interpreting 42 C.F.R. § 483.25(a)(1)(iv)(1999) (defining the term "eating" as "how resident ingests and drinks (regardless of self-feeding skill)").

40. *See Risk Management Primer*, *supra* note 34, at 332.

41. *See* JANIE L. KRECHTING & VICTORIA E. KOPER, INTERDISCIPLINARY CARE PLANS FOR LONG-TERM CARE 2:3 (2000).

42. *See id.*

to eat.⁴³ Addressing the depression without providing adequate dentures is equally ineffective.⁴⁴

III. Nutritional Services Department Staffing and Responsibilities

In general, nursing homes must provide a nourishing, palatable,⁴⁵ well-balanced diet that meets the daily nutritional,⁴⁶ special dietary, and therapeutic⁴⁷ needs of each individual resident.⁴⁸ According to federal regulations and select state statutes, the facility must provide “at least three meals daily, at regular times comparable to normal mealtimes in the community.”⁴⁹ These “regular times” must accommodate resident preferences and schedules.⁵⁰ However, federal and certain state requirements provide that “[t]here must be no more than 14 hours between a substantial evening meal and breakfast the following day.”⁵¹ In addition, the facility must daily offer snacks at bed-

43. *See id.*

44. *See id.*

45. *See* 42 C.F.R. § 483.35(d)(2) (1999) (requiring “[f]ood that is palatable, attractive, and at the proper temperature”).

46. *See id.* § 483.35(c)(1) (using the requirements specified by the Food and Nutrition Board of the National Research Council, National Academy of Sciences).

47. *See id.* § 483.35(e) (noting need for physician prescription of therapeutic diet); 42 C.F.R. § 483.25(i)(2) (1999) (stating that “the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem”).

48. *See id.* § 483.35(d)(3)-(4) (preparing food “in a form designed to meet individual needs” and offering substitutes “of similar nutritive value to residents who refuse food served.”).

49. *Id.* § 483.35(f)(1); *see, e.g.*, ARIZ. ADMIN. CODE 9-10-911(A)(3)(a) (2000) (providing that residents must have three meals daily).

50. *See* 42 U.S.C. §§ 1395i-3(c)(1)(A)(v)(I), 1396r(c)(1)(A)(v)(I) (1999); 42 C.F.R. § 483.15(b)(1) (“resident’s right to choose activities, schedule, and healthcare consistent with his or her interests, assessments, and plan of care.”); WASH. ADMIN. CODE § 388-97-12010(3)(a) (2000) (observing that a facility must “[a]ccommodate individual mealtime preferences and portion sizes, as well as preferences for between meal and evening snacks when not medically contraindicated.”); WASH. ADMIN. CODE § 388-97-12010(3)(b) (serving either a late breakfast or an alternative to breakfast to residents who are late risers).

51. 42 C.F.R. § 483.35(f)(2); *see, e.g.*, ARIZ. ADMIN. CODE 9-10-911(A)(3)(a) (noting that, in general, no more than 14 hours passing between the evening meal and breakfast the following day).

time.⁵² Failure to follow federal and state requirements may expose the facility to legal action.⁵³

Some states have unique requirements for resident meals. In New York, for instance, every resident has “the right to receive upon request kosher food or food products prepared in accordance with the Hebrew orthodox religious requirements.”⁵⁴ Interestingly, Washington requires the nursing home to provide fresh fruit and vegetables every day when in season.⁵⁵

A. Federal/State Regulations Concerning Dieticians

Federal regulations require nursing homes to “employ a qualified dietician either full-time, part-time, or on a consultant basis.”⁵⁶ “If a qualified dietician is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultations from a qualified dietician.”⁵⁷ JCAHO accreditation standards similarly require the services of an employed dietician or regularly scheduled visits by a consultant dietician to provide dietary counseling for residents and/or their families.⁵⁸ State staffing requirements for dieticians may be more detailed than federal regulations.⁵⁹

52. See 42 C.F.R. § 483.35(f)(3); see also CAL. CODE REGS. tit. 22, § 72335(a)(2) (2000) (offering of bedtime snacks to residents); MO. CODE REGS. ANN. tit. 13, § 15-14.052(7) (2000) (declaring that bedtime snacks must be offered to residents unless medically contraindicated); WASH. ADMIN. CODE § 388-97-12010(5)(a) (providing evening snacks unless medically contraindicated).

53. See THE ELDERLAW PORTFOLIO SERIES 13-1 (Julie A. Braun ed., forthcoming 2001) (copy on file with authors).

54. N.Y. PUB. HEALTH LAW § 2803-c(3)(k) (2000), N.Y. COMP. CODES R. & REGS. tit 10, § 415.3(f)(6) (2000).

55. See WASH. ADMIN. CODE § 388-97-12010(2).

56. 42 C.F.R. § 483.35(a). “A qualified dietician is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning and implementation of dietary programs.” *Id.* § 483.35(a)(2); see also HCFA GUIDANCE, *supra* note 15, at PP-141 (interpreting 42 C.F.R. § 483.35(a)); COMPLIANCE RESOURCE MANUAL, *supra* note 17, at 5:7 (discussing the credentials for a qualified dietician employed by a long-term care facility).

57. 42 C.F.R. § 483.35(a)(1).

58. See JCAHO MANUAL, *supra* note 10, at 167, 222.

59. See generally INSTITUTE OF MED., *supra* note 26, at 340-51 (including in appendix material state licensure laws for the practice of dietetics (as of June 1999), the American Dietetic Association knowledge and skills for competency requirements for entry-level dieticians and offering additional appendix material detailing advanced level credentials in nutrition).

B. Staff Responsibilities

The dietician's primary responsibility is "planning, managing and implementing dietary service activities in order to assure that the residents receive adequate nutrition."⁶⁰ This responsibility entails:

[a]ssessing the special nutritional needs of geriatric and physically impaired persons; [d]eveloping therapeutic diets; [d]eveloping "regular diets" to meet the specialized needs of geriatric and physically impaired persons; [d]eveloping and implementing continuing education programs for dietary services and nursing personnel; [p]articipating in interdisciplinary care planning; [b]udgeting and purchasing food and supplies; and [s]upervising institutional food preparation, service and storage.⁶¹

Composition of the nutritional support team varies depending on facility size and nature.⁶² Certified Nursing Assistants (CNAs), under the supervision of a licensed nurse, are primarily responsible for feeding residents.⁶³

The food service department should balance clinical requisites against individual food preferences.⁶⁴ The nursing and dietary staffs are responsible for evaluating resident acceptance of food and consumption of meals.⁶⁵ This can be done formally or informally, by observation in the dining room, plate waste logs, or formal audits of food quality and acceptance based on staff and resident surveys.⁶⁶ However, several studies have found that nursing home staff overestimate meal consumption and, therefore, it is not a useful indicator of intake.⁶⁷

60. HCFA GUIDANCE, *supra* note 15, at PP-141 (interpreting 42 C.F.R. § 483.35(a)).

61. *Id.*

62. See 42 C.F.R. § 483.35(b) (noting that "[t]he facility must employ sufficient support personnel competent to carry out the functions of the dietary service."); HCFA GUIDANCE, *supra* note 15, at PP-142 (interpreting 42 C.F.R. § 483.35(b)); see also *Risk Management Primer*, *supra* note 34, at 338 (discussing staffing needs in food or nutritional services departments in nursing homes).

63. See Elaine J. Amella, *Factors Influencing the Proportion of Food Consumed by Nursing Home Residents with Dementia*, 47 J. AM. GERIATRICS SOC'Y 879 (1999).

64. See, e.g., WASH. ADMIN. CODE § 388-97-12010(3)(a) (2000) (observing that a facility must "[a]ccommodate individual mealtime preferences and portion sizes, as well as preferences for between meal and evening snacks when not medically contradicted."); *id.* § 388-97-12010(3)(b) (serving either a late breakfast or an alternative to breakfast to residents who are late risers).

65. See *Risk Management Primer*, *supra* note 34, at 334.

66. See *id.*

67. See Helene S. Pokrywka et al., *Accuracy of Patient Care Staff in Estimating and Documenting Meal Intake of Nursing Home Residents*, 45 J. AM. GERIATRICS SOC'Y 1223, 1226 (1997); Sandra F. Simmons & David Reuben, *Nutritional Intake Monitoring for Nursing Home Residents: A Comparison of Staff Documentation, Direct Observa-*

C. Mealtime Staffing

A 1997 study found that each CNA on the daytime shift had, on average, seven to nine residents to assist or feed, while the evening shift CNA was assigned twelve to fifteen residents.⁶⁸ According to clinical nurse researchers, inadequate staffing means that residents are fed quickly, forcefully, or not at all.⁶⁹ Researchers and resident advocacy organizations have recommended instituting national minimum direct-care staffing at mealtimes and using all nursing home personnel to assist during mealtimes to improve resident nutrition and hydration.⁷⁰

IV. Weight Loss

“[W]eight loss is commonly used as a screening tool to assess quality of care and nutritional status in the nursing home setting.”⁷¹ Not all weight loss, however, indicates poor quality of care or negligence. It is not always possible to reverse the weight loss seen in residents with terminal illnesses such as metastatic cancer or those in the end stages of certain conditions including dementia, Parkinson’s disease, congestive heart failure, or chronic obstructive pulmonary disease.⁷² Although many nursing home residents are at high risk for weight loss, most causes can be treated with appropriate and timely intervention.⁷³

tion, and Photography Methods, 48 J. AM. GERIATRICS SOC’Y 209, 209 (2000) (concluding that “the photography method of nutritional assessment yielded the same information as direct observations by research staff, and both of these methods showed the intake levels of nursing home residents to be significantly lower than the intake levels documented by facility staff”).

68. See Jeanie Kayser-Jones, *Inadequate Staffing at Mealtime: Implications for Nursing Health and Policy*, 23 J. GERONTOLOGICAL NURSING 14, 17 (1997).

69. See *id.*

70. See Sarah Greene Burger et al., *Malnutrition and Dehydration in Nursing Homes: Key Issues in Prevention and Treatment* (visited Nov. 11, 2000) <<http://www.cmwf.org>>.

71. June I. Chang et al., *Weight Loss in Nursing Home Patients: Prognostic Implications*, 30 J. FAM. PRAC. 671, 671 (1990).

72. See John E. Morley & Andrew Jay Silver, *Nutritional Issues in Nursing Home Care*, 123 ANNALS INTERNAL MED. 850 (1995).

73. See John D. Gazewood & David R. Mehr, *Diagnosis and Management of Weight Loss in the Elderly*, 47 J. FAM. PRAC. 19 (1998); Ruth Gants, *Detection and Correction of Underweight Problems in Nursing Home Residents*, 23 J. GERONTOLOGICAL NURSING 26, 26, 30–31 (1997); Morley & Silver, *supra* note 72, at 850–59.

A. Definition and Prevalence of Weight Loss in American Nursing Homes

Survey guidelines suggest parameters for evaluating weight loss among nursing home residents.⁷⁴ Significant weight loss—five percent or greater in thirty days, seven and one-half percent or more in ninety days or ten percent in one hundred eighty days—should prompt an immediate evaluation.⁷⁵ The National Aging Information Center reports that thirty-one percent of the nursing home population is underweight.⁷⁶

B. Causes of Weight Loss

The most common causes of weight loss among nursing home residents are the adverse effects of medications (leading to nausea, vomiting, and constipation) and depression⁷⁷ (producing a lack of interest in food).⁷⁸ Psychiatric disorders such as anorexia nervosa (or anorexia tardive, if developed late in life), mania, and paranoia may also affect food consumption.⁷⁹ In addition, some medical conditions negatively affect appetite or produce early satiety (for example, gastroesophageal reflux, peptic ulcer, atrophic gastritis, delayed gastric emptying, constipation, chronic obstructive lung disease, severe cardiac disease, and various types of cancer), while others increase the resident's caloric or protein requirements (hyperthyroidism, hyperparathyroidism, pressure ulcers, and infections, for instance).⁸⁰ Difficulty transporting food from the plate to the mouth (due to stroke, tremors, paralysis and contractures), chewing difficulties (from poor

74. See MARILYN J. RANTZ ET AL., OUTCOME-BASED QUALITY IMPROVEMENT FOR LONG-TERM CARE 3:109 (1999).

75. See *id.* (providing a weight loss assessment form and a weight loss data retrieval worksheet); JCAHO MANUAL, *supra* note 10, at 169 (detailing in the intent statement for Standards TX.5 and TX.5.1 the significant weight loss by percent of body weight); see also FELDMAN & BAKER, *supra* note 17, at 106–07 (recording weight loss measured in percentages: 5% or more in the last 30 days or 10% or more in the last 180 days); INSTITUTE OF MED., *supra* note 26, at 66–67 (defining clinically important weight loss as “more than 10 pounds in 6 months, 4 to 5 percent of body weight in 1 year, or 7.5 percent in 6 months”).

76. See Melissa Lipowski, *When Seniors Won't Eat . . . Improved Nutrition Becomes a Priority*, FOOD MGMT., Aug. 1998, at 30.

77. See Donna Cohen, *Dementia, Depression, and Nutritional Status*, 21 PRIMARY CARE 107, 107 (1994).

78. See Morley & Silver, *supra* note 72.

79. See *id.*

80. See *id.*

dentition, ill-fitting dentures, and mouth ulcers, for example) or swallowing problems (secondary to stroke, dementia, and Parkinson's disease) also significantly affect food intake.⁸¹

Many residents consider institutional food unpalatable because they are on a therapeutic diet⁸² that does not reflect their food preferences.⁸³ Further, residents may find the presentation⁸⁴ and the environment in which the food is served unappealing.⁸⁵ Lastly, for those residents requiring feeding assistance, the method employed by the nursing or dietary assistant is paramount.⁸⁶ If the resident is rushed, given too much to chew or swallow, or is inappropriately positioned, the resident likely will not consume an adequate amount of food.⁸⁷

C. Facility Response to Resident Weight Loss

From a risk management perspective, detection and correction of underweight problems in nursing homes is critical. Researchers associate a weight increase of at least five percent body weight in previously undernourished residents with a decreased incidence of death and morbidity events.⁸⁸

In assessing the facility's response to resident weight loss, in contemplation of legal action, the following guidelines might help.⁸⁹ First, examine the resident's nursing home record for actions taken (or

81. See Elaine Jensen Amella, *Assessment and Management of Eating and Feeding Difficulties for Older People: A NICHE Protocol*, 19 GERIATRIC NURSING 269, 271 (1998); Morley & Silver, *supra* note 72.

82. See HCFA GUIDANCE, *supra* note 15, at PP-145 (defining "therapeutic diet" as "a diet ordered by a physician as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet (e.g., sodium), or to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet)" (that is, one in which the texture of a diet is altered)).

83. See Amella, *supra* note 81, at 269, 270; Kayser-Jones, *supra* note 68, at 17; Jeanie Kayser-Jones & Ellen Schell, *The Effect of Staffing on the Quality of Care at Mealtime*, NURSING OUTLOOK, Mar.-Apr. 1997, at 68; Morley & Silver, *supra* note 72.

84. See Digna Cassens, *Enhancing Taste, Texture, Appearance, and Presentation of Pureed Food: Improved Resident Quality of Life and Weight Status*, 54 NUTRITION REV. 552 (1996).

85. See Jacob Dimant, *The Psychosocial and Environmental Approach to Nutritional Management in Long Term Care*, J. MED. DIRECTION, Aug. 1992, at 54.

86. See Sally Kennedy Holzapfel et al., *Feeder Position and Food and Fluid Consumed by Nursing Home Residents*, 22 J. GERONTOLOGICAL NURSING 6, 7-8 (1996).

87. See Kayser-Jones, *supra* note 68, at 16-18.

88. See Heather H. Keller, *Weight Gain Impacts Morbidity and Mortality in Institutionalized Older Persons*, 43 J. AM. GERIATRICS SOC'Y 165, 166-67 (1995).

89. See RANTZ ET AL., *supra* note 74, at 3:109.

not taken) to “arrest the [resident’s weight loss] within the boundaries of the resident’s wishes and/or health care directive.”⁹⁰ Did a qualified dietician, for instance, evaluate the resident’s diet?⁹¹ Did the resident receive and eat the prescribed diet?⁹² Did the resident receive and consume nutritional supplements?⁹³ Were resident requests for food or fluid honored in a timely fashion?⁹⁴ Was the resident on a repletion diet (that is, one designed to increase the nutrient density of the diet)?⁹⁵ Was the resident evaluated for an underlying illness and/or medication regimen that might affect appetite?⁹⁶

Next, evaluate the interdisciplinary team’s management of the resident’s weight loss. Identify any significant trends in the identification, documentation, or occurrence of the weight loss. Ascertain any deficiencies or areas of concern in interdisciplinary team communication, team process, or implementation of team interventions to stabilize weight.⁹⁷

The resident in *Estate of Collins v. Beverly Enterprises-Florida, Inc.*⁹⁸ lost forty-one pounds of body weight during a three-year residency at the defendant’s nursing home and was malnourished upon her final hospitalization.⁹⁹ In this negligence-based survival action, a Florida jury awarded just over \$12 million to the decedent’s estate, finding that, among other things, the resident died of dehydration.¹⁰⁰

In *Marsh v. Bay Convalescent Center, Inc.*,¹⁰¹ an eighty-two-year-old man with Alzheimer’s disease weighed two hundred twelve pounds upon nursing home admission.¹⁰² Thirty-five days later he was transferred to a hospital in a severely dehydrated condition and weighed only one hundred sixty pounds.¹⁰³ He died of dehydration

90. *Id.*

91. *See id.*

92. *See id.*

93. *See id.*

94. *See id.*

95. *See id.*

96. *See id.*

97. “The assessment process includes . . . communication with licensed and nonlicensed direct care staff members on all shifts.” 42 C.F.R. § 483.20(b)(1) (1999).

98. No. 98-433-CA, 2000 WL 1203896 (Taylor County Ct. Mar. 31, 2000).

99. *See id.*

100. *See id.* (breaking down the \$12,021,630.83 verdict into \$1,000,000 for resident’s rights violations; \$1,000,000 for negligence; \$21,630.83 for medical and funeral bills and \$10,000,000 in punitive damages).

101. No. 93-3758B, 1995 WL 871652 (Bay County Ct. Nov. 1995).

102. *See Settlement in Suit Against Nursing Home*, 16 VERDICTS, SETTLEMENTS & TACTICS 106 (1996) (discussing *Marsh v. Bay Convalescent Ctr., Inc.*).

103. *See id.*

and malnourishment.¹⁰⁴ The plaintiff contended that both defendants, the nursing home and the attending physician, failed to properly care for the resident and “failed to monitor his [nourishment] intake.”¹⁰⁵ The defendants maintained that the decedent had not lost approximately fifty pounds during his stay at the facility, but that the medical records were in error and that the resident’s death was brought about because of his medical condition and natural causes.¹⁰⁶ The parties settled for \$400,000.¹⁰⁷

V. Tube Feeding

The subject of tube feeding is complex. It involves advance care planning, nursing home staff feeding techniques, assessment of swallowing disorders, and maintenance of a treatment intervention that may lead to many complications.¹⁰⁸ Further, use of feeding tubes may reduce the resident’s quality of life because physical restraints may be employed to prevent tube displacement or removal.¹⁰⁹

In reviewing a tube feeding case for trial or settlement, the attorney should evaluate whether the nursing home met the standard of care for feeding tube management, whether proper feeding tube techniques were employed and whether adequate instructions in feeding tube use were provided to facility personnel.¹¹⁰

A. Tube Feeding: Definition and Examples

Tube feeding provides “the [resident’s] fluids and nutritional requirements by instilling foods into the stomach” via a tube.¹¹¹ Several types of feeding tubes are used in the nursing home setting. When the expected use of artificial enteral feeding¹¹² is for a short duration (less than two weeks following hip fracture or to facilitate pressure ulcer

104. *See id.*

105. *Id.*

106. *See id.*

107. *See id.*

108. *See infra* notes 148–73 and accompanying text.

109. *See* Linda O’Brien et al., *Tube Feeding Preferences Among Nursing Home Residents*, 12 J. GEN. INTERNAL MED. 364 (1997) (concluding that demographic and social factors are associated with preferences for tube feedings).

110. *See infra* notes 119–26 and accompanying text.

111. *TABER’S CYCLOPEDIA MEDICAL DICTIONARY 2051* (18th ed. 1997) [hereinafter *TABER’S*].

112. *See id.* at 645 (defining enteral).

healing),¹¹³ for instance, then a nasogastric/enteric tube¹¹⁴ is inserted through the resident's nose into the stomach or small intestine¹¹⁵ (jejunum).¹¹⁶ Nursing home residents requiring long-term usage or feedings for an indefinite period of time receive a percutaneous endoscopic gastrostomy (PEG tube),¹¹⁷ gastrostomy (G tube),¹¹⁸ or jejunostomy (J tube).¹¹⁹ The PEG tube is placed in the stomach using an endoscope, while G and J tubes are placed surgically into the stomach and jejunum, respectively.¹²⁰

B. Prevalence Estimates of Tube Feeding in American Nursing Homes

Approximately ten percent of American nursing home residents use artificial enteral nutrition or "feeding tubes."¹²¹ Residents with swallowing disorders related to dementia, stroke and/or chronic neuromuscular disorders such as Parkinson's disease are the most likely candidates for feeding tube placement.¹²² Many of these residents, however, are in the terminal stages of their disease process and may not receive the purported benefits of treatment; research has not demonstrated either increased survival rates or prevention of aspiration pneumonia among nursing home residents who receive long-term tube feedings.¹²³ For this reason, advance care directives include the

113. See Morley & Silver, *supra* note 72, at 850-59.

114. See TABER'S, *supra* note 111, at 1269-70 (defining nasogastric tube).

115. See *id.* at 1034 (defining jejunum).

116. See GERIATRIC SECRETS 75-76 (Mary Ann Forcica & Risa Lavizzo-Mourey eds., 1996).

117. See TABER'S, *supra* note 111, at 1437 (defining percutaneous).

118. See *id.* at 782 (defining gastrostomy).

119. See *id.* at 1034 (defining jejunostomy); see also GERIATRIC SECRETS, *supra* note 116, at 75-76.

120. See GERIATRIC SECRETS, *supra* note 116, at 75-76.

121. See Susan L. Mitchell et al., *A Cross-National Survey of Tube-Feeding Decisions in Cognitively Impaired Older Persons*, 48 J. AM. GERIATRICS SOC'Y 391 (2000).

122. See Susan L. Mitchell et al., *The Risk Factors and Impact on Survival of Feeding Tube Placement in Nursing Home Residents with Severe Cognitive Impairment*, 157 ARCHIVES INTERNAL MED. 327 (1997).

123. See Raymond Cogen & Joan Weinryb, *Aspiration Pneumonia in Nursing Home Patients Fed Via Gastrostomy Tubes*, 84 AM. J. GASTROENTEROLOGY 1509, 1511 (1989); Mark E. Cowan et al., *Survival Estimates for Patients with Abnormal Swallowing Studies*, 12 J. GEN. INTERNAL MED. 88, 88 (1997); Kenneth A. Fox et al., *Aspiration Pneumonia Following Surgically Placed Feeding Tubes*, 170 AM. J. SURGERY 564 (1995); Susan L. Mitchell et al., *Does Artificial Enteral Nutrition Prolong the Survival in Institutionalized Elders with Chewing and Swallowing Problems*, 53A J. GERONTOLOGY: MED. SCIENCES M207, M210 (1998); Mitchell et al., *supra* note 122, at 327-32.

decision for tube feeding among the choices for initiating or removing life-sustaining treatment.¹²⁴

C. Risk Factors Associated with Tube Feeding

Risks associated with tube feedings include aspiration pneumonia, diarrhea, tube displacement, clogging of the tube, cramping/bloating, skin breakdown due to tube drainage, skin necrosis related to tube pressure on skin, dry mouth, and nausea.¹²⁵ If the enteral feeding is the only source of nutrition, the resident must receive additional water to prevent dehydration or electrolyte disturbances.¹²⁶ Most of these problems can be prevented or treated with proper nursing monitoring; however, such care is contingent upon adequate staffing and professional (registered) nursing supervision.¹²⁷ Moreover, adequate staffing makes sense from a risk management point of view.

D. Federal Regulation and Agency Interpretive Guidance on Tube Feeding

Based on a resident's comprehensive assessment, the facility must ensure that:

- (1) A resident who has been able to eat enough alone or with assistance is not fed by [feeding] tube unless the resident's clinical condition demonstrates that use of a [feeding] tube was unavoidable; and
- (2) A resident who is fed by a [feeding] tube 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.¹²⁸

124. See Mitchell et al., *supra* note 121, at 391; Jeanie Kayser-Jones, *The Use of Nasogastric Feeding Tubes in Nursing Homes: Patient, Family and Health Care Provider Perspectives*, 30 GERONTOLOGIST 469, 475 (1990).

125. See Charles C. Tsai & Suzanne F. Bradley, *Group A. Streptococcal Bacteremia Associated with Gastrostomy Feeding Tube Infections in a Long-Term Care Facility*, 40 J. AM. GERIATRICS SOC'Y 821, 821 (1992).

126. See Margaret A. Drickamer & Leo M. Cooney, Jr., *A Geriatrician's Guide to Enteral Feeding*, 41 J. AM. GERIATRICS SOC'Y 672, 677 (1993).

127. See Charlene Harrington et al., *Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States*, 40 GERONTOLOGIST 5, 16 (2000).

128. 42 C.F.R. § 483.25(g)(1)-(2) (1999) (referencing use of a nasogastric or gastrostomy tube although the regulation presumably applies to other types of feeding tubes as well). State law may also address feeding tube use. See, e.g., N.C. ADMIN. CODE tit. 10, r. 03H.2305(f), (i) (July 2000) (stating that catheters and feeding tubes should be employed only when their use is unavoidable).

HCFA Guidance interprets the intent of federal regulations that address tube feeding.¹²⁹ The Guidance states that tube feeding is utilized only after adequate assessment, and then only if the resident's clinical condition makes this treatment necessary.¹³⁰ Therefore, a thorough assessment should be undertaken before initiating tube feeding. Consider, for example, asking a speech pathologist to assist with the diagnosis and management of a resident's dysphagia (a swallowing disorder) prior to initiating tube feeding. If the resident's dysphagia is unrecognized and thus not clinically evaluated or treated, the resident is at risk for malnutrition,¹³¹ and the nursing home is susceptible to a future lawsuit. Moreover, if the nursing home does not undertake assessment, the home may be cited for non-compliance with federal requirements in this area.

Decisions to use feeding tubes are not based solely on the nutritional status and swallowing ability of nursing home residents. Rather, insertion of a feeding tube must be examined within the context of the resident's condition and preference for treatment that may prolong life. HCFA advises nursing homes "to prevent the use of tube feeding when ordered over the objection of the resident."¹³² Further, the HCFA Guidance suggests that decisions about the appropriateness of tube feeding for a resident should be made by the resident, the resident's family, or a surrogate or representative as part of determining the care plan.¹³³

E. Staff Responsibilities for Tube Feeding

Surveyors evaluate facility compliance with federal requirements in this area to determine whether staff responsibilities for tube feedings were clearly assigned in accordance with regulatory guide-

129. See HCFA GUIDANCE, *supra* note 15, at PP-102 (interpreting 42 C.F.R. § 483.25(g)).

130. See *id.*

131. See Jeanie Kayser-Jones & Kathryn Pengilly, *Dysphagia Among Nursing Home Residents*, GERIATRIC NURSING, Mar./Apr. 1999, at 77 (reporting that 45 of the 82 residents studied (55%) had some degree of dysphagia, ranging from mild to profound, but only 10% of these 45 residents (22%) had been referred for a dysphagia evaluation).

132. HCFA GUIDANCE, *supra* note 15, at PP-102.

133. See *id.* The discussion of the clinical, ethical, and legal aspects of end-of-life treatment is beyond the scope of this article.

lines.¹³⁴ To assure compliance, the surveyors ask who is responsible for the feedings, formula, amount, feeding intervals, and flow rate.¹³⁵

In *Doe v. Nursing Home*,¹³⁶ a \$1 million settlement was reached in a case involving a resident in his seventies diagnosed with dementia and throat cancer.¹³⁷ The staff was responsible for feeding the resident through a G-tube.¹³⁸ Five months after admission, the resident was hospitalized and the nurse at the hospital “stated that the [resident] was the most neglected patient she had ever seen.”¹³⁹ The treating physician believed “that each of the conditions afflicting the ‘[resident]—the mouth ulcers, the [pressure ulcers], the contractures, the dehydration and the malnutrition’—must have been present ranging from weeks to months.”¹⁴⁰ The nursing home records allegedly reflected the provision of daily care; however, malnutrition and dehydration could only have occurred if staff neglected to feed the resident through a G-tube.¹⁴¹

In *Estate of Pichardo v. Meadowbrook Health Care Services, Inc.*,¹⁴² the defendant nursing home reached a \$1.3 million structured settlement after allegedly failing to adequately tube feed and administer prescribed medication to a sixty-one-year-old resident with Alzheimer’s disease following hospitalization for malnutrition.¹⁴³

[The resident’s] wife, who spent nearly every day with him and routinely fed him his meals, went out of town During this time the nursing staff failed to adequately feed decedent and his weight dropped from one hundred and seventeen pounds on May 19, 1993 to eighty-three pounds on June 2, 1993, at which point he was hospitalized for “poor appetite.” Decedent returned to the nursing home on June 10, 1993 with a prescription for Cipro and tube feedings. Between June 10 and June 16, 1993, he was never given the Cipro and many of his scheduled [tube] feedings were missed. He was sent back to the hospital on June 16th again malnourished, dehydrated, and with a temperature of 104.6 [degrees Fahrenheit]. He continued to deteriorate until his death on August 19, 1993.¹⁴⁴

134. See *id.* at PP-103

135. See *id.*

136. See \$1 Million Settlement in Suit Alleging Inadequate Care at Nursing Home, 14 VERDICTS, SETTLEMENT & TACTICS 329 (1994) (discussing *Doe v. Nursing Home*).

137. See *id.*

138. See *id.*

139. *Id.*

140. *Id.*

141. See *id.*

142. No. 93-20257, 1994 WL 729761 (Dade County Ct. July 1994).

143. See *id.*

144. *Id.* (emphasis added).

F. Monitoring the Tube-Fed Resident

Failure to properly monitor a tube-fed resident may expose the nursing home to liability. Residents receiving tube feedings should be monitored to reduce tube-related complications (aspiration, gastric distension, or diarrhea, for example) and to identify negative outcomes (for instance, agitation, depression, self-extubation, or restraint use without a medical reason).¹⁴⁵ Agency guidance interpreting federal regulations on tube feeding highlights the importance of staff monitoring.¹⁴⁶

In practice, the requisite standard of care requires checking tube placement, length of exposed tube, and whether the tube is held securely in place periodically and prior to administering a feeding.¹⁴⁷ The caregiver should reposition and re-tape nasal tubes to protect the resident from pressure necrosis of the nose.¹⁴⁸ The caregiver should watch for feeding tube leakage of gastric contents and change the method of tube anchoring when necessary.¹⁴⁹ "Skin breakdown due to leakage of gastrointestinal contents occurs quickly and must be dealt with aggressively."¹⁵⁰ The caregiver should administer mouth care to prevent dry mouth and dental decay (if applicable) from occurring.¹⁵¹ "If feasible, residents [should] not . . . lie flat during tube feeding."¹⁵² Caregivers must assess vomiting, distention, diarrhea, and abdominal pain and treat these conditions immediately.¹⁵³ The caregiver may need to change the feeding tube or adjust the amount provided to reduce or eliminate diarrheal episodes.¹⁵⁴

G. Staff Training and Education on Tube Feeding

Administrators at long-term care facilities should consider tube feeding as a risk management issue and provide ongoing staff training and education in, among other areas, feeding techniques and maintenance of a treatment intervention that may lead to complications. In

145. See HCFA GUIDANCE, *supra* note 15, at PP-103

146. *See id.*

147. See RANTZ ET AL., *supra* note 74, at 3:116.

148. *See id.*

149. *See id.*

150. *Id.*

151. *See id.*

152. *Id.*

153. *See id.*

154. *See id.*

Estate of Crump v. Texas Health Enterprises, Inc.,¹⁵⁵ a \$51,000 settlement was reached before trial following the death of a nursing home resident, allegedly because the defendant “failed to provide proper techniques in the use of tube feedings and failed to provide adequate instructions in the use of tube feedings to its personnel.”¹⁵⁶

H. Tube Feeding Complications

Guidance interpreting federal regulation of tube feeding discusses the potential for tube feeding complications, highlights the need to identify potential complications and, offers suggestions to minimize such complications (using a small bore, flexible nasogastric tube, for instance).¹⁵⁷

In *Estate of Burton v. Texas Health Enterprises, Inc.*,¹⁵⁸ a Texas jury returned a \$28,262,001 verdict after a seventy-eight-year-old resident died of malnourishment following four surgeries as a result of feeding tube complications.¹⁵⁹ The nursing home unsuccessfully argued that the resident was contributorily negligent in declining to consume food.¹⁶⁰

In *Boston v. 2510 Eagle, Inc.*,¹⁶¹ a \$1.5 million dollar settlement was reached in a suit alleging negligent nursing home care of a ninety-seven-year-old resident.¹⁶²

[The resident’s] condition grew steadily worse throughout the spring and summer of 1996. He began to experience alarming weight loss In March of 1996, [the resident] was transferred to [a hospital] for debridement of the bedsores, and placement of a PEG tube, and his weight loss was brought back to healthy levels. When he returned to the nursing home his *feeding tube was grossly mismanaged*, and his weight once again plummeted, dropping 43 pounds in the next 67 days In May of 1996, he was again admitted to the hospital for dehydration and sepsis. His bedsores again required treatment. Again, in September of 1996, he was hospitalized for dehydration and sepsis. After a week in

155. No. 137, 844-V, 1994 WL 751280 (Wichita County Ct. Sept. 1994).

156. *Id.* at *3.

157. See HCFA GUIDANCE, *supra* note 15, at PP-102, -103.

158. No. 95-00828, 1998 WL 891604 (Harris County Ct. Apr. 1998).

159. See *id.* at *2 (detailing surgeon’s negligence in lacerating resident’s portal vein causing him to bleed to death and nursing home’s negligence in failing to provide adequate care and treatment).

160. See *id.*

161. No. 99:7-57 (Leon County Ct. May 20, 1999).

162. See *id.*

the hospital, he was returned to the [nursing home], where he remained until his death a few weeks later.¹⁶³

I. Placing and Sizing Feeding Tubes

The regulatory Guidance prompts surveyors to investigate the correctness of feeding tube placement.¹⁶⁴ Although feeding tubes often are inserted to prevent aspiration of food into the lungs (aspiration pneumonia), improper placement of the tube may lead to aspiration of the enteral feeding and/or other gastric contents.¹⁶⁵ Prior to administering an enteral feeding, the tube should be checked for placement (lungs, stomach, or small intestine).¹⁶⁶ In clinical practice, radiological (x-ray) confirmation is considered the definitive method to ensure correct tube placement.¹⁶⁷ Further, residents should be elevated immediately if they display any clinical signs or symptoms of aspiration such as shortness of breath, infection, abnormal breath sounds, or acute mental status change.¹⁶⁸

A \$91,000 settlement was reached in *Walton v. Mt. Vernon Park Care Center*,¹⁶⁹ where a ninety-one-year-old nursing home resident allegedly died following improper feeding tube insertion.¹⁷⁰ Similarly, in *Estate of Diaz v. Ara Living Centers, Inc.*,¹⁷¹ a \$2.4 million dollar settlement followed a resident's death, allegedly from suffocation after an improperly placed feeding tube carried fluid into the resident's lungs instead of his stomach.¹⁷² Likewise, in *Estate of Dizon v. Nikkei*,¹⁷³ a \$96,000 settlement was arrived at following the death of an eighty-six-year-old resident "from respiratory distress and bronchopneumonia after a feeding tube was placed incorrectly into [the resident's] right lung at the defendant nursing home" and "the defendant's nurse

163. \$1.5 Million Settlement in Suit Alleging Negligent Nursing Home Care, 19 VERDICTS, SETTLEMENTS & TACTICS 388 (1999) (emphasis added) (discussing *Boston v. 2510 Eagle, Inc.*).

164. See HCFA GUIDANCE, *supra* note 15, at PP-103

165. See Cogen & Weinryb, *supra* note 123, at 1510-611; Fox et al., *supra* note 123, at 566-67.

166. See *id.*

167. See Norma A. Metheny et al., *PH and Concentration of Bilirubin in Feeding Tube Aspirates as Predictors of Tube Placement*, 48 NURSING RES., 189-90 (1999).

168. See GERIATRIC SECRETS, *supra* note 116, at 80.

169. No. 191CC1536, 1991 WL 475009 (Greene County Ct. June 1991).

170. See *id.* at *1.

171. No. 141973, 1993 WL 763777 (Hidalgo County Ct. May 1993).

172. See *id.* at *1.

173. No. 88-2-23275-0, 1994 WL 751501 (King County Ct. Sept. 1994).

turned on the feeding machine attached to the improperly-placed tube for a [twenty-two] hour period.”¹⁷⁴

In *Estate of Lowe v. Beverly California Corp.*,¹⁷⁵ the “[d]ecedent’s feeding tubes had to be surgically replaced . . . on so many occasions that the treating physician who reinserted the tubes, wrote in his medical record: ‘Patient has a J-tube which is frequently sabotaged at the nursing home.’”¹⁷⁶ Expert witnesses testified that the facility did not meet standards for care in seven different areas, including feeding tube management.¹⁷⁷ The jury awarded \$2,725,000 to the plaintiff.¹⁷⁸

In *Estate of McClelland v. Meadowbrook Manor*,¹⁷⁹ a sixty-eight-year-old resident required a feeding tube because he was unable to eat through his mouth after he suffered a stroke.¹⁸⁰ Unfortunately, when the resident’s feeding “tube came out while he was being turned, the defendant’s nurse replaced his tube with one of a different size.”¹⁸¹ The decedent’s estate alleged that the nurse was negligent in failing to insert the correct feeding tube.¹⁸² The defendant nursing home agreed to a \$200,000 settlement.¹⁸³

VI. Dehydration and Malnutrition

According to federal regulation, “[t]he facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.”¹⁸⁴ In addition, regulations require “proper treatment and care” for special services, including parenteral and enteral fluids.¹⁸⁵ Appropriate risk management involves identifying residents at risk for dehydration and ensuring the provision of interventions to prevent it.

174. *Id.* at *2.

175. No. 94-2006 CA, 1996 WL 901874 (Fla. Cir. Ct. May 21, 1996).

176. *Id.*

177. *See id.*

178. *See id.*

179. No. 97CC2065, 1998 WL 1084040 (St. Louis County Ct. Nov. 1998).

180. *See id.* at *2.

181. *Id.*

182. *See id.*

183. *See id.* at *1.

184. 42 C.F.R. § 483.25(j) (1999). *See generally* SARAH BURGER ET AL., NURSING HOMES: GETTING GOOD CARE THERE 54–63 (1996).

185. 42 C.F.R. § 483.25(k)(2).

A. Defining Dehydration and Malnutrition

Older adults often have a decreased sense of thirst,¹⁸⁶ and this, coupled with dependency on the caregiver for fluids, places the nursing home resident at risk for dehydration.¹⁸⁷ Dehydration is defined broadly as inadequate levels of water and/or sodium.¹⁸⁸ “Dehydration may be caused either by increased fluid loss or decreased fluid intake.”¹⁸⁹ Dehydration is the most common fluid and electrolyte disorder in long-term care settings.¹⁹⁰ Experts define malnutrition as “the intake of either too few macronutrients or too many micronutrients”¹⁹¹ and as “faulty nutrition due to inadequate or unbalanced intake of nutrients on their impaired assimilation or utilization.”¹⁹²

A recent investigation studying malnutrition and dehydration reports that among a myriad of potential contributing causes, deficient institutional factors, particularly inadequate staffing and lack of professional nursing supervision, are the most likely culprits.¹⁹³ These two factors lead to poor care practices such as undiagnosed dysphagia, inadequate pain management, liquids inaccessible to the resident, and inadequate amount of liquids offered to the resident (to prevent incontinence episodes and subsequent incontinence pad changes).¹⁹⁴ In addition, caregivers hurry residents or position them improperly so that they cannot drink comfortably.¹⁹⁵

186. See INSTITUTE OF MED., *supra* note 26, at 231 (“Ensuring adequate water intake is particularly important because elders often have a decreased sense of thirst.”).

187. See Andrew Weinberg et al., *Dehydration and Death During Febrile Episodes in the Nursing Home*, 42 J. AM. GERIATRICS SOC’Y 968, 968–69 (1994).

188. See Andrew Weinberg et al., *Dehydration: Evaluation and Management in Older Adults*, 274 JAMA 1552 (1995).

189. Jeanne 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 (1999) (investigating the factors that influenced fluid intake among nursing home residents who were not eating well).

190. See *id.*; see also HYDRATION AND AGING 181–200 (M.J. Arnaud et al. eds., 1998).

191. See Morley & Silver, *supra* note 72, at 851.

192. WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY 1368 (3d ed. 1981).

193. See Kayser-Jones et al., *supra* note 189, at 1187.

194. See *id.*

195. See *id.*

B. Prevalence of Dehydration and Malnutrition in American Nursing Homes

The National Aging Information Center reports that almost half of the nursing home population is malnourished and that thirty-one percent are so underweight that they are more susceptible to chronic disease and premature death.¹⁹⁶ Protein-calorie malnutrition is the most prevalent type and is associated with pressure ulcers, cognitive problems, infections, and anemia, as well as increased hospitalization and mortality.¹⁹⁷

In June of 2000, the National Citizens' Coalition for Nursing Home Reform released a report funded by The Commonwealth Fund that compiled various studies from over the last five to ten years.¹⁹⁸ According to the report, anywhere "from 35 percent to 85 percent of U.S. nursing home residents are malnourished" and thirty to fifty percent are below standard body weight.¹⁹⁹

C. Risk Factors for Dehydration and Malnutrition

The Office of Inspector General (OIG) of the Department of Health and Human Services identified "inappropriate or insufficient treatment and services to address residents' clinical conditions, including pressure ulcers, dehydration, [and] malnutrition" as a quality of care risk area.²⁰⁰

The recommended daily fluid intake for a nursing home resident is thirty milliliters per kilogram of body weight.²⁰¹ This equates to approximately 1600 to 2000 cc (1.6 to 2 liters) of daily fluid intake.²⁰²

196. See Lipowski, *supra* note 76, at 30.

197. See Morley & Silver, *supra* note 72; see also Dennis H. Sullivan et al., *Protein-Energy Undernutrition Among Elderly Hospitalized Patients: A Prospective Study*, 281 JAMA 2013 (1999); Dennis H. Sullivan, *The Role of Nutrition in Increased Morbidity and Mortality*, 11 CLINICS IN GERIATRIC MED. 661, 661-63 (1995).

198. See Burger et al., *supra* note 70.

199. *Id.*; see also *Nursing Homes: Study Finds Many Nursing Home Residents Suffering From Malnutrition and Dehydration*, Health Care Pol'y Rep. Stud. & Surv. (BNA) No. 8, at 1046 (June 2000).

200. Publication of the OIG Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,293 (2000).

201. See Weinberg et al., *supra* note 187.

202. See, e.g., C.A. Armstrong-Esther et al., *The Institutionalized Elderly: Dry to the Bone!*, 33 INT'L J. NURSING STUD. 619, 620 (1996) (recommending daily intake of 2000-2500 ml); Kayser-Jones et al., *supra* note 189, at 1187; Phyllis Meyer Gaspar, *Water Intake of Nursing Home Residents*, 25 J. GERONTOLOGICAL NURSING 23, 27 (1999) (describing a daily standard water requirement of 1,600 mL/m² body surface area); David H. Holben, *Fluid Intake Compared with Established Standards and*

Nursing home records may show the needs of a resident and may demonstrate neglect by showing that the resident was undernourished for a continuous period of time.²⁰³ Moreover, several studies demonstrate that nursing staff may lack adequate understanding of the fluid requirements of nursing home residents, as well as knowledge of the signs, symptoms, and complications of dehydration.²⁰⁴ It should be recognized, however, that the clinical diagnosis of dehydration may be difficult, as the signs and symptoms (such as dry mouth, poor skin turgor, constipation, orthostatic hypotension, and weight loss) are vague and frequently absent in older adults.²⁰⁵ Blood and urine tests can determine hydration status, but the results may be affected by other conditions.²⁰⁶ Residents at high risk of dehydration require specific interventions to ensure adequate fluid intake. Such interventions should be included in the care plan.

Certain chronic medical conditions may decrease thirst (stroke), increase fluid loss (nocturia), reduce the ability to swallow thin liquids (stroke, Parkinson's disease) or decrease fluid intake (depression, dementia).²⁰⁷ Acute medical illnesses, especially infections accompanied by fever, diarrhea, and vomiting, dramatically increase the body's need for additional fluid (and possibly electrolyte) intake.²⁰⁸ Medications such as diuretics and laxatives may result in excessive fluid loss.²⁰⁹ Functional deficits, including poor manual dexterity, inability to walk independently, and visual impairment, may impede the resident from obtaining adequate fluid.²¹⁰ Care practices such as using

Symptoms of Dehydration Among Elderly Residents of a Long-Term Care Facility, 99 J. AM. DIETETIC ASS'N 1447 (1999).

203. See J. Thomas Rhodes III & Juliette Castillo, *Proving Damages in Nursing Home Cases*, TRIAL, Aug. 2000, at 44.

204. See, e.g., Armstrong-Esther et al., *supra* note 202, at 625-26 (noting that the results of a 1996 study of 57 residents in psychogeriatric long-term care and geriatric admission units found nursing knowledge of the signs and complications of dehydration and the fluid requirements of the older adult inadequate); Kayser-Jones et al., *supra* note 189; Lowell C. Wise et al., *Evaluating the Reliability and Utility of Cumulative Intake and Output*, 14 J. NURSING CARE QUALITY 37 (2000) (suggesting that where caregiver charting compliance is optimal, daily intake and output recording provides unreliable results).

205. See Weinberg et al., *supra* note 187.

206. See *id.*

207. See Morley & Silver, *supra* note 72, at 850-59; Weinberg et al., *supra* note 187, at 1552-56.

208. See Weinberg et al., *supra* note 187, at 1552-56.

209. See *id.*

210. See *id.*

physical restraints and side rails²¹¹ further reduce the resident's ability to drink independently or to seek staff assistance.²¹²

Inadequate fluid intake in older adults "may lead to rapid dehydration and precipitate hypotension, fever, constipation, vomiting, muscosal tissue dryness, and confusion."²¹³ Fortunately, the consequences of dehydration are treatable if caregivers initiate intervention in a timely fashion.²¹⁴ Constipation secondary to dehydration may eventually lead to fecal impaction requiring surgical intervention.²¹⁵ Dehydration leading to acute mental status changes (delirium, for example) is a major reason for hospitalization of nursing home residents as well as a significant contributor to iatrogenic events during hospitalization and increased length of hospital stays.²¹⁶ Frequent episodes or untreated dehydration leading to serious health consequences may constitute a form of neglect.²¹⁷

D. Federal Law and Regulation Relating to Nutrition and Hydration

The Nursing Home Reform Act (NHRA)²¹⁸ enacted by Congress as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA)²¹⁹

211. See generally Julie A. Braun & Elizabeth A. Capezuti, *The Legal and Medical Aspects of Physical Restraints and Bed Siderails and Their Relationship to Falls and Fall-Related Injuries in Nursing Homes*, 4 DEPAUL J. HEALTH CARE L. 1 (2000).

212. See Morley & Silver, *supra* note 72, at 850-59.

213. *Id.*

214. See MERCK & CO., THE MERCK MANUAL OF GERIATRICS 562 (2000) (noting that "[n]urses can help prevent dehydration by closely monitoring fluid balance in elderly [residents].")

215. See Cathy A. Alessi & Chris T. Henderson, *Constipation and Fecal Impaction in the Long-Term Care Patient*, 4 CLINICS IN GERIATRIC MED. 571 (1988).

216. See Sharon K. Inouye, *The Dilemma of Delirium: Clinical and Research Controversies Regarding Diagnosis and Evaluation of Delirium in Hospitalized Elderly Medical Patients*, 97 AM. J. MED. 278, 283 (1994).

217. See Linda M. Wolf, *Elder Abuse and Neglect* (visited Nov. 11, 2000) <<http://www.webster.edu/~woolfm/abuse.html>>.

218. The Nursing Home Reform Act, Pub. L. No. 100-203, was included in the Omnibus Budget Reconciliation Act of 1987, codified at 42 U.S.C. §§ 1395(a)-(h) [Medicare] & 1396r(a)-(h) [Medicaid]. Its content was based on INSTITUTE OF MED., IMPROVING THE QUALITY OF NURSING HOME CARE (1986)). See generally Mary Kathleen Robbins, Comment, *Nursing Home Reform: Objective Regulation or Subjective Decisions?*, 11 COOLEY L. REV. 185 (1994) (providing background on the legal overhaul).

219. 42 U.S.C. §§ 1395i, 1396 (1994); see also H.R. REP. NO. 100-391, 408-21 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-1, 2313-228-41; H.R. CONF. REP. NO. 100-495, 666-730 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-1245, 2313-1412-76 (confirming the intent of Congress to implement major reforms in nursing home care and to create a resident-centered, outcome-oriented survey process).

and its implementing regulations²²⁰ explicitly address nutrition and hydration.²²¹ According to federal regulations, the facility must ensure that each resident “[m]aintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible.”²²² Similar language applies to hydration in that a “facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.”²²³ Other provisions relate to nutritional assessment and care planning: dietary staffing requirements;²²⁴ the provision of care, services, and quality of life;²²⁵ freedom from physical and chemical restraint,²²⁶ which are known to decrease appetite and impede eating; and the right to reasonable accommodation of individual needs,²²⁷ an important protection in assuring choice of food and an environment conducive to eating.

E. Failing to Report Condition to Physician

A complaint filed in a nursing home negligence case may allege a failure to inform a resident’s treating physician of the resident’s condition. According to federal regulation, the facility must immediately inform the resident’s physician when there is “[a] significant change in the resident’s physical, mental, or psychosocial status” or the need arises “to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment).”²²⁸

In *Estate of Hale v. Campbell Care of North Dallas, Inc.*,²²⁹ for example, the complaint alleged a failure to inform an eighty-five-year-old resident’s treating physician about her dehydration and infected ne-

220. See 42 C.F.R. § 483 (1999).

221. See, e.g., *id.* §§ 483.25(g), .25(i), .25(j), .25(k) (mentioning nasogastric tubes, nutrition, hydration, and parenteral and enteral fluids, respectively); *id.* § 483.35 (considering dietary services in the nursing home).

222. *Id.* § 483.25(i)(1).

223. *Id.* § 483.25(j).

224. See *id.* § 483.35.

225. See *id.* § 483.25.

226. See *id.* § 483.13(a) (“The resident has the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.”).

227. See *id.* § 483.15.

228. *Id.* § 483.10(b)(11)(B)–(C).

229. No. 89-9535-J, 1992 WL 695677 (Dallas County Ct. Apr. 1992).

croitic bedsores, as well as failure to render appropriate treatment for same.²³⁰ The case settled for \$780,000 before trial.²³¹

In *Estate of Burgstahler v. Springfield Retirement Village d/b/a Mount Vernon Park Care Center*,²³² an eighty-four-year-old resident died thirty-five days after she suffered two fractured femurs sustained when a nurse's aide attempted to lift the resident by himself and dropped her.²³³ The injuries were not diagnosed for eight days and the resident subsequently suffered from severe dehydration, malnutrition, and anemia.²³⁴ A Missouri jury awarded the decedent's estate \$526,000.²³⁵

In *Anonymous v. Anonymous*, a \$100,000 settlement agreement was reached following the death of a sixty-seven-year-old resident diagnosed with, among other things, Alzheimer's dementia, phlebitis, deep venous thrombosis, and diabetes.²³⁶ Twenty days after nursing home admission the resident was found in a catatonic state.²³⁷ "At that time, the [resident] had a blood sugar level of over 1000, was experiencing renal failure due to *profound dehydration*, had extensive blood clots in her lower extremities, and fell into a deep [diabetic] coma."²³⁸ Plaintiffs contended that their mother was improperly nourished, among other allegations, and that "her physical and mental status was not properly and timely monitored or reported."²³⁹

F. Negligence in Failing to Properly Care for Resident

In *Estate of Hary v. Horizon/CMS Healthcare Corp.*,²⁴⁰ a Texas jury returned a \$92,371,000 verdict in a negligence case involving a seventy-three-year-old resident's death due, in part, to dehydration and malnutrition sustained while in the care of the defendant nursing

230. *See id.*

231. *See id.*

232. No. 190CC2471, 1993 WL 763994 (Green County Ct. July 1993).

233. *See id.*

234. *See id.*

235. *See id.*

236. *See Settlement in Suit Alleging Negligent Nursing Home Care*, 17 VERDICTS, SETTLEMENTS & TACTICS 426 (1997) (reviewing *Anonymous v. Anonymous*, Los Angeles County Ct. June 30, 1997).

237. *See id.*

238. *Id.* (emphasis added).

239. *Id.*

240. No. 212802, 1997 WL 831687 (Tarrant County Ct. Nov. 1997).

home.²⁴¹ The punitive damages were capped at four times the actual damages, reducing the damage award to \$11,855,000.²⁴²

In *Rhodes v. HEB Nursing Home*, a jury awarded \$250 million, the largest nursing home verdict in U.S. history, for the neglect of a resident who was paralyzed on one side and, thus, experienced difficulty feeding himself.²⁴³ Texas jurors learned that the resident later developed a throat infection that made eating painful.²⁴⁴ A pattern of neglect emerged as testimony revealed that the staff, instead of investigating why the resident was not eating, allowed his condition to deteriorate until the resident was too ill to recover.²⁴⁵

In *Olson v. Chisolm Trail Living & Rehabilitation Center*,²⁴⁶ a Texas jury awarded \$25,028,424 in a wrongful death and injury case.²⁴⁷ The case involved a seventy-eight-year-old woman who died after a two and one-half month stay in the defendant facility from "malnourishment, dehydration and a urinary tract infection" that led to sepsis, an infection of the blood.²⁴⁸

In *Witt v. Sotal, Inc.*,²⁴⁹ a Michigan jury returned a \$605,523 verdict (reduced to \$265,000 because of a previous high/low agreement) in a negligence case.²⁵⁰ This case involved a diabetic resident who died as a result of serious dehydration, severe pressure sores, and pneumonia.²⁵¹

Settlement is not uncommon in cases involving negligence where the resident suffers or dies from malnutrition and/or dehydration allegedly as a result of the nursing home's failure to provide the appropriate care.²⁵² In *Hoel v. Counsel Nursing Properties, Inc.*,²⁵³ for ex-

241. *See id.*

242. *See id.*

243. *See \$250 Million Nursing Home Verdict Largest in U.S. History*, QUALITY CARE ADVOC., Feb./Mar. 1999, at 5.

244. *See Janet Shafer Boyanton, Nursing Home Litigation: An Emerging Field for Elder Law*, ELDER LAW REP., Apr. 1999, at 1.

245. *See id.*

246. *Tx Jury Awards \$25M for Nursing Home Resident's Wrongful Death*, ANDREWS NURSING HOME LITIG. REP., Oct. 1999, at 1.

247. *See \$25 Million Jury Verdict in Suit Alleging Negligent Nursing Home Care*, 19 VERDICTS, SETTLEMENTS & TACTICS 458 (1999) (considering *Chisolm v. Chisolm*).

248. *Id.*

249. No. 92-5363 CZ, 1997 WL 372297 (Macomb County Ct. June 1996).

250. *See id.*

251. *See id.*

252. *See, e.g., Estate of Magro v. Drew Village Nursing Home, Inc.*, No. 98-002216-CI-007, 1999 WL 1567489 (Pinellas County Ct. Oct. 12, 1999) (alleging that decedent suffered severe dehydration, several falls, and an upper gastrointestinal fecal impaction due to negligence of nursing home employees and reaching a

ample, a \$4.5 million dollar settlement was reached in a case where the decedent resident suffered from the following conditions:

the left femur fracture had become compounded and the bone was sticking through the skin; the fracture site was oozing foul smelling purulent green drainage, ultimately determined to be gangrene; she was *malnourished*; she had three Stage IV (to the bone) bed sores; she had dried feces on her buttocks, hips, pelvic area and leg casts; her sheet had yellow pus stains from the drainage of her wounds; *she had severe protein calorie malnutrition*; and she had what was described as a horrible malodorous smell. Ultimately, [the resident's] leg was amputated above the knee.²⁵⁴

In *Rhodes v. Sensitive Care, Inc.*, the jury found for the plaintiff and awarded a large sum of punitive damages. Jay K. Gray, of Hurst, Texas, explained to jurors in his opening statement how a nursing home resident died of malnutrition as a result of the negligent care provided at a nursing home.²⁵⁵

Ladies and gentlemen, Bryan Sellers died on October 8, 1995. The evidence will show that he was allowed through inadequate care in this nursing home to die—his body needing nutrients, eating itself away. That's what malnutrition is. When there is no food going in, the body eats itself. Cannibalism inside.

\$500,000 settlement after plaintiff obtained an order allowing an amendment to allege punitive damages); *Estate of McRae v. Rodriguez & A & J Foster Care*, No. CV05-059, 1996 WL 433441 (Yamhill County Ct. May 1996) (arriving at a \$48,000 settlement in a nursing home negligence case alleging failure to render adequate care in the matter of an 89-year-old resident suffering from pneumonia, dehydration, a urinary tract infection, hyponatremia from long-term neglect, and a hip contusion when he fell under the care of the male defendant at the co-defendant nursing home); *Estate of Edgerton v. Olathe Health Care Ctr.*, No. 95C1106, 1995 WL 902695 (Johnson County Ct. Aug. 1995) (crafting a \$75,000 settlement where a nursing home resident suffered urinary retention, malnutrition, and dehydration resulting in death under the alleged negligent care of the nursing home); *Estate of Bowlin v. Capital View Care Ctr.*, No. 93-74263-NO, 1995 WL 932414 (Ingham County Ct. July 1995) (arriving at a \$32,500 settlement in a nursing home negligence case contending resident died from serious infection, resulting from a hip replacement, infections of lacerations, and malnourishment after she slipped and fell at the defendant nursing home); *Estate of Kulwinski v. Parklane Nursing & Diplomat Health*, No. 89L1672, 1991 WL 517371 (Cook County Ct. Apr. 1991) (reaching a \$250,000 settlement in a nursing home negligence case featuring allegations that the resident "was not properly fed or cared for and that this resulted in ulcers, pneumonia, anemia, malnutrition, dehydration, and the aggravation of heart disease").

253. *Settlement in Suit Against Nursing Home for Inadequate Care*, 15 VERDICTS, SETTLEMENT & TACTICS 287 (1995) (considering *Hoel v. Counsel Nursing Properties, Inc.*) (emphasis added).

254. *\$250 Million Nursing Home Verdict in U.S. History*, *supra* note 243, at 5.

255. See ASS'N OF TRIAL LAWYERS OF AM., *Opening Statement: Lasting Impressions*, TRIAL, June 1999, at 62 (excerpting six opening statements, including *Rhodes v. Sensitive Care, Inc.*, that won verdicts favorable to the plaintiffs).

Ladies and gentlemen, we have alleged that Sensitive Care staff didn't notify the doctor of Bryan Seller's change in condition. In September 1995, he had a *change in condition in regard to his eating habits*. Bryan Sellers started developing problems—breathing problems, infection. And the doctor was not notified.

You will hear testimony from Sensitive Care's own hired expert—a doctor the defense hired—who says that the nursing home's doctor should have been notified of the change in condition. That is one of the steps that is taken to prevent malnutrition. But the doctor wasn't notified until it was too late—almost four days after the change in condition. I suspect, really, it was a month and a half too late.

With regard to feeding, the nursing home's own doctor—and remember, the home is denying these allegations—will testify that Sensitive Care *didn't offer Mr. Sellers feeding assistance, that it didn't do a nutritional re-evaluation* when it should have been done. And because of the horrible, horrible kitchen facility at this home, Bryan Sellers did not like the food, and that led to the malnutrition.

You will hear that at one point Bryan Sellers was able to gain 10 to 15 pounds back because there was a short time period when somebody at this nursing home actually showed some attention. He was given assistance with food.

But you will see that this home has a turnover rate that is incredible. Anybody with any ethics who goes to work there doesn't stay very long

Ladies and gentlemen, I don't know what Bryan Sellers' life is worth. Moneywise, it's a hard, hard thing to decide. And that's why you are here—to make that decision. What is it worth to be allowed to get to that condition? To die, after 80 years, fighting, struggling, and living and then having your body eat itself away.²⁵⁶

G. Failing to Observe/Monitor Resident

In *Estate of Fann v. Delmar Gardens of Olathe*,²⁵⁷ a \$32,500 settlement was reached in the case of a resident who died allegedly due to severe dehydration and aspiration pneumonia after the home “failed to provide the proper standard of care, failed to supervise its employees, [and] failed to monitor the decedent's condition.”²⁵⁸ Similarly, in *Marsalese v. Park Imperial Convalescent Center*,²⁵⁹ the nursing home “was negligent in [allegedly] failing to monitor [the eighty-one-year-old

256. *Id.* at 66–68 (emphasis added).

257. No. 93C8802, 1996 WL 934439 (Johnson County Ct. Sept. 1996).

258. *Id.* at *1.

259. No. YC 027 366, 1997 WL 372874 (Los Angeles County Ct. June 1997).

resident's] health and in allowing it to deteriorate."²⁶⁰ The resident suffered from dehydration, bacterial pneumonia, influenza, hypoxia, and had pressure sores on his genitals and buttocks that required surgery.²⁶¹ The defendant denied negligence, claiming that the resident was "in general poor health and that his injuries could not have been prevented."²⁶² A \$45,000 settlement was reached.²⁶³ Again, in *Brown v. Acorn Health Centers, Inc.*,²⁶⁴ the nursing home allegedly failed to "observe the plaintiff's failing condition, failed to document her condition, [and] failed to administer fluids to avoid dehydration, [among other failures]."²⁶⁵ Defense counsel argued that the resident was contributorily negligent in that she failed to intake sufficient fluids and failed to obey her physician and facility employees.²⁶⁶ The negligence case settled for \$50,000.²⁶⁷

H. Nutrition and Pressure Ulcers

1. ROLE OF NUTRITION IN PRESSURE ULCER PREVENTION, DEVELOPMENT, AND TREATMENT

Significant malnutrition increases the bony prominences of a resident's body and, thus, heightens risk of pressure ulcer development.²⁶⁸ Dehydration further reduces the skin integrity and contributes to breakdown.²⁶⁹ After a pressure ulcer develops, the body requires an increase in nutrients, especially protein, to promote

260. *Id.* at *1.

261. *See id.*

262. *Id.*

263. *See id.*

264. No. CV93-19759, 1994 WL 766895 (Jackson County Ct. May 1994).

265. *Id.*

266. *See id.*

267. *See id.*

268. *See* Jonathan M. Evans et al., *Pressure Ulcers: Prevention and Management*, 70 MAYO CLINIC PROC. 789 (1995); David M. Smith, *Pressure Ulcers in the Nursing Home*, 123 ANNALS INTERNAL MED. 433 (1995); *see also* Shirley A. Gilmore et al., *Clinical Indicators Associated with Unintentional Weight Loss and Pressure Ulcers in Elderly Residents of Nursing Facilities*, 95 J. AM. DIETETIC ASS'N 984 (1995); Gayle D. Pinchofsky-Devin & Mitchell V. Kaminski, Jr., *Correlation of Pressure Sores and Nutritional Status*, 34 J. AM. GERIATRICS SOC'Y 435 (1986); INSTITUTE OF MED., *supra* note 26, at 229-30 (describing the relationship between nutrient intake and pressure ulcers and considering whether undernutrition contributes to pressure ulcer development).

269. *See* Evans et al., *supra* note 268, at 789.

healing.²⁷⁰ If the ulcer becomes infected (a situation frequently observed among diabetic residents), protein and other nutrient (vitamin) needs are further increased.²⁷¹ Specific treatments should be documented in the physician orders and nursing notes.²⁷² There may also be a record detailing treatment progress.²⁷³

2. INCREASING MEDICAL MALPRACTICE RISK RELATED TO PRESSURE ULCERS

There has been a documented increase in the number of cases involving pressure ulcers in the United States.²⁷⁴ A review of federal and state legal databases from 1937 through 1997 identified 173 lawsuits related to pressure ulcers, with all but eleven (six percent) recorded in the last fifteen years (between 1982 and 1997).²⁷⁵ Interestingly, the four states with the most cases—California (36), Texas (23), Illinois (15), and Florida (25)—are among the states with the most numbers of older adults.²⁷⁶ This represents a small fraction of the total number of pressure ulcer malpractice cases brought nationally inasmuch as the vast majority of cases never reach a courtroom.²⁷⁷ “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.”²⁷⁸

An Alabama jury awarded \$65,000,000 in *Estate of West v. Vari-Care, Inc.*,²⁷⁹ a nursing home negligence case involving an eighty-three-year-old resident who died of malnutrition and a ten-inch diameter gangrenous pressure ulcer.²⁸⁰ Subsequently, the case settled for an undisclosed amount.²⁸¹

270. See INSTITUTE OF MED., *supra* note 26, at 230–31 (assessing whether nutrient needs are altered in persons with pressure ulcers, and evaluating the role nutrition plays in healing pressure ulcers).

271. See *id.*

272. See Jeffrey M. Levine, *The Pressure Sore Case: A Medical Perspective*, 2 ELDER'S ADVISOR 44, 45–46 (2000).

273. See *id.*

274. See Richard G. Bennett et al., *The Increasing Medical Malpractice Risk Related to Pressure Ulcers in the United States*, 48 J. AM. GERIATRICS SOC'Y 73, 75–76 (2000).

275. See *id.* at 75.

276. See *id.* at 75, 77.

277. See *id.* at 76.

278. *Id.*

279. No. CV91-0617, 1993 WL 631314 (Baldwin County Ct. Nov. 1993).

280. See *id.*

281. See *id.*

Mediation produced a \$550,000 settlement (plus court costs) in *Rice v. Skyline Nursing Home*,²⁸² where a comatose seventy-nine-year-old nursing home resident was discharged to a hospital to be treated for dehydration, anemia, hypovolemia (loss of fluid volume),²⁸³ staph infections, and pressure ulcers.²⁸⁴

A \$1,300,000 settlement was agreed upon in the matter of a Texas nursing home resident who died of sepsis, malnutrition, and dehydration.²⁸⁵ The resident developed pressure ulcers allegedly because of the staff's failure to turn and position the resident.²⁸⁶ The pressure ulcers became infected, and the infection spread into her bloodstream, developing into sepsis.²⁸⁷ Another Texas nursing home negligence case with similar facts resulted in a \$1,625,000 settlement.²⁸⁸

In *Estate of Wade v. Arbor Health Care Co.*,²⁸⁹ a \$1 million settlement resulted from the matter of an eighty-six-year-old resident who died after developing multiple pressure sores.²⁹⁰ The alleged facts involved hospitalization due to a Stage IV pressure ulcer with a grey/green foul smelling drainage accompanied by dehydration and significant weight loss over several months.²⁹¹ "[R]ecords indicate that she had eaten less than 25 [percent] of most meals, if she ate at all, and the nursing staff had not fully notified her physician of her lack of intake."²⁹² The complaint alleged a failure to follow physician orders and a failure to communicate with the decedent's physicians regarding significant changes in the resident's condition including weight loss.²⁹³

282. No. 95-6785-B, 1996 WL 386168 (Dallas County Ct. Mar. 19, 1996).

283. See TABER'S, *supra* note 111, at 952-53 (defining hypovolemia).

284. See *\$1 Million Settlement in Suit Alleging Negligent Nursing Home Care*, 16 VERDICTS, SETTLEMENTS & TACTICS 295 (1996) (discussing *Rice v. Skyline Nursing Home*).

285. See Plaintiff v. Defendant, JVR No. 140016, 1992 WL 695212 (Dist. Ct. Tex. Nov. 1992).

286. See *id.*

287. See *id.*

288. See Plaintiff v. Defendant, JVR No. 140012, 1993 WL 761862 (Dist. Ct. Tex. May 1993).

289. No. 95-1194CA, 1995 WL 1086432 (Leon County Ct. Nov. 1998).

290. See *id.*

291. See *id.*

292. *Wade v. Arbor Health Care Co.*, No. 99FJVR 4-62, 1999 WL 378669, at *1 (Leon County Ct. Apr. 1999).

293. See *id.*

VII. Swallowing Disorders

Approximately forty to seventy-five percent of nursing home residents have identifiable signs and symptoms of dysphagia,²⁹⁴ a swallowing disorder.²⁹⁵ Some residents may be completely unable to swallow or may have trouble swallowing liquids, foods, or saliva.²⁹⁶ Eating then becomes a challenge. Dysphagia often makes it difficult to take in enough calories and fluids to nourish the body. Residents with swallowing disorders take more time to eat and may depend on enteral feeding solutions for their nutritional needs.²⁹⁷ Swallowing disorders often lead to dehydration, malnutrition, aspiration pneumonia,²⁹⁸ and asphyxiation.²⁹⁹ Consultation with subspecialists (speech pathologists, gastroenterologists or ear, nose, and throat specialists) may confirm difficult diagnoses and guide treatment.³⁰⁰

The dietary management of the dysphagic resident requires modification of the standard nursing home resident diet.³⁰¹ Liability

294. See TABER'S, *supra* note 111, at 590 (defining dysphagia).

295. See Kayser-Jones & Pengilly, *supra* note 131, at 78 (estimating that 40% to 60% of institutionalized older adults have identifiable signs and symptoms of a swallowing disorder); Grainne O'Loughlin & Chris Shanley, *Swallowing Problems in the Nursing Home: A Novel Training Response*, DYSPHAGIA, Summer 1998, at 172-83 (suggesting that between 50% and 75% of nursing home residents have some difficulty swallowing); Adam Golden et al., *Long-Term Survival of Elderly Nursing Home Residents After Percutaneous Endoscopic Gastrostomy for Nutritional Support* (visited Nov. 11, 2000) <<http://.mmhc.com/nhm/articles/NHM9710/Silverman.html>> (noting that the prevalence of feeding or swallowing disorders is "very high, ranging from 50 percent to 85 percent of a nursing home census").

296. See generally NATIONAL INST. ON DEAFNESS & OTHER COMMUNICATION DISORDERS, NATIONAL INST. OF HEALTH, PUB. NO. 99-4307, DYSPHAGIA, (1998), available at <http://www.nidcd.nih.gov/textonly/health/pubs_vsl/dysph.htm> (visited Oct. 30, 2000) [hereinafter DYSPHAGIA] (covering such topics as swallowing; dysphagia occurrence, cause, treatment, and research; problems associated with dysphagia, and where to obtain additional information on the subject).

297. See Golden et al., *supra* note 295.

298. See generally, DYSPHAGIA, *supra* note 296 (describing aspiration pneumonia as a result of food or liquid in a resident's windpipe that coughing or throat clearing cannot remove which enters the resident's lungs and allows harmful bacteria to grow).

299. See Kayser-Jones & Pengilly, *supra* note 131, at 77.

300. See, e.g., Michael R. Spieker, *Evaluating Dysphagia*, 61 AM. FAM. PHYSICIAN 3639 (2000) (diagnosing, classifying, and treating dysphagia); Barbara M. Baker, *Symptoms, Diagnosis, and Management of Dysphagia*, 96 J. KY. MED. ASS'N 362 (1998); Joan C. Kosta & Carol Ann Mitchell, *Current Procedures for Diagnosing Dysphagia in Elderly Clients*, 19 GERIATRIC NURSING 195 (1998); Gregory Wisdom & Andrew Blitzer, *Surgical Therapy for Swallowing Disorders*, 31 OTOLARYNGOL. CLINIC. N. AM. 537 (1998) (reviewing the diagnostic evaluation of dysphagia along with a range of surgical strategies to correct swallowing disorders).

301. See Ann W. Martin, *Dietary Management of Swallowing Disorders*, 6 DYSPHAGIA 129, 129 (1991).

may result if certain foods are served to dysphagic residents through error or lack of knowledge.³⁰² Residents with known dysphagia should receive eating and drinking assistance to reduce the possibility of aspiration.³⁰³ Assisting residents who have dysphagia requires special skill and knowledge.³⁰⁴ The resident should sit in an upright position, and the chin tuck position should be used. The nursing or dietary assistant should sit at or below the resident's eye level. Texture and consistency of food should match prescriptions. Sticky foods (such as peanut butter) should be avoided. Foods should be given in small amounts (1/2-1 teaspoon solid; 5-10 ml liquid). "Post-stroke resident's foods [should be] placed where mouth sensitivity is the greatest," and "after meals, oral hygiene [should be] provided to reduce the possibility of aspirating hidden food."³⁰⁵

VIII. Choking

Allegations involving choking in the nursing home setting usually entail unattended, unsupervised residents choking on food that they cannot chew or swallow.³⁰⁶ Alternatively, the facility allows a person with no specialized training to feed a resident who is unable to feed himself or herself, thus, violating the standard of care.³⁰⁷ In *Crowne Investments, Inc. v. Reid*,³⁰⁸ an Alabama jury returned a \$750,000 verdict involving the asphyxiation death of a resident after the facility allowed the resident's wife to feed him.³⁰⁹

[T]he standard of care for skilled nursing homes when feeding a [resident] who had been identified as a "total feeder" (a [resident] who is unable to feed himself or herself) was to allow the [resident] to be fed only by a qualified certified nursing assistant ("CNA"). . . . [I]t is the standard of care in a nursing-home facility that when a CNA brings a meal tray to the resident's room, the CNA feeds the resident, removes the tray, and documents how much the resident ate. A CNA [the expert noted] should not

302. See *id.* at 129-30.

303. See RANTZ ET AL., *supra* note 74, at 3:110.

304. See Martin, *supra* note 301, at 129-30.

305. RANTZ ET AL., *supra* note 74, at 3:110 (considering monitoring criteria for dysphagia).

306. See, e.g., *Beverly Enters.-Virginia, Inc. v. Nichols*, 441 S.E.2d 1, 2 (Va. 1994) (finding a nursing home negligent after an unattended resident with Alzheimer's disease choked to death on food that she could neither chew nor swallow).

307. See, e.g., *Crowne Invs., Inc. v. Reid*, 740 So. 2d 400, 402 (Ala. 1999) (per curiam).

308. 740 So. 2d 400.

309. See *id.* at 405.

leave the tray in the room [I]t was the standard of care that all CNAs have CPR training and that a failure to perform the Heimlich maneuver for a choking [resident] is a deviation from the standard of care. [The expert further] testified that . . . it is a breach of the standard of care not to perform a suctioning technique in an attempt to open the [resident's] air passage. . . . [The owner-operator of the nursing home and its management company] breached these standards of care and . . . these breaches proximately caused [the resident's] death.³¹⁰

IX. Standard of Care

The elements of the cause of action in a nursing home negligence case must be clearly stated within the complaint. General statements describe the legal duty owed by the nursing home to the resident-plaintiff, how the facility breached that duty (accomplished by outlining the fact situation), how the plaintiff's injury was directly caused by the breach, and the damages the plaintiff suffered resulting from the defendant's negligent acts.³¹¹

Defense counsel, in practice, answers the complaint with a general denial of the allegations contained in the complaint.³¹² If the defendant chooses to admit to some allegations and deny others, only those issues denied are subject to litigation.³¹³ In *Estate of Spilman v. Beverly Enterprises-Florida, Inc.*,³¹⁴ for instance, the defendant admitted liability but contended that the nursing home resident's injuries (pressure ulcers, malnutrition, and dehydration) were not as severe as claimed.³¹⁵ Florida jurors awarded \$2,719,064 to the decedent's estate.³¹⁶ In addition, the defense may plead affirmative defenses in the answer to discredit the plaintiff's cause of action and prevent recovery of damages.³¹⁷ For example, in a negligence action, depending upon the circumstances, the defense attorney for a nursing home may submit such affirmative defenses as contributory negligence or statute of limitations.³¹⁸

310. *Id.*

311. See PETER J. BUTTARO, LEGAL GUIDE FOR LONG-TERM CARE ADMINISTRATORS 8 (1999); see also THE ELDERLAW PORTFOLIO SERIES, *supra* note 53, at 13-1, 13-2.1.

312. See BUTTARO, *supra* note 311, at 9.

313. See *id.*

314. No. 92-1345-CA-01, 1994 WL 729874 (Hernando County Ct. Apr. 1994).

315. See *id.*

316. See *id.*

317. See BUTTARO, *supra* note 311, at 9.

318. See *id.*

Attorneys may evaluate the standard of care used in nutrition-related cases through federal statutes and companion regulations, interpretive guidance to federal regulations, state statutes and regulations,³¹⁹ nursing home industry standards of practice,³²⁰ facility policy

319. See, e.g., ALA. CODE §§ 6-5-481, 22-21-20 (1993 & 1997) (making “long term care facilities, such as, but not limited to, skilled nursing facilities” subject to the provisions of the Alabama Medical Liability Act); *id.* § 6-5-542(2) (1993) (defining the standard of care as “that level of such reasonable care, skill and diligence as other similarly situated health care providers in the same general lines of practice, ordinarily have and exercise in like cases”); ALASKA STAT. § 18.20.010 (Michie 2000) (providing for the development and establishment of standards for nursing homes); Long-Term Care, Health, Safety, and Security Act of 1973, CAL. HEALTH & SAFETY CODE §§ 1417-1439.8 (West 1990) (regulating nursing homes); CONN. GEN. STAT. ANN. § 52-184c (West 1991) (establishing the standard of care); FLA. STAT. ANN. § 400 (West 1998 & Supp. 2001) (delineating the standard of care for nursing home residents as well as standards for the maintenance and operations of nursing homes.); IDAHO CODE § 6-1012 (1998) (establishing the standard of care and requiring expert testimony); MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-02 (1998) (establishing the standard of care); OKLA. STAT. ANN. tit. 76, § 20.1 (West 1995) (establishing the standard of care); TEX. REV. CIV. STAT. ANN. art. 4590i, (West Supp. 2000) (including nursing homes within the Texas Medical Liability and Insurance Improvement Act without explicitly defining the standard of care); TEX. HEALTH & SAFETY CODE ANN. § 242.001-.186 (West 1992) (establishing minimum acceptable levels of care for convalescent and nursing homes); *id.* § 242.037(e) (requiring adoption of regulations regarding specific issues such as nutrition); VT. STAT. ANN. tit. 12, § 1908 (1973 & Supp. 2000) (establishing the standard of care); WASH. REV. CODE ANN. § 4.24.290 (West 1988 & Supp. 2001) (establishing the standard of care); WYO. STAT. ANN. § 1-12-601 (Michie 1999) (establishing the standard of care). The Florida statute provides that residents have a right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

FLA. STAT. ANN. § 400.022(1)(1); see also *Estate of Gregory v. Beverly Enters., Inc.*, 95 Cal. Rptr. 2d 336, 342 (2000) (finding that state and federal regulations were a permissible source for jury instructions defining standards of care applicable in nursing home resident’s action for elder abuse where the jury heard testimony describing how nursing home professionals construed and applied regulatory standards at issue).

320. See, e.g., Agency for Healthcare Research & Quality (visited Dec. 12, 2000) <<http://www.ahrq.gov>> (including online access to various evidence-based clinical practice guidelines and research on several areas, including many issues in “elderly healthcare”); American Nurses Ass’n (visited Dec. 12, 2000) <<http://www.nursingworld.org>> (offering (in Pub # GE-14) standards that apply to basic and advanced practice level gerontological nurses in clinical practice across all settings and may be used in quality assurance programs as a means of evaluating and improving care).

and procedure, voluntary accreditation standards, and standards promulgated by professional organizations.³²¹

A. Federal Statutes and Regulations

Litigators should frame a nursing home case investigation and all aspects of litigation in terms of applicable federal (and state) law and regulations. It is best to incorporate references to the same in the allegations contained in the complaint and use them as an outline for all written and oral discovery. Statutory and regulatory requirements may reveal the appropriate professional standard of care.³²² The minimum standard of care that nursing homes are expected to meet appears in the federal Nursing Home Reform Act (NHRA)³²³ and its implementing regulations.³²⁴

B. Interpretive Guidelines to Federal Regulations

HCFA Interpretive Guidelines serve as the primary guide to federal and state agency nursing home surveyors when evaluating facility compliance with federal requirements.³²⁵ The Guidance does not

321. See generally Deborah D. D'Andrea, *The Role of the Legal Nurse Consultant in Gathering and Analyzing the Nursing Home Record*, ELDER'S ADVISOR, Fall 2000, at 32, 41.

322. See LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 171 (2d ed. 1999) ("look to the various Federal and state certification standards to provide a proper standard of care"); Marilyn Askin, *Nursing Home Residents as Clients*, 164 N.J. LAW. 30, 31 (1994) (highlighting remarks presented at a National Academy of Elder Law Attorneys symposium that referenced attorney use of the "copious standards set forth in the [Nursing Home Reform Act] and states' nursing home licensing laws as the basis for the standard of care"); Marshall B. Kapp, *Malpractice Liability in Long-Term Care: A Changing Environment*, 24 CREIGHTON L. REV. 1235, 1244 (1991) ("The courts . . . relied on the facility's compliance with applicable federal and state regulations regarding the safeguarding of resident welfare in holding that the facility had satisfied the legal standard of care, even if resident injury unfortunately took place anyway."); Steven M. Levin et al., *Protecting the Rights of Nursing Home Residents Through Litigation*, 84 ILL. B.J. 36, 36 (1996) ("OBRA and its regulations establish a national standard of care applicable to nursing homes which affects all nursing home cases"); Angela Snellenberger Quin, Comment, *Imposing Federal Criminal Liability on Nursing Homes: A Way of Detering Inadequate Health Care and Improving the Quality of Care Delivered*, 43 ST. LOUIS U. L.J. 653, 658 (1999) ("OBRA 87 provided a national standard of care applicable to all nursing homes participating in Medicare or Medicaid[.]").

323. 42 U.S.C. §§ 1395i-3(a)-(h) (Medicare), 1396r(a)-(h) (1994) (Medicaid).

324. See 42 C.F.R. § 483 (1997).

325. See, e.g., U.S. GEN. ACCOUNTING OFFICE, TESTIMONY BEFORE THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, GAO/T-HEHS-00-27, NURSING HOMES: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY CARE (1999) (recounting testimony regarding the oversight of state agen-

have the force of law; however, it represents current agency interpretation of the statutory and regulatory requirements governing, for example, nutrition and hydration.³²⁶

C. State Statutes and Regulations

Nursing homes are extensively regulated at the state level.³²⁷ In *Texas v. Tri-State Care Centers, Ltd.*, a record \$300,000 settlement was reached with a Texas nursing home resolving long-standing violations of the state health and safety code.³²⁸ A state investigation “revealed that [facility] residents suffered from severe malnutrition and pressure

cies that perform surveys of nursing homes to ensure that homes meet federal care standards protecting residents); U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, GAO/HEHS-00-6, NURSING HOMES: ENHANCED HCFA OVERSIGHT OF STATE PROGRAMS WOULD BETTER ENSURE QUALITY CARE (1999) (reviewing survey process); U.S. GEN. ACCOUNTING OFFICE, [LETTER REPORT], GAO/HEHS-99-154R, NURSING HOME OVERSIGHT: INDUSTRY EXAMPLES DO NOT DEMONSTRATE THAT REGULATORY ACTIONS WERE UNREASONABLE (1999) (responding to survey findings); U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, GAO/HEHS-98-202, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT (1998) (considering the survey process in California).

326. See *supra* notes 305–08 and accompanying text.

327. See, e.g., ALASKA STAT. § 47.30.825(d) (Michie 1996); ARIZ. ADMIN. CODE R9-10-917(C)(3)(a) (1995); ARK. CODE ANN. § 20-10-1204(a)(14)(A) (Michie 1998); CAL. CODE REGS. tit. 22, § 73080 (2000); COLO. REV. STAT. § 25-1-120(1)(j) (1999); CONN. GEN. STAT. § 19a-550(b)(8) (1999); DEL. CODE ANN. tit. 16, § 1121(7) (1999); FLA. STAT. ANN. §§ 400.022(1)(o), 400.402(7), (18) (1999); GA. COMP. R. & REGS. r. 290-5-39-.09(a), 290-5-8.10(9) (1999); 210 ILL. COMP. STAT. ANN. 45/1-101 (West 2000); IND. ADMIN. CODE tit. 410, r. 16.2-3.1-3 (1999); IOWA CODE ANN. § 135C.14(8) (West 1993); IOWA ADMIN. CODE r. 481-58.43 (1990); KAN. ADMIN. REGS. 28-39-144(tr), 28-39-150(a) (1999); KY. REV. STAT. ANN. § 216.515 (Michie 1998); LA. REV. STAT. ANN. § 40:2010.7–.8 (West 1999); ME. REV. STAT. ANN. tit. 5, § 19503 (West 1998); MD. CODE ANN., HEALTH-GEN. I § 19-343(5) (1997); MASS. GEN. LAWS ANN. ch. 111, §§ 70E, 72F (West 1996); MICH. COMP. LAWS ANN. § 333.20201 (West 1997); MINN. STAT. § 114.651(4) (1999); MO. REV. STAT. § 198.088.1(6)(g) (1994 & Supp. 1998); MO. CODE REGS. ANN. tit. 13, § 15-18.010(19)–(20) (1999); MONT. CODE ANN. § 50-5-1104(1) (1990); NEB. REV. STAT. §§ 71-460, 461 (2000); NEV. REV. STAT. § 449 (2000); N.H. REV. STAT. ANN. § 151:21(vii) (1999); N.J. ADMIN. CODE tit. 8, § 8:43-14.2(a)(6) (1999); N.Y. COMP. CODES R. & REGS. tit. 10, § 86-2.30(18)(M) (2000); N.C. GEN. STAT. § 131E-117(6) (2000); N.C. ADMIN. CODE tit. 10, r. 3H.2305(c) (July 2000); N.D. CENT. CODE § 50-10.2-02(k) (West 1999); OHIO REV. CODE ANN. § 3721.13(a)(13) (1999); OKLA. STAT. tit. 63, § 1-1918(19) (1990); OR. REV. STAT. § 441.605(7) (1990); OR. ADMIN. R. § 411-85-310(7) (1990); R.I. GEN. LAWS § 23-17.5-9(a) (1996); S.C. CODE ANN. § 44-81-40 (Law. Co-op. 2000); S.D. CODIFIED LAWS § 34-12-1 to 38 (Michie Supp. 2000); TENN. CODE ANN. § 68-11-910 (1996); UTAH ADMIN. CODE § 432-150-5 (2000); VT. STAT. ANN. tit. 33, § 7301 (Supp. 2000); W. VA. CODE § 16-5C-5 (1995); WIS. STAT. ANN. § 50.09-1-6 (West Supp. 2000).

328. See *Texas: Cornyn Announces \$300,000 Settlement with Nursing Home for Health Violations*, BNA HEALTH CARE DAILY, Aug. 1, 2000, at d5 (discussing *Texas v. Tri-State Care Ctrs. Ltd.*).

sores, without their doctors being notified.”³²⁹ Likewise, in *Texas v. Texas Health Enterprises, Inc.*, a state health and safety code violation was alleged by the state attorney general who obtained an emergency court order putting a trustee in charge of a chain-operated nursing home.³³⁰ The order stemmed from a lawsuit filed after four residents died within six weeks.³³¹ One resident allegedly “refused meals, fluids and medications for weeks and another suffered severe dehydration.”³³² Further, the facility allegedly “failed to notify physicians or families of the deteriorating conditions of the [residents].”³³³

In an action for elder abuse, under California’s elder abuse statute, and nursing home malpractice, *Settles v. Regency Health Services*,³³⁴ one of the experts offered by the plaintiff, a psychiatrist, testified that the care provided to a seventy-year-old nursing home resident “fell below the standard of care and that her severe contracture, decubiti, dehydration, sepsis and brain injury were caused by [the provision of] inadequate care. Poor dietary attention led to weight loss, dehydration and hypovolemia.”³³⁵ In like fashion, a long-term care nursing consultant and standard of care expert testified that “severe and accelerated behavioral changes were evidence of hypoxic brain injury due to extreme hypovolemia (loss of fluid volume) due to acute and chronic dehydration.”³³⁶ The defense countered these allegations with the expert testimony of a neurologist who determined that the resident’s “decline in mental function was consistent with the natural progression of that disease and that she did not suffer a brain injury as a result of the care provided.”³³⁷ Further, an internist and infectious diseases physician testified that the resident’s acute dehydration “was secondary to a sore throat caused by an improperly managed series of infections and courses of antibiotic therapy by plaintiff’s own treating

329. *Id.*

330. See *Trusteeship: Texas State Court Puts Trustee in Charge of State Nursing Home*, BNA HEALTH CARE DAILY, Sept. 30, 1993, at d18 (discussing *Texas v. Texas Health Enterprises, Inc.*).

331. See *id.*

332. *Id.*

333. *Id.*

334. No. BC160410, 1999 WL 1212754 (Los Angeles County Ct. June 11, 1999).

335. *Id.* Hypovolemia is “diminished blood volume.” See TABER’S, *supra* note 111, at 952.

336. *Settles v. Regency Health Servs.*, No. BC160410, 1999 WL 1212754 (Los Angeles County Ct. June 11, 1999).

337. *Id.*

physician.”³³⁸ The attempt to direct responsibility to the plaintiff’s treating physician continued through testimony offered by a gerontologist who found “that the care provided by defendant’s facility met the standard of care and that the care provided to plaintiff by her own treating physician fell below the standard of care.”³³⁹ The net amount of the verdict for the plaintiff was \$81,308.³⁴⁰ The jury allocated fifteen percent comparative fault to the plaintiff, sixty percent fault to the non-party treating physician, and twenty-five percent fault to the defendant nursing home.³⁴¹

D. Nursing Home Industry Standards of Practice

The legal standard of care may be determined, in part, by the prevailing customary practice of the industry at the time that the alleged negligence occurred. Consider, for example, HCFA’s “Best Practices Guidelines” that address the care of nursing home residents at risk of dehydration and malnutrition³⁴² or the recommended daily dietary allowances for older adults established by the Food and Nutrition Board of the National Research Academy and the National Academy of Sciences.³⁴³ In addition, the Nutrition Screening Initiative, a project of the American Academy of Physicians, the American Dietetics Association, and the National Council on Aging, features *Nutrition Care Alerts*, educational tools to identify residents at risk for nutrition-related conditions such as dehydration, unintended weight loss, pressure ulcers, and complications of tube feeding.³⁴⁴

E. Facility Policy and Procedure

An attorney should submit case-specific written discovery requesting a complete copy of the facility policies and procedures man-

338. *Id.*

339. *Id.*

340. *See id.* The plaintiff did not seek punitive damages. *See id.*

341. *See id.*

342. *See* Sharing Innovations in Quality, *Professional Standards/Guidelines* (visited Nov. 11, 2000) <<http://www.hcfa.gov/medicaid/siq/siqpsq.htm>> (hosting a repository of best practice guidelines created by the Health Care Financing Administration for the care of residents at risk of dehydration, malnutrition, pressure ulcers, and other clinical conditions.).

343. *See* 42 C.F.R. § 483.35(c)(1) (1999); *see also* HCFA GUIDANCE, *supra* note 39, at PP-142 (interpreting 42 C.F.R. § 483.35(c)(1)).

344. *See generally* Am. Dietetic Ass’n—Your Link to Nutrition and Health! (visited Nov 11, 2000) <<http://www.eatright.org>>.

ual in effect at the time of the alleged injury. Counsel should review facility policies and procedures that affect the care of residents with nutritional problems for consistency with federal and state law and regulations.³⁴⁵ These standards can be compared to current recognized care guidelines and standards on the subject that have been developed at the national and regional levels.³⁴⁶ Evidence that facility policy and procedure have not been followed may be used to establish that the standard of care has not been met.³⁴⁷

F. Voluntary Accreditation Standards

JCAHO accreditation³⁴⁸ is awarded following an on-site survey of the facility by a team of physicians, nurses, and administrators if

345. See RANTZ ET AL., *supra* note 74, at 3:103.

346. See *id.* See generally COMM. ON NUTRITION SERVCs. FOR MEDICARE BENEFICIARIES, FOOD & NUTRITION BD., THE ROLE OF NUTRITION IN MAINTAINING HEALTH IN THE NATION'S ELDERLY: EVALUATING COVERAGE OF NUTRITION SERVICES FOR THE MEDICARE POPULATION (2000); Dorothy M. Baker, *Assessment and Management of Impairments in Swallowing*, 28 NURSING CLINICS OF N. AM. 793, 795-97 (1993); W. Blaser Bonnel, *Managing Mealtime in the Independent Group Dining Room: An Educational Program for Nurse's Aides*, 16 GERIATRIC NURSING 28 (1995); June Chidester & Alice Spangler, *Fluid Intake in the Institutionalized Elderly*, 97 J. AM. DIETETIC ASS'N 23 (1997); Drickamer & Cooney, *supra* note 126, at 672; Mark Grant et al., *Declining Cholesterol and Mortality in a Sample of Older Nursing Home Residents*, 44 J. AM. GERIATRICS SOC'Y 31-36 (1996); Catherine Jacobsson et al., *Outcomes of Individualized Interventions in Patients with Severe Eating Difficulties*, 6 CLINICAL NURSING RES. 25 (1997); Jeanie Kayser-Jones et al., *An Instrument to Assess the Oral Health Status of Nursing Home Residents*, 35 GERONTOLOGIST 814 (1995) (presenting data from the development and testing of an instrument to evaluate the oral health of nursing home residents by nursing personnel and suggesting that nursing staff can be taught to evaluate resident oral health); Kayser-Jones, *supra* note 68, at 67-69; Pamela Martyn-Nemeth & Kathleen Fitzgerald, *Clinical Considerations: Tube Feeding in the Elderly*, 18 J. GERONTOLOGICAL NURSING 30 (1992); Joseph G. Ouslander et al., *Decisions about Enteral Tube Feeding Among the Elderly*, 41 J. AM. GERIATRICS SOC'Y 70, 73-75 (1993); Irwin H. Rosenberg & Joshua W. Miller, *Nutritional Factors in Physical and Cognitive Functions of Elderly People*, 55 AM. J. CLINICAL NUTRITION 1237S (1992); B. Sidenvall & A.C. Ek, *Long-Term Care Patients and Their Dietary Intake Related to Eating Ability and Nutritional Needs: Nursing Staff Interventions*, 18 J. ADVANCED NURSING 565, 568-70 (1993); Tsai & Bradley, *supra* note 125, at 823; Suzanne Van-Ort & Linda R. Phillips, *Nursing Interventions to Promote Functional Feeding*, 21 J. GERONTOLOGICAL NURSING 6 (1995); Weinberg et al., *supra* note 187, at 1552-56; Barbara Ayn Wright, *Weight Loss and Weight Gain in a Nursing Home: A Prospective Study*, 14 GERIATRIC NURSING 156 (1993); Cora Zembrzuski, *A Three-Dimensional Approach to Hydration of Elders, Administration, Clinical Staff, and In-Service Education*, 18 GERIATRIC NURSING 20 (1997).

347. See sources cited *supra* note 346.

348. See generally 42 C.F.R. § 488.4 (1999) (addressing application and reapplication procedures that apply to private accreditation organizations requesting deeming authority to nursing homes); Medicare Program, 55 Fed. Reg. 51,434 (1990) (proposing JCAHO nursing home accreditation); BARRY R. FURROW ET AL.,

the facility meets JCAHO's minimal standards, including nutrition care standards, for the long-term care setting.³⁴⁹ Although adherence to accreditation guidelines is voluntary, these guidelines may be allowed into evidence as to the acceptable standard of care.³⁵⁰

G. Standards Promulgated by Professional Organizations

Courts also look to major organizational policy statements as evidence of the appropriate standard of care in negligence actions involving dehydration and malnutrition. For example, the American Dietetics Association has developed assessment tools for determining the nutritional status of the older adult.³⁵¹

H. Expert Testimony

Expert testimony may demonstrate or refute that the particular matter in question is within or outside the standard of care in the malnutrition and/or dehydration case.³⁵² In *Caruso v. Pine Manor Nursing Center*,³⁵³ for instance, direct examination at trial of the plain-

HEALTH LAW 6-12 (2d ed. 2000) (evaluating deemed status for JCAHO accredited health law providers); U.S. GEN. ACCOUNTING OFFICE, [LETTER REPORT], GAO/HEHS-99-197R, MEDICARE: HCFA'S APPROVAL AND OVERSIGHT OF PRIVATE ACCREDITATION ORGANIZATIONS 10 n.13 (1999) (discussing accreditation by a recognized private organization such as JCAHO); *Report to Congress: Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Incentives, and Effectiveness of the Survey and Certification System* <<http://www.hcfa.gov/medicaid/exectv2.htm>> (last modified July 21, 1998) (examining the three issues identified in the title).

349. See Joint Comm'n on Accreditation of Health Care Orgs, *Long-Term Care Survey Agendas* (visited Oct. 30, 2000) <http://www.jcaho.org/accred/ltc/ltc_agen.html> (supplying sample survey agendas). See generally Gretchen E. Robinson, *Applying the 1996 JCAHO Nutrition Care Standards in a Long-Term Care Setting*, 96 J. AM. DIETETIC ASS'N 400 (1996).

350. See MARSHALL B. KAPP, GERIATRICS AND THE LAW: PATIENT AND PROFESSIONAL RESPONSIBILITIES 144 (2d ed. 1992) "[JCAHO] guidelines are frequently relied on by courts as legally enforceable standards".

351. See American Dietetic Ass'n Reports, *Position of the American Dietetic Ass'n: Liberalized Diets for Older Adults in Long-Term Care*, 98 J. AM. DIETETIC ASS'N 201, 203 (1998); Dian Weddle et al., *Position of the American Dietetic Association: Nutrition, Aging, and the Continuum of Care*, 100 J. AM. DIETETIC ASS'N 580, 594 (2000).

352. See generally PAUL F. ROTHSTEIN ET AL., EVIDENCE STATE AND FEDERAL RULES IN A NUT SHELL 320 (3d ed. 1997); Julie A. Braun, *Handling Witnesses: Interviews, Depositions, and Trial Testimony of Geriatric Witnesses in NURSING HOME LITIGATION: PRETRIAL LITIGATION AND TRIALS* (forthcoming 2001) (copy on file with authors); Julie A. Braun & Elizabeth A. Capezuti, *Working with Older Witnesses*, 87 ILL. B.J. 607 (1999) (describing certain factors that may affect a nursing home resident's ability to serve as an effective witness).

353. 538 N.E.2d 722, 725 (Ill. App. Ct. 1989).

tiff's expert, a nurse, revealed that maintenance of input and output records represented the required standard of care that should have been followed in this case involving a resident who died from severe dehydration.³⁵⁴ In contrast, nurses from the defendant facility unconvincingly testified that the resident

received three meals a day, three snacks which included juice or milk, medications four times a day with which he was given four ounces of water, and [that] he was offered something to drink during the nighttime every two hours when the nurses would wake him to change bed clothing and to reposition him.³⁵⁵

Moreover, testimony elicited by plaintiff's counsel established that the facility "kept no chart of [the resident's] intake and output of fluid" and "offered no alternative explanation for [the resident's] dehydrated condition."³⁵⁶

Expert testimony may also prove or disprove that a deviation from the standard of care was the proximate cause of the injuries stated in the complaint. In *Caruso*, for example, according to the treating physician and emergency room records, the resident was diagnosed as suffering from severe dehydration.³⁵⁷ Thus, the jury was able to conclude that the facility's treatment of the resident proximately caused his dehydration.³⁵⁸

X. Medico-Legal Aspects of the Nursing Home Record

There is no set formula that, if followed, guarantees a favorable result for the plaintiff or defendant. However, adopting and implementing a system that evaluates potential nursing home cases will help the attorney determine if a case should be pursued to trial, mediation, or settlement. This multistep process includes a medico-legal review of the nursing home record.³⁵⁹ In litigating any nursing home case, including one involving dehydration and/or malnutrition, the

354. *See id.* at 725.

355. *Id.* at 724.

356. *Id.* at 725.

357. *See id.* at 724.

358. *See id.* at 725.

359. *See generally* WANDA L. HURR, ATTORNEY'S GUIDE TO MEDICAL RECORDS (Debra Tillinghast ed., 1993); D'Andrea, *supra* note 321, at 32; Elliott B. Oppenheim, *A Trial Lawyer's Guide to the Medical Record*, 84 ILL. B.J. 637 (1996) [hereinafter Oppenheim I]; Elliott B. Oppenheim, *Examining Medical Records: How to Know What Is Said When You Read What the Doctor Wrote*, 82 A.B.A. J. 88 (1996) [hereinafter Oppenheim II].

attorney should know what key documents to obtain and analyze.³⁶⁰ These documents reflect the care (or lack thereof) provided by the facility and may constitute the best evidence of deviation from or adherence to the applicable standard of care.³⁶¹

A clear, comprehensive, understandable, chronological narrative of a resident's condition and all the care that has been delivered tells a compelling story of what care was necessary and when and why. . . . If the records are incomplete, spotty, illegible, or incomprehensible, a lawyer will be able to challenge any assertion by the health care provider that a certain event took place.³⁶²

Common nursing home records include, among others, hospital discharge summaries, nursing home admission notes and physical examination forms, physician orders and progress notes, daily nursing notes, nutritional reviews, meal forms, dietician/nutritional consultant forms, medication records, subspecialty records, intake and output (I & O) records, weight records, and dental/oral health records.³⁶³ The events triggering suit are likely to evolve over weeks, months, or years and presumably entail complex medical issues.³⁶⁴ Reviewing the voluminous nursing home record is time consuming and often demands a health professional's review.³⁶⁵

A. Hospital Discharge Summary

The hospital discharge summary contains valuable information, including the resident's diagnosis and treatment.³⁶⁶ It details diagnostic procedures and relays a brief medical history.³⁶⁷ Typical information includes the resident's age and a statement of the events preced-

360. See D'Andrea, *supra* note 321, at 32-36 (considering the following nursing home records: the face sheet, advance directives, consent forms, physician orders and progress notes, care plan, minimum data set, resident assessment protocols, intake and output records, laboratory values, medication administration records, speech therapy records, physical and occupational therapy records, dietary/meal forms, policy and procedure manuals, personnel files, log or report books, and various staffing documents).

361. See Oppenheim I, *supra* note 359, at 637.

362. *Risk Management Primer*, *supra* note 34, at 521-22.

363. See generally HURR, *supra* note 359; D'Andrea, *supra* note 321, at 32-36; Oppenheim II, *supra* note 359.

364. See D'Andrea, *supra* note 321, at 32.

365. Steven M. Levin & David H. Brinton, *First Things First: Evaluating a Nursing Home Case*, 88 ILL. B.J. 349, 361 (2000).

366. See JUDITH A. STEIN & ALFRED J. CHIPLIN, JR., *MEDICARE HANDBOOK* App. 3A at 3-37 (2000) [hereinafter *MEDICARE HANDBOOK*].

367. See *id.*

ing hospitalization.³⁶⁸ Advocates should seek references concerning future treatments to be performed at the nursing home and review the listing of discharge medications³⁶⁹ (the psychotropic medication Haldol, for example, can affect a resident's appetite).³⁷⁰

The nursing home's knowledge of special facts surrounding a resident's hydration and/or nutrition status may give rise to liability if that resident subsequently becomes dehydrated or malnourished. Consider, for example, *Estate of Gray v. Golden Isles*,³⁷¹ involving a ninety-two-year-old man who was hospitalized for dehydration and subsequently released to the defendant nursing home.³⁷² Conceivably, the hospital discharge summary that described the resident's dehydration diagnosis and detailed the treatment received at the hospital placed the facility on notice of the resident's hydration status.³⁷³ While at the nursing home, the resident became more dehydrated because staff allegedly failed to ensure sufficient fluid intake.³⁷⁴ As a result, the resident's leg became cold, blue, and painful, requiring amputation upon his return to the hospital three days later.³⁷⁵ The decedent's estate received a \$400,000 settlement.³⁷⁶

B. Nursing Home Admission Notes and Physical Examination Forms

Next, an attorney should review the nursing home admission notes, including those prepared by a licensed nurse and those completed by the resident's treating physician.³⁷⁷ These records offer insight into the resident's nutrition and hydration status upon admission.³⁷⁸ Again, this documentation establishes whether the facility was aware of or should have been aware of the resident's nutrition and hydration status and, thus, impacts liability. An admission note re-

368. *See id.*

369. *See id.*

370. *See* Kathryn L. Locatell, *Physician Liability Issues*, in *NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION* 77, 91 (1999) (discussing liability when neuroleptics (e.g., Haldol, Mellaril, Risperdal) are prescribed and weight loss, malnutrition, dehydration, or pressure ulcers result).

371. No. 96-03244 1996 WL 796117 (Broward County Ct. Dec. 1996).

372. *See id.*

373. *See id.*

374. *See id.*

375. *See id.*

376. *See id.*

377. *See* MEDICARE HANDBOOK, *supra* note 366, App. 3A at 3-37.

378. *See id.*

garding a frail eighty-five-year-old woman recently admitted to a nursing home following hospitalization for pneumonia might read:

The infection was resolved, but the [resident], who had previously maintained adequate nutrition, will not eat or eats poorly. The resident is transferred to a [nursing home] for monitoring of fluid and nutrient intake, [and] assessment of the [resident's swallowing ability]. Observation and monitoring by skilled nursing personnel of the resident's oral intake is required to prevent dehydration.³⁷⁹

When the eighty-eight-year-old decedent in the *Estate of DiDonato v. Waverly Group, Inc.*,³⁸⁰ entered the defendant nursing home, he was continent, ambulatory, and had no skin eruptions or contractures.³⁸¹ Presumably, the admission notes reflected his physical status upon entry into the defendant facility. Within one month, the resident "became incontinent, suffered 26 falls which were not investigated, developed pressure sores on his left and right hips and left heel, and marked flexion contractures of all extremities."³⁸² He died after being hospitalized for treatment of pneumonia, urosepsis, severe dehydration, and malnutrition.³⁸³ The defendant unsuccessfully argued that the resident's condition resulted from the normal aging process and Alzheimer's disease.³⁸⁴ A \$572,000 verdict favored the plaintiff.³⁸⁵

C. Physician Orders and Progress Notes

At this point, the attorney should also carefully review physician orders and progress notes assessing the medical needs of each resident, including risk of weight loss, dehydration, and malnutrition. This information may help define negligence issues in the malnutrition/dehydration case. "Failure of the physician to adequately attend to nutritional issues will guarantee a share of liability."³⁸⁶ Moreover, "[a]ny dehydration-related complication [can also be] blamed on the physician who does not carefully consider, evaluate for, and treat dehydration."³⁸⁷ For this reason, it is important to decipher these docu-

379. *Id.* at 3-36.

380. No. 95-3213 CA, 1997 WL 372470 (Marion County Ct. May 1997).

381. *See id.*

382. *Id.*

383. *See id.*

384. *See id.*

385. *See* *Estate of DiDonato v. Waverly Group, Inc.*, No. 95-3213 CA, 1997 WL 372470 (Marion County Ct. May 1997).

386. Locatell, *supra* note 370, at 96.

387. *Id.* at 96.

ments and interpret their meaning. The physician orders and progress notes indicate the resident's primary and secondary diagnoses, treatment regimen, the frequency with which the resident's medical condition required physician intervention (an increase in frequency of physician visits, for instance, may signal a deterioration of the resident's medical condition), and services (skilled and nonskilled) provided.³⁸⁸

It is crucial to determine whether the facility followed the physician's orders. If physician orders were given and not carried out accurately and appropriately, the physician would be able to highlight that fact.³⁸⁹ "For example, a resident is found to be dehydrated, the physician prescribes oral rehydration, but the nurses fail to document and notify the physician of the results. The physician had no control over the action of the nurses and, therefore, should not be held liable."³⁹⁰ Likewise, in *Liquori v. Beverly Enterprises*,³⁹¹ a physician's orders to reconnect a resident's feeding were not followed, and the resident died as a result.³⁹²

D. Daily Nursing Notes

The daily nursing notes recorded during each shift are also extremely important.³⁹³ These clinical records reveal day-to-day treatment and relay resident clinical status.³⁹⁴ The nurses' notes should be reviewed for mention of hydration and/or nutrition-related problems that form the basis of the lawsuit. In addition, these entries can be compared with other records, such as physician's notes, to assess the treatment and responsiveness of one discipline with another. A pattern of missing daily entries may indicate that the facility did not provide the care necessary for the resident's condition.

388. See MEDICARE HANDBOOK, *supra* note 366, at 3-37, 3-38.

389. See Locatell, *supra* note 370, at 106.

390. *Id.*

391. No. 5D99-2428, 2000 WL 1033056 (Fla. Dist. Ct. App. July 28, 2000).

392. See *id.*

393. See MEDICARE HANDBOOK, *supra* note 366, at 3-38, 3-39.

394. See *id.*

E. Nutritional Reviews, Meal Forms, and Dietician/Nutritional Consultant Forms

An attorney should also review dietary/meal forms for signs of weight loss and/or nutritional problems. "For example, a resident with no clinical weight loss indicators, who is shown on the meal consumption flow sheets with excellent daily appetite, presumably should not lose weight. A significant weight loss during a defined period may [indicate] inadequate food portions, charting integrity, or inadequate clinical assessment" and ultimately prompt a lawsuit alleging weight loss tied to facility failure to provide adequate food portions.³⁹⁵ In addition, registered dietician/nutritional consultant forms and progress notes are essential to review, however, these recommendations may not be ordered by the attending physician, or, if ordered, they may not be followed by the nursing staff.³⁹⁶ These forms may contain a discussion of calorie counts completed, meal rounds to confirm nutritional intake, further identification of food tolerances and preferences, supplements and dietary liberalization initiated, modification of food textures, and evaluation of need for tube feeding.³⁹⁷ A rationale for use of supplements should be evident because these should not be used without a thorough evaluation of the underlying causes of the present symptom (weight loss, lack of appetite, and/or swallowing problems).³⁹⁸

F. Medication Records

Medication records document the daily administration of prescribed medications.³⁹⁹ These records reveal, among other information, the drug prescribed, dosage, mode and route of administration, frequency of administration, date of administration, original date of

395. Byron S. Arbeit, *The Administrator and Nursing Home Liability Issues*, in NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION 111, 133 (1999).

396. See generally Jill R. Ellis & Eileen D. Cowles, *Physician Response to Dietary Recommendations in Long-Term Care Facilities*, 95 J. AM. DIETETIC ASS'N 1424, 1424-25 (1995).

397. See *id.*

398. See Jeanie Kayser-Jones et al., *A Prospective Study of the Use of Liquid Oral Dietary Supplements in Nursing Homes*, 46 J. AM. GERIATRICS SOC'Y 1378 (1998) (findings indicate that supplements were used nonspecifically as an intervention for weight loss in nursing home residents without regard to dose, diagnosis and management of underlying problem(s), amount of supplement consumed, and outcome).

399. See MEDICARE HANDBOOK, *supra* note 366, at 3-39.

prescription, and prescription renewal dates.⁴⁰⁰ These records should also document the reasons for medication delivery on an as-needed basis or why a prescribed medication was withheld.⁴⁰¹ A pharmacist may review the resident's medication record to determine whether the medication regimen played a role in the resident's substantial weight loss.

In *Caruso v. Pine Manor Nursing Center*, the court used a *res ipsa loquitur* analysis in upholding the jury's finding that the resident's dehydration was caused by the nursing home's neglect.⁴⁰² The evidence showed that when the resident entered the nursing home, he had a significant degree of orientation, but was dependent upon the home for fluid intake because of his physical ailments which included renal insufficiency, organic brain syndrome, and Parkinson's disease, requiring treatment with the prescribed medication, amantadine.⁴⁰³ Six and one-half days later, when he was taken to the hospital emergency room, the treating physician diagnosed the resident as suffering from severe dehydration that exacerbated his renal insufficiency, preventing him from excreting the amantadine, which rose to toxic levels.⁴⁰⁴

G. Subspecialty Records

Subspecialists may be involved in resident care. By law, the nursing home must provide or obtain from an outside source any specialized rehabilitative services, such as speech language pathology, required by the resident's comprehensive plan of care.⁴⁰⁵ Qualified personnel must provide such services under written order of a physician.⁴⁰⁶ Specialty records in the form of daily progress notes or flow sheets signed or initialed by the treating specialist, set forth the specific modality of treatment and its frequency.⁴⁰⁷

Dysphagia, for example, "illustrates the interdependence of the nutrition professional and speech pathologists, occupational therapists, nurses, and physicians in providing appropriate nutrition care

400. *See id.*

401. *See id.*

402. *See id.* at 725–26.

403. *See id.* at 725.

404. *See id.*

405. *See* 42 C.F.R. § 483.45(a)(1), (2) (1999).

406. *See id.* § 483.45(b).

407. *See* MEDICARE HANDBOOK, *supra* note 366, at 3–39.

to the nursing home resident.”⁴⁰⁸ A speech therapist, for instance, can confirm a dysphagia diagnosis and help guide treatment strategies.⁴⁰⁹ Another example is the initial assessment performed by an occupational therapist who evaluates a resident’s fine motor skills and need for adaptive feeding equipment.⁴¹⁰ The facility must provide special eating equipment and utensils for residents, if needed.⁴¹¹ For example, grasp may be improved by enlarging silverware handles with foam padding to aid residents with impaired coordination.⁴¹² The occupational therapist recommends the adaptive equipment and prescribes postural/positional strategies for head, trunk, and arms, if indicated.⁴¹³

H. Intake and Output Records

A detailed review of intake and output records may help determine whether the staff was meeting resident hydration needs. These reports provide volume measurements for all solids and fluids the resident takes in and eliminates.⁴¹⁴ For example, the following should be monitored as intake: all oral and tube feedings, including intrave-

408. INSTITUTE OF MED., *supra* note 26, at 232.

409. See Kosta & Mitchell, *supra* note 300, at 196.

410. See, e.g., ARIZ. ADMIN. CODE 9-10-911(D) (2000) (“Residents who need help in eating shall be assisted in a manner that recognizes each individual’s nutritional and social needs, including the provision of adaptive eating equipment or utensils.”); CAL. CODE REGS. tit. 22, § 72315(g) (2000) (stating that each resident “requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs . . . to encourage independence in eating”); MINN. R. 4658.0530(1) (2000) (requiring self-help devices for residents who need help in eating); N.C. ADMIN. CODE tit. 10, r. 03H.2305(h) (July 2000) (“The facility shall ensure that [residents] who are unable to feed themselves receive the appropriate assistance, retraining and assistive devices when needed.”).

411. See 42 C.F.R. § 483.35(g).

412. See John Burdett Redford, *Assistive Devices in DUTHIE: PRACTICE OF GERIATRICS* 173, 179 (3d ed. 1998).

Poor grasp can be improved readily by enlarging silverware handles either with foam padding, such as pipe insulation, or other materials. A universal cuff that encircles the hand and holds utensils by a sleeve-like opening is a useful option. If the [resident] is one-handed, rocker knives and pizza cutters can replace regular knives.

Id.

413. See *id.* at 179-80.

414. See Pokrywka et al., *supra* note 67, at 1223-27 (indicating that the present system used to document nursing home residents’ intake is inadequate and that a more accurate mechanism or an entirely different process for identifying residents at risk for nutritional problems should be developed and implemented).

neous fluids, blood products, and fluid medications.⁴¹⁵ “Output may consist of urine, emesis, diarrhea, blood loss, or drainage from tubes.”⁴¹⁶ Comparing these reports with the resident’s care plan should identify the resident as being at risk for weight loss, dehydration, or malnutrition.⁴¹⁷ “These records can also help justify the award of punitive damages in the event that plaintiff’s counsel can establish that the resident was repeatedly given a small fraction of the recommended daily amount of fluid.”⁴¹⁸

I. Resident’s Weight Record

All residents will have a monthly weight record that may be recorded on a graph record.⁴¹⁹ Completed and documented special daily or weekly weight orders may exist for residents at high risk for weight loss or who are experiencing a significant amount of weight loss.⁴²⁰

J. Dental/Oral Health Records

Poor dental/oral health may contribute to inadequate nutritional intake, leading to dehydration and malnutrition.⁴²¹ One study reports that almost seventy percent of nursing home residents have untreated dental decay.⁴²² Another finds “[a]t least 80 percent of nursing home residents have some tooth loss; 50 percent of those who wear dentures need replacement or relining of their dentures, and about one-third have mucosal lesions.”⁴²³ One more study reports that fifty-one percent of the nursing home residents under observation had few or no teeth and either poorly fitting or no dentures.⁴²⁴ An initial assessment for adequacy of dentition to accomplish oral intake is present in the resident’s clinical record, along with any routine follow-up evaluations.⁴²⁵ If caregivers do not perform an assessment, the nursing home may be cited for non-compliance with federal requirements in this

415. See D’Andrea, *supra* note 321, at 34.

416. *Id.*

417. See Rhodes & Castillo, *supra* note 203, at 44.

418. *Id.*

419. See generally INSTITUTE OF MED., *supra* note 26, at 69.

420. *See id.*

421. See Burger et al., *supra* note 70.

422. See Merete Vigild, *Dental Caries and the Need for Treatment Among Institutionalized Elderly*, 17 COMMUNITY DENTAL ORAL EPIDEMIOLOGY 102, 103 (1989).

423. Burger et al., *supra* note 70.

424. *See id.*

425. *See id.*

area.⁴²⁶ Moreover, the nursing home is required by law to “assist residents in obtaining routine and 24-hour emergency dental care.”⁴²⁷

XI. Conclusion

Unfortunately, nutrition and hydration-related problems are common among the nursing home population⁴²⁸ and strongly associated with negative outcomes, including increased morbidity, hospitalization, risk of pressure ulcers, and poor quality of life.⁴²⁹ Dehydration, malnutrition, and weight loss are infrequently the natural consequence of medical illness.⁴³⁰ Substandard institutional practices such as inadequate mealtime staffing can be a major contributing factor.⁴³¹ The legal cases described in this article demonstrate that dehydration and malnutrition play a significant role in the growing field of nursing home negligence. As noted, federal and state nursing home regulations, as well as professional reports and guidelines, support individualized assessment and treatment of nutrition and hydration problems.⁴³² An individualized, resident-centered approach will avoid litigation and greatly improve the lives of frail nursing home residents.⁴³³

426. *See id.*

427. 42 C.F.R. § 483.55 (1999).

428. *See* Amella, *supra* note 63, at 879–85; Morley & Silver, *supra* note 72, at 850–59; Weinberg et al., *supra* note 188.

429. *See* Amella, *supra* note 63; Kayser-Jones et al., *supra* note 189, at 1187; Kayser-Jones et al., *supra* note 398, at 1378; Morley & Silver, *supra* note 72; Sullivan, *supra* note 197; Sullivan et al., *supra* note 197; Weinberg et al., *supra* note 187.

430. *See* INSTITUTE OF MED., *supra* note 26, at 69 (highlighting the “potentially correctable” problems associated with weight loss in nursing home settings).

431. *See* Kayser-Jones & Pengilly, *supra* note 131, at 77–82; Kayser-Jones et al., *supra* note 189, at 1187; Kayser-Jones et al., *supra* note 398, at 1378–86; Kayser-Jones, *supra* note 68, at 14–21; Kayser-Jones & Schell, *supra* note 83, at 64–72; Jeanie Kayser-Jones & Ellen Schell, *Staffing and the Mealtime Experience of Nursing Home Residents on a Special Care Unit*, 12 AM. J. ALZHEIMER’S DISEASE 67–72 (1997); Jeanie Kayser-Jones et al., *Reliability of Percentage Figures Used to Record the Dietary Intake of Nursing Home Residents*, 5 NURSING HOME MED. 69, 75 (1997); Jeanie Kayser-Jones, *Mealtime in Nursing Homes: The Importance of Individualized Care*, J. GERONTOLOGICAL NURSING, Mar. 1996, at 26–31 [hereinafter Kayser-Jones II]; Kayser-Jones et al., *supra* note 346, at 814–24; Kayser-Jones, *supra* note 124, at 469–79; Jeanie Kayser-Jones et al., *Factors Contributing to the Hospitalization of Nursing Home Residents*, 29 GERONTOLOGIST 1502 (1989).

432. *See generally* Amella, *supra* note 81.

433. *See* Kayser-Jones & Pengilly, *supra* note 131, at 77; Kayser-Jones et al., *supra* note 189, at 1187; Kayser-Jones, *supra* note 68, at 14–21; Kayser-Jones & Schell, *supra* note 83, at 64–72; Kayser-Jones & Schell, *supra* note 431, at 67–72; Kayser-Jones II, *supra* note 431 at 26–31; Kayser-Jones, *supra* note 124, at 469–79.