ELDER ABUSE ASCERTAINMENT OF TRUTH IN LITIGATION IN THE FACE OF OBSTRUCTION AND INCIVILITY

[CoverStory]

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Often above all other considerations, our clients in elder and dependent adult abuse and neglect cases come to us because they are seeking the truth. After the untimely death or injury to their loved ones, our clients are certainly contending with injuries or grief from the loss of a loved one when they walk in our doors. However, the primary reason our clients take the step of retaining counsel is because they have been denied answers about how and why their loved ones suffered unexplained trauma or injuries while in custody of nursing homes and staff who had a duty to keep their family members safe.

Unfortunately, once litigation begins we find that the stonewalling our clients experienced which led them to our doors is only a taste of the degree of obfuscation we can expect to experience as their counsel through the course of discovery in their case. However, despite these obstacles, our clients deserve nothing less than our relentless efforts to find the truth, particularly in the face of increasing incivility and discovery abuse from opposing counsel endemic in this area of practice.

Misdirection & Omission Pre-Litigation

It is axiomatic that the statutes, regulations, and applicable standards of care require health care providers and caregivers in post-acute care settings to keep accurate records and keep responsible parties/patients informed of changes in condition, including changes in condition arising from falls, injuries, and other newly developed problems. (See, e.g., Cal. Code Regs., tit. 22, §§ 72528, 72543; 42 C.F.R. §§ 483.20, 483.70.) As such, it should be assumed that the content of medical records is truthful, accurate, and complete.

In actuality however, the desire to evade liability and avoid accountability for wrongdoing is a greater influence driving the conduct of the employees and operators of nursing homes than their fear of consequences arising from violation of their legal duty to maintain accurate records. There are both financial and reputational pressures upon nursing home operators to avoid the discovery of preventable accidents and injuries in their buildings. The Centers for Medicare and Medicaid Services (CMS) monitors skilled nursing facilities' performances on certain clinical indicators and staffing levels as part of its five-star rating system, a score which is negatively impacted based upon an operator's violations of regulations or failures to provide care leading to falls, injuries, and re-hospitalizations of patients. (Centers for Medicare & Medicaid Services, Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (April 2019).) More specifically, one category of CMS' five-star rating system, "Quality Measures," is designed to advise the public of data about a facility's quality of care based on self-reported data regarding a

number of factors including residents in their facilities who suffered falls, developed new or worsened pressure ulcers, reported moderate to severe pain, or were hospitalized or sent to the emergency department during their stay, among other things. (www.medicare.gov/NursingHomeCompare/About/nhcinformation.html)

The California Department of Social Services performs enforcement and investigatory functions for non-medical residential care facilities. Both of these bodies make results available to the public. Deaths, preventable injuries, and preventable accidents affect not only skilled nursing facilities' five-star ratings, but also give rise to monetary penalties, loss of certification to receive Medicare or Medi-Cal payments, and potential license revocation for operators who fail to comply with minimum state and federal standards. As resident complaints can give rise to such adverse actions, operators who prioritize their own interests above their duty to their patients are incentivized to conceal or minimize injuries and their causes.

Acute care hospitals face financial repercussions from adverse preventable events as well. Termed "Never Events," CMS declared in 2007 that Medicare would no longer pay for the medical costs of treating preventable errors, injuries, and infections that occur in acute care hospitals. (O'Rourke et al., Never-Event Implications (Feb. 2009) The Hospitalist.) Never Events include, but are not limited to, pressure ulcers, injuries caused by falls, and certain infections. (Health & Saf. Code, § 1279.1.) In other words, if a patient suffers a preventable fall, documentation of the facts of the fall can have the effect of denying the provider payment for the curative care for resulting injuries. The unintended result is that care providers are incentivized to minimize or mischaracterize the injury producing event. For example, providers may not document a "fall" occurred, but rather that the patient was "found on the floor without injury."

In practice, we are seeing alarming examples of this conduct in which patients have serious injuries, bedsores, or life-threatening fractures which are not referenced in the charting at all. Omission of reference to the injury itself in charting is often just the tip of the iceberg in terms of intentional efforts to conceal injuries, because most serious injuries manifest themselves in observable signs and symptoms in the days thereafter including: loss of mobility, inability to bear weight, changes in levels of consciousness, increases in pain complaints, and decreases in food intake, among other things. Furthermore, many of these injuries cause patients to experience severe pain every time they are moved, toileted, or assisted with activities of daily living like showering and changing of clothing. As such, any reasonable nurse or caregiver assisting these patients after such injuries day after day and shift after shift would undoubtedly be in a position to observe signs and symptoms of these serious injuries such that there should be descriptions of these issues in the chart. However, more often than not, we observe that the days and shifts which follow these injuries read in the medical records as if the resident is doing well and at their baseline. These false claims that the patient is doing well after such injuries appear, on paper, to be credible until they are juxtaposed with ambulance or hospital records of the patient at the time of their emergency discharge from a facility. These often paint a dire and contrary picture of serious injuries which logically would have been obvious and apparent in the days leading up to the patient's removal from the facility.

> **"Our clients expect and deserve champions of their rights to the truth who will fight every battle – large or small – despite the obstacles placed before us by litigants, their counsel, or those obstacles associated with the burdens on some of our courts. While it is not an easy road, nevertheless we should persist because it is the only worthwhile one for our clients."**

Some examples of this type of misleading charting in recent cases include:

• Resident with dementia in a residential care facility sustained bilateral ankle fractures in an undocumented incident at facility, and after three days of deprivation of medical treatment, the facility staff took the resident to the hospital posing as the resident's family in an attempt to prevent the hospital from contacting the resident's family;

• Resident was dropped by facility staff while providing services. The fall resulted in multiple lower extremity fractures which went untreated for days, however defendants in litigation denied a fall or injury causing event occurred and charting contained no reference to a fall;

• Resident of residential care facility developed an infected Stage IV pressure ulcer (a prohibited health condition in such a facility), however, staff did not alert the resident's family or physician to the condition and instead chose to "treat" it themselves by inserting cotton, powder, and Vaseline into the wound without medical supervision. Defendants admitted to state investigators that a Stage III wound existed, but later in litigation denied a wound ever developed, and produced a resident record in litigation that had no reference to the wound;

• Resident of skilled nursing facility entered the facility with a non-displaced

hip fracture that was able to bear weight and engage in therapy, was documented to have sudden complaints of severe pain with movement during physical therapy and loss of ability to bear weight. However, charting revealed no nursing assessment of this change in condition in the ensuing four days before the patient's transfer to the hospital for an unrelated reason. At the hospital, the patient was diagnosed with a displaced hip fracture with a shortened and externally-rotated limb, multiple bruises, and skin tears, none of which were referenced in the facility chart. In litigation, defendants denied a fall and claimed that the injury must have been caused by the resident hitting their leg on a tray table.

• Non-ambulatory resident of residential care facility who lacked ability to stand, walk, or pick herself up from the floor was "found" in bed with five rib fractures and a broken pelvis. However charting makes no reference to a cause of the injury. In litigation, Defendants denied any incident occurred.

Particularly in the context of skilled nursing facilities, operators who are under a duty to self-report accurate data to CMS are also the same persons who have a vested interest in ensuring that CMS does not reduce their facility's five-star rating – the likely result of providing accurate data about incidence of falls, pressure sores, pain, and hospitalizations to CMS. For example, if the staff of a facility documents a "fall," it must be included in the facility's quality measures, which in turn will affect its five-star rating. If a resident is documented to enter a facility with no pressure ulcers and then develops one "in-house," that must be included in the facility's quality measures, which in turn will affect its five-star rating. Thus, if operators choose to mislabel these conditions in their reporting, they can avoid the requirement to report them to CMS, thus falsely inflating their five-star ratings to their benefit, and to the detriment of consumers who rely on said scores as evidence of the quality of care to be provided at the facility.

Long term care facility operators are also acutely aware that government regulators are not the only source of unwanted publicity arising from preventable injuries and deaths of their patients. Reviews from patients and their families on Yelp and other similar platforms are often a primary resource utilized by those conducting research in order to select a facility for themselves or loved ones. As such, if a patient or resident suffers a preventable injury in a facility, the facility administration may be incentivized to minimize or withhold description of the true cause of the harm in response to residents' demands for information, in part to decrease the possibility that former patients or their families will publicize these harms in reviews visible to other prospective future residents.

Omission or minimization of a description of the injury is not the only barrier to discovery of the truth prior to commencement of litigation. It is typical

of chain nursing home operators to have a systematic approach to conducting periodic "audits" of records and charts of patients both during admission and after discharge, as well as mandating that a corporate office legal department or chain affiliated nursing consultant audits records before release in response to patient requests.

At first blush, the term "audit" may suggest to the uninitiated that the records were reviewed for the benefit of the patient, and to ensure accuracy of their chart. In actuality, nursing home staff will frequently admit that "audits" of a resident's medical records conducted during and after discharge are done for no reason other than to identify whether there were blanks left by staff which need to be filled in. These blanks are left by staff who should have made certain documentation on a certain shift, and those staff are then directed to rely on their memories to fill in the blanks often days and sometimes weeks later as part of the process. This "audit" procedure, in practice, is not aimed towards ensuring the patient's or resident's records are accurate for later health care providers to rely on in making treatment decisions for the patient. Rather, such "audits" are done to minimize evidence of omissions, mistakes, and understaffing for purposes of evading liability for injuries.

Frequently, litigation will ultimately reveal multiple "versions" of the resident's medical records. Sometimes these are innocent, but sometimes evidence demonstrates that these irregularities are anything but. In many instances, pages of charting which were given to the family shortly after discharge are not present in versions of the chart later produced in discovery. In other situations, residents' families are provided much smaller versions of a chart, only to discover upon commencement of litigation that dozens or hundreds of additional pages of charting exist which were not provided to the family. Additionally, at times there are numerous successive document productions over the course of litigation as additional documents are "found." At other times, charting entries themselves are evidence that the original charting entries were rewritten, altered, added to, or omitted. This can be determined through deposition testimony, comparison of records, handwriting analysis, and electronic evidence in the form of access and audit logs. While committing fraud in medical records is a potentially criminal act (Pen. Code, § 471.5), that alone is not enough to deter such conduct based on testimony from witnesses who have ultimately admitted to destroying original charting entries and rewriting entries or pages of entries at the direction of, or with the knowledge of, facility leadership.

The impediment to establishing liability against owners and operators of nursing

homes created by the above-referenced factual tampering is not the only impediment we as lawyers face in our search for truth. Identifying and establishing liability against those who make decisions which actually drive the poor quality of care at the facility level is often made more difficult by confusing and intentionally complex webs of corporate entities. It is a well-known practice for nursing home operators to protect themselves through opaque multi-entity constructs and "corporate restructuring" done for the stated purpose of "avoiding exposure to exclusion from Medicare and Medicaid programs and exposure to financial liability." (Casson et al., Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring (Fall 2003) Journal of Health Law, vol. 36, No. 4.) The guidance recommended to and employed by these operators is to form "legal entities such as corporations, limited liability companies, and limited liability partnerships...to benefit nursing home companies by limiting the financial liability and Medicare and Medicaid exclusion exposure of the real-estate investors and business owners." (Id.)

As such, while evidence typically establishes that multiple parent, subsidiary, or sibling entities (or their shared officers or directors) are engaging in conduct which creates the resource shortages that lead to the injuries subject to our cases, and while cost reports and other required filings by these entities in fact prove that these entities are involved in the funneling of revenues into the hands of various entities or persons which share common ownership or control as that of the facility, establishing liability against these entities is nonetheless made more difficult by the "on paper" legal separation between these entities.

Discovery Abuse, Evasion, and Misdirection

With the above-referenced barriers to finding the truth already erected prior to the inception of litigation, the importance of consistency and persistence in pursuing your client's right to discovery during litigation becomes critical. We must develop not only the evidence of "what" happened at the facility level that caused our client's harm, but also more globally "why" that was allowed to occur. While substantial opposition is presented to nearly any request for discovery, pursuit of the evidence establishing "why" the care failure occurred is often more strenuously resisted. This is because this analysis requires evidence of what defendants' officers, directors, or managing agents knew when they made critical operational decisions. This affects our ability to prove the conduct was done with recklessness, oppression, fraud, or malice in order to permit recovery for your client

of the enhanced remedies under the Elder Abuse and Dependent Adult Civil Protection Act. (Welf. & Inst. Code, § 15657; Civ. Code, § 3294.) This necessitates the need for depositions of regional and corporate representatives in their individual capacities, "person most qualified" (PMQ) depositions (Code Civ. Proc., § 2025.230), discovery of email communication, internal memoranda, data and reports used by defendants in their operations related to staffing and variance to budget, among other things.

In litigation of such cases, the tactics employed to oppose this kind of written and deposition discovery go well beyond asserting legal objections, and nearly unanimously include tactics such as: blanket objections to all written discovery requests even including objection to form interrogatory 1.1, requests for extensions promising progress or provision of deposition dates which are not upheld, refusal to produce a single policy and procedure, provision of unverified or intentionally misnumbered discovery responses, provision of eleventh-hour supplemental responses on the eve of hearings on motions to compel further responses in an effort to moot motions before court orders are issued, production of "document dumps" which do not include production of the actual documents requested, repeated production of identical documents to support a suggestion that "thousands" of documents were produced, refusal to identify any witnesses or staff, pulling of confirmed depositions repeatedly, and "assuming representation" of subpoenaed third-party witnesses prior to deposition and claiming the witness is no longer available to testify, among many other tactics.

Outside of written discovery, defendants often also create delay on progression of discovery by filing frivolous appeals which have the effect of staying all proceedings until the appeal is heard. Typically, nursing home operators require unwary residents or their families to execute pre-dispute arbitration agreements which often are found to be unenforceable for a number of reasons. However, once the lower court rules to deny a defendant's petition to compel arbitration, an appeal is routinely filed regardless of merit, which can cause a delay in conducting any discovery for sometimes more than a year, and while plaintiff is precluded from conducting discovery until the appeal is resolved, witnesses' recollections fade by the day to the benefit of defendants.

Defendants employ these scorched earth obstruction tactics to delay plaintiffs' prosecution of the case in general, but also specifically so as to preclude plaintiff from progressing "up the chain" to higher-level corporate representative depositions. An often-employed tactic to delay depositions is the filing of motions for protective orders seeking to preclude plaintiffs from taking any depositions of persons above the nursing home level based on a misapplication of the holding in *Liberty Mutual Insurance Company v. Superior Court* (1992) 10 Cal. App. 4th 1282.

In *Liberty Mutual*, the court overturned the trial court's order denying a defendant's motion for protective order precluding the deposition of the CEO of Liberty Mutual Insurance Company, which was brought on grounds that the CEO's only connection to the litigation was that he was copied on two letters sent by plaintiff's counsel which he did not see, and that the plaintiff sought this deposition in the first instance without exhausting less-intrusive means to obtain the information requested. While said holding is certainly understandable in the factual set presented in *Liberty Mutual*, the defense bar in neglect and abuse cases typically employ this case holding in situations beyond these facts. This is done to improperly delay deposition of witnesses even though the witnesses are: 1) not at the top of any corporate hierarchy based on their position; 2) directly implicated in facility operational functions or are known to possess relevant percipient knowledge; and 3) sought for deposition not "in the first instance" but only after other substantial evidence has been obtained justifying their depositions in litigation.

While defendants' objections to depositions on this ground do not ultimately prevail in the majority of instances, the mere filing of such a motion can have the effect of creating multiple months of delay, each of which represents another month in which the plaintiff is being denied the opportunity to identify whether or not witnesses higher in the hierarchy of operations will be necessary to address the questions at issue in litigation.

While the above-referenced conduct results in delays in and of itself, it should be noted that defendants often enhance the dilatory effects of their conduct by taking advantage of the impaction in our courts. Practitioners recognize and appreciate the efficiency with which the judicial officers manage the substantial caseloads assigned to them in the course of balancing the needs of all litigants assigned to their departments. However, due to constraints in resources arising from overburdened dockets in many counties, the fact is that many courts do not have time to address discovery motions – a fact which is well known to defense counsel. This impaction can have many effects on the timing of resolution of discovery disputes, such as motion hearing dates set many months after filing and limits on the number of motions which can be heard in one day forcing the need to schedule hearings on discovery disputes over the course of months. Furthermore, defense counsel are aware that briefings are at times necessarily lengthy because they require adjudication of multiple and complex issues, and that courts and their staff may not have the resources to dedicate the optimal amount of time needed to fully explore and weigh the evidence and briefings at issue. Each of these factors can negatively impact

our clients' ability to obtain orders to receive necessary discovery in a sufficient or timely manner. This impact is often exacerbated where multiple of these factors occur simultaneously.

Where the factfinder has the time necessary to closely examine the evidence and good cause in support of plaintiffs' motions and the authority in support, a plaintiff's right to discovery typically prevails based on the merit of the disputes. However, where the court may lack resources to fully apprise itself of the procedural posture and supporting evidence of motions, defendants often seek to take advantage by issuing hyperbolic statements that plaintiffs are engaging in excessive discovery, misrepresenting that documents or information have been provided where they were not, or claiming that meet and confer efforts have been incomplete or insufficient. The conduct of asserting these often unfounded positions in order to "see what sticks" even where contradicted by law or facts exacerbates the threat to our clients' right to fair resolution of discovery disputes. The only way to defeat such specious claims is to ensure the judge has the evidence disputing the claims and sufficient time to consider it.

A solution to level the playing field is to bring a motion pursuant to Code of Civil Procedure section 639 for the appointment of a discovery referee. Good cause for this can be established based on the number of outstanding disputes, proximity to trial, the need for certain discovery in order to prepare for necessary depositions, and the protracted hearing schedule on motions necessitated by the court's other pending matters. Discovery referees can also be sought arising from a stipulation between counsel. (Code Civ. Proc., § 638.) While there is significant associated cost for a discovery referee, requests can be made that the referee's fees be shifted at various intervals based on the merit of the disputes or conduct of the parties among other things, to ensure that plaintiff does not bear an undue burden.

The costs of a referee, on balance, are outweighed by the clients' increased ability to have their disputes considered on the merits, and considered more quickly. Referees are in a greater position to dedicate the time necessary to review complex or lengthy pleadings and to hear more substantial argument than some impacted courts, thereby increasing the chance that a fair ruling can be issued and decreasing the effect that mischaracterizations of evidence or hyperbolic claims of "excessive discovery" will have on any ruling.

As well, overall, discovery referees present a means to resolve disputes more quickly over time, in the sense that numerous hearings may be heard at one time and that parties have the opportunity to request half- and full-day hearings to resolve discovery disputes rather than having to work within a busy court schedule to locate hearing dates over time. There are inherent delays related to use of a discovery referee at the inception due to logistical matters in setting up a file, and at the conclusion of hearings due to the fact that recommendations are subject to further objection by defendants and ultimate approval by the court. (Code Civ. Proc., § 639, subd. (a)(5).) Typically, the ability to have a greater volume of discovery matters resolved at one time far outweighs any incidental delays in this process.

Furthermore, use of a discovery referee tends to inure to the benefit of plaintiff in terms of ensuring matters are decided on the merits where the referee may have a greater memory of the facts of the case and positions taken by the parties. The court often has many hundreds of cases before it, and often weeks or months will elapse between hearings on any discovery matters in your case, such that the judge likely and reasonably will not recall from hearing to hearing whether one side or the other has taken contradictory, unmeritorious, or unsupported positions. Credibility lost by defendants' counsel due to making of false or misleading statements in one hearing may be restored to them in the next hearing due to nothing other than the passage of time. Use of a discovery referee also has the effect of leveling this playing field, as referees can spend greater amounts of time with the parties hearing argument, may have fewer matters under their supervision, and therefore will have a greater likelihood of recalling relevant facts and conduct of counsel from hearing to hearing which can and should be taken into consideration in the adjudication of these matters.

While there are benefits to the use of a discovery referee, it should be noted that resorting to such process comes with substantial cost to the plaintiff. Discovery referees can charge hourly rates in the range of $600-$900 per hour, and over the course of numerous discovery disputes use of a discovery referee can often incur, conservatively, tens of thousands of additional dollars in costs to plaintiff which would not have been incurred if such disputes were resolved in the Superior Court. Such substantial costs directly impact and decrease the net distribution available to the client after a verdict or settlement is achieved, and is a risk that should be discussed with your client.

Civility

Many rules and guidelines pertaining to civility between opposing counsel preclude conduct of the type we often see employed against our clients' positions in neglect and abuse cases. Sentimentally, many of us recall earlier times in our careers where civility guidelines and rules

were viewed as a bright line under which none of us would sink.

But in practice, we are seeing erosion of that civility, and an increase in instances in which counsel are willing to take liberties with the Discovery Act and guidelines of civility to cause delays in discovery with the ultimate target of obfuscating and obstructing the truth, ostensibly in the interests of advocating for their client.

Pursuant to the California Attorney Guidelines for Civility and Professionalism from the State Bar, counsel are urged to observe priority in deposition setting, avoid bad faith delays in deposition scheduling, to treat counsel and participants with courtesy and to avoid conduct that would be inappropriate in the presence of a judicial officer, to refrain from coaching responses in depositions or employing speaking objections, avoiding instructing witnesses not to answer questions without legal basis, to refrain from intentionally misconstruing document demands to avoid disclosure, to refrain from producing disorganized or unintelligible documents, to refrain from producing documents in a way to obscure existence of other documents, to refrain from delaying in producing a document prior to a scheduled deposition for tactical reasons, or assert unmeritorious objections among other things. (Cal. Atty. Guidelines of Civility and Professionalism (State Bar of California, 2007) Discovery, § 9.)

However, perhaps due to the pressures of gaining and keeping the business of multi-facility operators, and related pressures to minimize large verdicts or settlements against their clients, defendants' counsel may find themselves in a perceived conflict between acting in conformity with civility guidelines versus taking certain actions they deem otherwise necessary to advocate for their clients' interests. Where those competing interests converge, some defendants' counsel choose to turn a blind eye to civility guidelines where its demands conflict with the perceived needs of their clients.

These pressures can cause defense counsel to likewise ignore ethical rules, including those regarding representation of multiple clients with conflicting interests. (Rules Prof. Conduct, rule 1.7.) In some instances, counsel for the facility defendant will nonetheless represent other defendants in the action including facility medical directors, owners, management companies, or other health care providers even though said defendants have interests and defenses which conflict with the facility. However, rather than ensuring separate counsel of these parties with diverging interests, defenses, and varying levels of exposure, they represent multiple defendants concurrently.

Much like situations in which nursing home staff and operators may choose to knowingly violate applicable laws and regulations due to pressure to conceal wrongdoing, defendants and their counsel at times may choose to act in contradiction to civility rules and ethical requirements due to a perceived pressure to succeed or retain business of their clients.

While we do not purport to have the entire solution to this great and growing concern, there can be no dispute that one step in the right direction to stem this tide is to exemplify in ourselves, and seek to hold opposing counsel to, the word and spirit of applicable civility guidelines. This can be accomplished through adhering to these guidelines in our own conduct, in providing language of relevant guidelines to counsel during meet and confer efforts in writing and at depositions when problems arise, in seeking that counsel stipulate at inception of litigation to abide by civility guidelines. (See Cal. Atty. Guidelines of Civility and Professionalism, supra, Attorneys Pledge, p. 14.) As a last resort, we can raise offending conduct in the course of law and motion if necessary and relevant. It is not unheard of for counsel to bring a motion to direct opposing counsel to cease engaging in inappropriate conduct when a pattern of such conduct is demonstrated, and, if merited, is a step which will inure to the benefit of your client's fundamental right to ascertain the truth in his or her litigation.

Conclusion

In litigation of these complex and highly-contested matters, civility cannot be compelled and justice cannot be guaranteed to our clients, but at minimum what should still be obtainable is access to the truth. Our clients expect and deserve champions of their rights to the truth who will fight every battle – large or small – despite the obstacles placed before us by litigants, their counsel, or those obstacles associated with the burdens on some of our courts. While it is not an easy road, nevertheless we should persist because it is the only worthwhile one for our clients.

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