

What Attorneys Should Know About Nursing Home Standards of Care

Expert Insights for Successful Litigation

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Introduction

Attorneys involved in nursing home litigation, whether representing plaintiffs or defendants, must understand the unique clinical, regulatory, and operational landscape of long-term care facilities. Unlike hospitals, nursing homes operate under a distinct set of federal and state guidelines that shape standards of care. These standards are complex and continuously evolving, which can make identifying breaches and liabilities challenging without the proper knowledge and context.

This guide aims to equip attorneys with a foundational understanding of:

- The regulatory framework governing nursing homes
- The definition and application of “standards of care”
- Common issues that lead to litigation
- The critical role expert witnesses play in building strong cases

Whether you are assessing a potential claim, preparing for deposition, or reviewing facility records, this resource will help you recognize key areas of concern and strengthen your legal strategy.

Regulatory Framework: Federal and State Oversight

Understanding the regulatory environment is critical to evaluating whether a nursing home has met the applicable standards of care. Skilled Nursing Facilities (SNFs) are among the most heavily regulated healthcare entities in the United States. Two primary layers of oversight exist: federal regulations (for facilities participating in Medicare and Medicaid) and state-specific requirements (through licensure and inspections).

1. Federal Oversight

Nursing homes that receive federal funding must comply with regulations found in 42 CFR §483, commonly known as the Requirements for Participation. These rules establish standards for:

- Resident rights
- Quality of care
- Staffing requirements
- Infection control
- Nutrition and hydration
- Resident assessments and care planning
- Medication management
- Administration and governance

The Centers for Medicare & Medicaid Services (CMS) enforces these rules through:

- Annual surveys (inspections) conducted by state survey agencies
- Complaint investigations
- Civil monetary penalties, denial of payment, or even termination from the Medicare/Medicaid program for noncompliance

Survey findings are published publicly through CMS's Care Compare website, offering insight into a facility's past citations and quality indicators.

2. State Oversight

Each state has its own department of health or licensing authority responsible for enforcing state-specific regulations in nursing homes. These may go beyond federal minimums and include:

- Minimum staffing ratios

- Administrator licensure and continuing education requirements
- Building safety codes
- Enhanced abuse reporting mandates
- Resident rights specific to the state

State surveyors conduct both scheduled and unannounced inspections for complaint investigations as well as annual recertification surveys. Deficiencies noted during these visits are categorized by scope and severity and can be used as evidence in civil litigation to demonstrate a pattern of substandard care.

Key Takeaways for Attorneys

- Always request/obtain the facility's full CMS survey history, including Statements of Deficiency and Plans of Correction.
- Compare alleged incidents to applicable federal and state rules from the time of the incident.
- Be aware that a facility may technically meet federal requirements but still be in violation of higher state standards or vice versa.
- Use regulatory deficiencies as a tool to support or refute allegations of systemic issues.

Common Allegations in Nursing Home Litigation

Nursing home litigation typically arises when there is a perceived or actual failure to meet the applicable standards of care. While the details of each case vary, most claims fall into several recurring categories. Attorneys should be familiar with these common allegations and understand how to evaluate the facility's actions (or inactions) within each context.

1. Neglect and Inadequate Supervision

Neglect often results from insufficient staffing, poor training, or lax oversight. Examples include:

- Failure to respond to call lights in a timely manner
- Missed meals or medications
- Failure to assist with activities of daily living (ADLs)
- Prolonged periods without repositioning bedbound residents

Key Legal Consideration: Was the facility adequately staffed, and did it follow its own supervision policies?

2. Falls and Fall-Related Injuries

Falls are among the most litigated incidents in long-term care. Residents at risk of falling should receive interventions such as alarms, lower beds, floor mats, frequent rounding, and assistive devices.

Key Legal Consideration: Was a fall risk assessment performed and were appropriate interventions implemented and monitored?

3. Pressure Ulcers (Bedsore)

Pressure injuries are often seen as a sign of neglect, particularly if they are advanced or infected. Preventative measures include regular turning, adequate nutrition, skin assessments, and pressure-relieving devices.

Key Legal Consideration: Did the facility have an individualized skin integrity plan and did staff document implementation?

4. Dehydration and Malnutrition

These conditions may result from failure to monitor food and fluid intake, improper assistance during meals, or delays in physician notification. Severe cases can lead to hospitalization or death.

Key Legal Consideration: Were weight changes and intake records closely monitored, documented and addressed in care plans?

5. Medication Errors

Mistakes can involve missed doses, overdoses, incorrect medications, or failure to monitor side effects. These may occur due to poor communication, overworked staff, or systemic pharmacy issues.

Key Legal Consideration: Was the medication error documented, and were protocols for follow-up and reporting followed?

6. Abuse (Physical, Emotional, Sexual, or Financial)

Allegations may involve staff or other residents. Facilities are required by law to screen staff, investigate all abuse allegations promptly, and report them to appropriate authorities.

Key Legal Consideration: Did the facility have proper hiring, training, and abuse reporting protocols in place?

7. Wrongful Death

These claims often combine several other allegations (e.g., neglect leading to infection or fall-related injuries leading to fatal complications). Expert review is critical in connecting the alleged breach to the cause of death.

Key Legal Consideration: Is there a direct link between the breach of duty and the resident's death?

Each of these categories requires careful review of medical records, staffing logs, facility policies, and regulatory history. A qualified expert witness can assist in identifying whether standards of care were violated and whether those violations contributed to the alleged harm.

Primary Areas of Concern in Nursing Home Care

While the legal claims in nursing home cases may vary, they often stem from systemic issues in key areas of facility operations. Identifying and evaluating failures in these areas is essential for building a compelling legal argument.

1. Staffing and Supervision

Adequate staffing is fundamental to quality care. Understaffing can lead to delayed care, missed treatments, and increased risk for falls, infections, and resident dissatisfaction.

Indicators of concern:

- Low staff-to-resident ratios, especially on night shifts
 - Overreliance on agency or temporary staff
 - Staff complaints or turnover
 - Missed or late care tasks (e.g., toileting, repositioning)
-

2. Assessment and Care Planning

Federal regulations require a comprehensive Minimum Data Set (MDS) assessment and a corresponding interdisciplinary care plan for each resident. These documents must be personalized, updated routinely, and followed by staff.

Indicators of concern:

- Generic or boilerplate care plans
 - Lack of updates following a change in condition
 - Failure to involve resident/family in planning
 - Care provided that contradicts the documented plan
-

3. Fall Prevention

Falls are often preventable with appropriate risk assessments and safety interventions. A failure to assess or respond to known fall risks is a frequent basis for litigation.

Indicators of concern:

- Missing or outdated fall risk assessments
 - Inconsistent documentation of fall interventions
 - Lack of root-cause analysis following a fall
 - Recurrent falls without a change in strategy
-

4. Pressure Ulcer Prevention

Pressure injuries can generally be avoided with proper skin care, mobility assistance, and nutritional support. Facilities are expected to take proactive measures, especially for immobile residents.

Indicators of concern:

- Poor or inconsistent turning/repositioning schedules
 - Delayed reporting of skin breakdown
 - Insufficient use of pressure-relieving equipment
 - Documentation gaps in wound care progress
-

5. Abuse and Neglect

All staff must be trained to recognize, report, and prevent abuse and neglect. Facilities must have policies in place and act swiftly when allegations arise.

Indicators of concern:

- Delayed or missing abuse investigation reports
 - Staff with incomplete background checks
 - Poorly documented training on abuse prevention
 - History of prior citations for abuse
-

6. Medication Management

Residents often take multiple medications requiring close monitoring. Errors can stem from transcription mistakes, rushed medication passes, or failure to communicate changes in orders.

Indicators of concern:

- Medication errors without documented follow-up
 - Gaps between physician orders and administration records
 - Lack of pharmacist reviews or drug regimen evaluations
 - Delays in administering time-sensitive medications
-

7. Documentation Practices

The medical record is both a clinical tool and a legal document. Inconsistent or missing documentation often signals deeper issues in care delivery.

Indicators of concern:

- Charting done in bulk or at the end of shifts
 - Use of pre-filled templates with no individualization
 - Backdated entries or unusual time stamps
 - Inconsistencies between nursing notes and other records
-

Each of these areas can be analyzed through facility documentation, staff interviews, and expert witness review. Identifying breakdowns in these systems helps establish whether a breach of the standard of care occurred, and how it contributed to the alleged harm.

The Role of the Expert Witness

In nursing home litigation, expert witnesses play a pivotal role in bridging the gap between complex clinical standards and legal arguments. Their analysis and testimony can make the difference between a dismissed case and a successful outcome, whether for the plaintiff or the defense.

1. Interpreting Standards of Care

Expert witnesses evaluate whether the facility met the applicable standards of care. These standards may come from:

- Federal and state regulations (e.g., 42 CFR §483)
- Industry best practices
- Accreditation standards
- Internal facility policies and procedures
- Customary practices within the long-term care field

The expert applies these standards to the specific facts of the case, offering opinions about whether care was appropriate under the circumstances.

2. Reviewing Medical and Facility Records

Expert witnesses analyze a range of documents, including:

- Clinical records (progress notes, medication administration, vital signs, etc.)
- Minimum Data Set (MDS) assessments
- Care plans and updates
- Incident and accident reports
- Staffing schedules
- Survey results and deficiencies
- Policies and training logs

They look for inconsistencies, omissions, or red flags that point to system failures or substandard care.

3. Causation and Damages

In addition to identifying whether a breach occurred, experts often weigh in on causation; that is, whether the facility's action or inaction contributed directly to the resident's injury, decline, or death. Their opinion can help link, or disconnect, the facility's conduct from the alleged damages.

4. Expert Reports and Testimony

Depending on the case, expert witnesses may provide:

- **Written reports** summarizing their findings and opinions
- **Deposition testimony** to explain their conclusions under oath
- **Trial testimony** to help the judge or jury understand clinical and regulatory complexities

A credible, experienced expert delivers **clear, unbiased, and well-supported opinions**. Courts and juries rely heavily on their ability to communicate complex issues in an understandable way.

5. When to Involve an Expert

Early engagement is highly beneficial. An expert can:

- Assist with case screening and viability analysis
- Help shape discovery requests
- Identify missing or altered records
- Guide deposition strategy
- Spot overlooked regulatory violations

Engaging an expert during the **pre-litigation or early discovery phase** can significantly strengthen a case and save time and resources.

Key Takeaway:

An expert witness is more than a consultant. They are a vital part of the litigation team who can explain what happened, why it matters, and whether it met the standard of care.

Red Flags in Nursing Home Records

Nursing home medical records are central to any case involving allegations of neglect, abuse, or substandard care. These records can either support or undermine a legal claim, depending on their accuracy, completeness, and consistency. Experienced attorneys and expert witnesses are trained to identify specific “red flags” that may indicate problems in care delivery or documentation practices.

1. Gaps or Inconsistencies in Charting

Documentation should reflect continuous, consistent care. Gaps may suggest missed care or retroactive charting.

Warning signs:

- Large time gaps between nursing notes or vital signs
 - Missing shift documentation
 - Sudden drop-off in notes leading up to an incident
 - Entries clustered at the end of a shift or with identical time stamps
-

2. Repetitive or Boilerplate Entries

Copy-and-paste or pre-filled templates may indicate that staff are not documenting the residents’ actual condition or changes over time.

Warning signs:

- Identical language across multiple days or shifts
 - Notes that do not reflect significant changes in status
 - “Resident resting comfortably” documented during a known medical crisis
-

3. Delayed or Missing Incident Reports

When a fall, injury, or medical event occurs, the facility must document it and follow a reporting process. Delays can raise questions about whether the incident was initially concealed or mishandled.

Warning signs:

- Incident report created days after the event
 - No physician or family notification documented
 - Lack of post-incident assessment or monitoring
-

4. Inconsistent Vital Signs or Weight Documentation

Vital signs and weights should be monitored regularly and show trends over time. Missing data or suspiciously normal readings can indicate that assessments were not truly performed.

Warning signs:

- Long gaps in weight or blood pressure records
 - Vital signs identical across multiple days or residents
 - No explanation for significant changes in values
-

5. Infrequent or Vague Progress Notes

Progress notes are a window into the residents' condition and how staff respond to issues. Sparse or vague notes may suggest inadequate monitoring or care.

Warning signs:

- "No change in condition" documented repeatedly despite decline
 - Lack of physician follow-up when clinical indicators worsen
 - Minimal nursing assessment before a hospitalization or death
-

6. Discrepancies Between Records and Outcomes

When the documentation indicates a stable condition, but the resident experienced a serious decline, it may point to missing or falsified information.

Warning signs:

- Charting suggests the resident was ambulatory, yet a fall occurs
- Pressure injury documented as healing, followed by hospitalization for sepsis

- Food intake logs marked as adequate during a period of weight loss
-

7. Altered or Backdated Entries

Electronic records often include audit trails that show when an entry was made versus when the care was delivered. Backdated entries may be an attempt to cover up missed care.

Warning signs:

- Handwritten corrections or additions without initials or dates
 - Entries added after litigation begins
 - Discrepancies between paper and electronic records
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Identifying these red flags helps attorneys and experts challenge the credibility of the documentation and uncover potential breaches in care. Patterns of documentation issues may point to larger systemic failures within the facility.

How Attorneys Can Strengthen Their Cases

Whether representing the plaintiff or defense, attorneys handling nursing home cases must develop a strategic, evidence-based approach. Leveraging documentation, regulations, expert insight, and practical tools can make the difference between a strong case and a missed opportunity.

1. Know the Regulatory Landscape

Stay familiar with:

- Federal regulations (42 CFR §483) — particularly the Requirements for Participation
- State-specific nursing home regulations and licensure rules
- Survey findings, including deficiencies, Plans of Correction, and complaint investigations

Tip: Use publicly available CMS reports and inspection histories to evaluate a facility's regulatory track record early in your case.

2. Request Comprehensive Records Early

Request all relevant records promptly and thoroughly. Consider asking for:

- Complete medical records (not summaries)
- Minimum Data Set (MDS) and care plans
- Medication Administration Records (MARs)
- Nursing and CNA notes
- Incident/accident reports and investigation files
- Staffing schedules and timecards
- Abuse reports and investigations
- Survey results and deficiencies
- Facility policies and procedures

Tip: Look for discrepancies between the care provided and what was documented or required by facility policy.

3. Involve an Expert Early

Engaging an expert early in the case allows for:

- Preliminary case viability assessment
- Identification of weak points or strengths
- Focused discovery tailored to care failures
- Expert input during depositions and mediation

Tip: A qualified expert witness can also help spot red flags and regulatory violations you might otherwise overlook.

4. Align Claims with Breach and Causation

To succeed, a case must show:

- **Duty:** The facility owed a duty to the resident.
- **Breach:** The standard of care was not met or violated.
- **Causation:** The breach contributed directly to the harm.
- **Damages:** The resident suffered an injury or loss.

Tip: Use the facility's own documentation, internal policies, and regulatory requirements to build the narrative.

5. Evaluate the Facility's Systems

Don't focus solely on the individual incident. Assess whether the event reflects broader systemic failures, such as:

- Chronic understaffing
- Inadequate supervision or training
- Repeated survey citations for similar issues
- A history of complaints or adverse events

Tip: System failures can support arguments for punitive damages or corporate liability in certain jurisdictions.

6. Humanize the Resident

Use depositions, interviews, and photos to show who the resident was before the injury. This can:

- Clarify the level of dependency and risk
- Emphasize how the injury impacted quality of life
- Counter generic “inevitable decline” defenses

Tip: Family testimony and staff statements can be powerful tools to illustrate neglect or quality care.

Attorneys who approach these cases with a working knowledge of nursing home standards, documentation practices, and regulatory frameworks are better positioned to advocate effectively. The most successful cases combine technical precision with a compelling narrative built around the resident’s experience.

Conclusion and Call to Action

Nursing home cases are uniquely complex, requiring a firm grasp of clinical care, federal and state regulations, facility operations, and human dignity. For attorneys, understanding the standards of care, and how to identify breaches, is essential to navigating these cases effectively.

Whether you're representing a client alleging neglect or defending a facility's care decisions, the ability to:

- Interpret regulatory requirements,
- Evaluate documentation critically,
- Recognize systemic care issues, and
- Leverage expert insight

is crucial to building a persuasive case.

Action Steps for Attorneys:

1. **Deepen Your Knowledge**
Stay current on changes to nursing home regulations and enforcement trends.
 2. **Build Your Team Early**
Engage a qualified expert witness early to guide strategy and discovery.
 3. **Focus on the Evidence**
Request complete, unfiltered records, and scrutinize them for red flags.
 4. **Develop a Narrative**
Show how the breach occurred, why it mattered, and how it impacted the resident.
 5. **Connect Standards to Outcomes**
Use policies, regulations, and documentation to link care failures to injury or death.
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Need Help with a Case?

As a seasoned expert in nursing home operations and compliance, I assist attorneys nationwide by:

- Reviewing records for standard of care violations
- Providing objective, defensible opinions
- Preparing expert reports and offering deposition/trial testimony
- Advising on facility systems, staffing, and regulatory context

If you're evaluating a nursing home case and want clarity on whether the standard of care was met, let's talk.

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