Instructor	**Professor Thaddeus Mason Pope**
Course Title	**Health Law: Quality & Liability**
Format	**Take Home Final Exam**
Total Time for Exam	**24 hours**
Total Number of Pages	**21 pages**

Reference Materials Allowed

Open Book (all reference materials allowed)

Take-Home Exam Instructions

1. Please know your **correct Fall 2019 exam number** and include this number at the top of each page of your exam answer (for example, in a header).

2. Confirm that you are using and have typed the **correct exam number** on your exam document.

3. You may download the exam from the course CANVAS site any time after 12:01 a.m. on Wednesday, December 4, 2019. All exam answers must be submitted within 24 hours of download. But, in any case, all exam answers must be submitted by the end of the final exam period, i.e. by 11:59 p.m. on Monday, December 16, 2019. Therefore, you will want to download your exam no later than 11:59 p.m. on December 15, to ensure that you have the full allowed 24 hours to complete your exam.

4. Write your answers to all parts of the exam in a word processor. Save your document as a **single PDF file** before uploading to CANVAS. Use your exam number as the name for the PDF file.

Instructions Specific to This Examination

GENERAL INSTRUCTIONS:

1. **Honor Code**: While you are taking this exam, you are subject to the Mitchell Hamline Code of Conduct. You may not discuss it with anyone until after the end of the entire exam period. It is a violation of the Code to share the exam questions. Shred or delete the exam questions immediately upon completion of the exam. They will be reposted after the end of the exam period.

2. **Competence**: Accepting this examination is a certification that you are capable of completing the examination. Once you have accepted the examination, you will be held responsible for completing the examination.

3. **Exam Packet**: This exam consists of **21 pages**, including this cover page. Please make sure that your exam is complete.

4. **Identification**: Write your exam number on the top of each page of your exam answer.

5. **Anonymity**: The exams are graded anonymously. Do not put your name or anything else that may identify you (except for your exam number) on the exam. **Failure to include your correct exam number will result in a 10-point deduction.**

6. **Total Time**: Your completed exam is due within 24 hours of downloading it. If your exam is uploaded more than 24 hours after downloading the exam, your exam grade will be **lowered by one point** for every minute in excess of the 24 hours. If the timestamp on your uploaded exam indicates that you have exceeded the 24-hout limit by more than 15 minutes, the situation may be referred for a Code of Conduct investigation and potential discipline. Please save sufficient time to successfully upload your exam.

7. **Timing:** The exam has been written as a three-hour exam. A student could write basically complete answers to all the questions in three hours. But since this is a take-home exam, you will want to take some extra time (perhaps one-half hour) to outline your answers and consult your course materials. You will also want to take some extra time (perhaps one-half hour) to revise and polish your answers, such that you will not be submitting a "first draft." In short, while this is a 24-hour take home, you really need not spend more than around five (5) hours on this exam.

8. **Scoring**: There are 100 total points on the exam. The final exam comprises 45% of your overall course grade. The points will be weighted accordingly.

9. **Open Book**: This is an OPEN book exam. You may use any written materials, including, but not limited to: any required and recommended materials, any handouts from class, PowerPoint slides, class notes, and your own personal or group outlines.

10. **Additional Research**: While you may use any materials that you have collected for this class, you are neither expected **nor are you permitted** to do any online or library research (e.g. on Lexis, Westlaw, Google, reference materials) to answer the exam questions.

11. **Format**: The exam consists of two (roughly equal) parts:

    PART ONE comprises thirty multiple choice questions.
    These are worth 2 points each, for a combined total of 60 points.

    PART TWO comprises one essay question.
    This is worth 40 points.

12. **Grading**: All exams will receive a raw score from zero to 100. The raw score is meaningful only relative to the raw score of other students in the class. Your course letter grade is computed by summing the midterm, final, and quiz scores. I will post an explanatory memo and a model answer to CANVAS a few weeks after the exam.

SPECIAL INSTRUCTIONS FOR PART ONE:

1. **Numbered List of Letters:** In your exam document create a vertical numbered list (1 to 30). Next to each number type the letter corresponding to the best answer choice for that problem.

2. **Ambiguity**: If (and only if) you believe the question is ambiguous, such that there is not one obviously best answer, neatly explain why immediately after your answer choice. Your objection must (i) identify the ambiguity or problem in the question and (ii) reveal what your answer would be for all possible resolutions of the ambiguity. I do not expect this to be necessary.

SPECIAL INSTRUCTIONS FOR PARTS TWO AND THREE:

1. **Submission**: In your exam document create clearly a marked separate section for your essay answer.

2. **Statutory Appendix:** For both your short and long essay answers, use the statutory appendix when a provision there is relevant to the analysis. The statutes in the Appendix preempt any other law that we may have discussed in the course. On issues not addressed by the statutes, Minnesota common law and the rules and principles discussed in the course apply.

3. **Outlining Your Answer**: I strongly encourage you to use at least one-fourth of the allotted time per question to outline your answers on scrap paper before beginning to write. Do this because you will be graded not only on the substance of your answer but also on its clarity and conciseness. In other words, organization, precision, and brevity count. If you run out of insightful things to say about the issues raised by the exam question, stop writing until you think of something. Tedious repetition, regurgitations of law unrelated to the facts, or rambling about irrelevant issues will negatively affect your grade.

3. **Answer Format**: This is very important. **Use headings and subheadings.** Use short single-idea paragraphs (leaving a blank line between paragraphs). Do not completely fill the page with text. Leave white space between sections and paragraphs.

4. **Answer Content**: Address all relevant issues that arise from and are implicated by the fact pattern and that are responsive to the "call" of the question. Do not just summarize all the facts or all the legal principles relevant to an issue. Instead, apply the law you see relevant to the facts you see relevant. Take the issues that you identify and organize them into a coherent structure. Then, within that structure, examine issues and argue for a conclusion.

5. **Citing Cases**: You are welcome but not required to cite cases. While it is sometimes helpful to the reader and a way to economize on words, do not cite case names as a complete substitute for legal analysis. For example, do not write: "Plaintiff should be able to recover under A v. B." Why? What is the rule in that case? What are the facts in the instant case that satisfy that rule?

6. **Cross-Referencing**: You may reference your own previous analysis (e.g. B's claim against C is identical to A's claim against C, because __." But be very clear and precise what you are referencing. As in contract interpretation, ambiguity is construed against the drafter.

7. **Balanced Argument**: Facts rarely perfectly fit rules of law. So, recognize the key weaknesses in your position and make the argument on the other side.

8. **Additional Facts**: If you think that an exam question fairly raises an issue but cannot be answered without additional facts, state clearly those facts (reasonably implied by, suggested by, or at least consistent with, the fact pattern) that you believe to be necessary to answer the question. Do not invent facts out of whole cloth.

Exam Misconduct

The Code of Conduct prohibits dishonest acts in an examination setting. Unless specifically permitted by the exam or proctor, prohibited conduct includes:

- Discussing the exam with another student
- Giving, receiving, or soliciting aid
- Referencing unauthorized materials
- Reading the questions before the examination starts
- Exceeding the examination time limit
- Ignoring proctor instructions

PART ONE
Multiple Choice Questions

- 30 Questions worth 2 points each
- Worth a combined total of 60 points

1. Hospitals screen potential employees in several ways, including through criminal history searches, drug testing, and credit history screening. There are business reasons for doing this screening. The following is the BEST legal reason:

A. To avoid liability under EMTALA.
B. To avoid direct liability, if other hospitals are doing this screening.
C. To avoid vicarious liability, if other hospitals are doing this screening.
D. There is no legal reason to do more screening than confirming a clinician's active license, because everything else has already been checked by the medical board.

2. Hospitals are legally responsible for the actions of independent contractors in the following situations:

I. The hospital retains direct control over the work leading to the injury.
II. An injury is the result of a non-delegable duty owed by the hospital to the patient.
III. The patient reasonably (though falsely) believes that the independent contractor is an employee of the hospital.

A. I only
B. I and II
C. II and III
D. I and III
E. I, II, and III

3. On December 2, 2019, Georgina's delivery was going slowly, though safely. So, without informing Georgina, Dr. Shuen performed an episiotomy, a surgical incision to enlarge the vaginal opening. As Georgina kept pushing, she began to tear. Yet, because she had an epidural, she could not feel anything from the waist down. Georgina was tearing with each push and ended up with a third-degree tear of the perineum. Dr. Shuen quickly sutured up the deep wound that Georgina did not even know she had. In fact, Georgina did not realize the extent of her injuries until three days later. If this jurisdiction has a 2-year statute of repose and a 3-year statute of limitations, Georgina must file a claim against Dr. Shuen by:

A. December 2, 2021
B. December 5, 2021
C. December 2, 2022
D. December 5, 2022

4. Use the same facts as in Question 3. But suppose that this jurisdiction has a 4-year statute of repose and a 2-year statute of limitations. If that were the law, then Georgina must file a claim against Dr. Shuen by:

A. December 2, 2021
B. December 5, 2021
C. December 2, 2023
D. December 5, 2023

5. Dr. Shuen makes $500 for a vaginal delivery on a weekday. But he makes $750 for a vaginal delivery on the weekend. To maximize his income by assuring more weekend deliveries, Dr. Shuen inserted induction agents into his patients without their knowledge or consent. Dr. Shuen is MOST definitely liable for:

A. Breaching his duty of informed consent
B. Medical malpractice
C. Battery
D. Abandonment

6. On the same facts as in Question 5, what additional sanctions might befall Dr. Shuen?

A. Revocation of his license
B. Loss of hospital privileges
C. Both A and B
D. Neither A not B, because double jeopardy prohibits the imposition of both civil liability and other penalties

7. Reasonable physicians everywhere swab a patient's skin with alcohol before giving an injection. Dr. Shah has failed to do that. If the patient does not subsequently develop an infection or other injury as a result, which of the following are TRUE?

I. Dr. Shah has breached the standard of care
II. Dr. Shah cannot be found liable

A. I only
B. II only
C. Both I and II
D. Neither I nor II

8. Dr. Goldman sent Kavita an email, promising that she would deliver her baby by C-section. But when the time came, Dr. Goldman proceeded with a vaginal delivery, consistent with the standard of care, and delivered a healthy baby. Kavita's breach of contract action will probably:

A. Succeed
B. Fail, because there was no breach of the standard of care
C. Fail, because breach of contract is not a valid cause of action against a physician
D. Fail, even if the merits are valid. Since the claim about not getting what was promised, it is preempted by ERISA.

9. To complete a Minnesota "health care directive" under Minn. Stat. 145C, you need:

A. An attorney
B. A judge
C. A notary
D. All the above
E. None of the above

10. Every adult in Minnesota (including you) should have a healthcare agent. You can generally appoint anyone you want, whether related to you or not. But under Minn. Stat. 145C.01 and 145C.03, you GENERALLY may not appoint:

A. Your current attending physician
B. Nurses at the hospital where you are being treated at the time
C. Someone under 18 years old
D. Any of the above (A, B, C) are allowed
E. None of the above (A, B, C) are allowed

11. Every adult in Minnesota (including you) should have a healthcare agent. You can generally appoint anyone you want, whether related to you or not. But under Minn. Stat. 145C, you generally may not APPOINT:

F. Your spouse
G. Your spouse if already separated
H. Your spouse if already divorced
I. All the above are permitted

12. Oncologists determined that knowing gender identity is a vital aspect of medical care. Therefore, in addition to asking patients what sex they were assigned at birth, Dr. Paz has a touchscreen system that asks them: "What is your gender identity?" "What is your sexual orientation?" "How do you want to be addressed? "What pronouns should we use?" Under the ACA section 1557 regulations, these questions are:

A. Prohibited
B. Permitted
C. Prudent
D. Required

13. In September 2019, the *New York Times* ran a story about "long term care hospitals" (LTCHs). Often patients who are discharged from acute hospital ICUs, yet still dependent upon mechanical ventilation, go to LTCHs. Must LTCHs comply with EMTALA?

A. No, if they have no ED
B. Yes, because they participate in Medicare
C. Yes, because they are licensed as hospitals
D. Both B and C

14. Compared to court litigation, arbitration is faster, cheaper, and more flexible. Plus, parties can select their own tribunal, which means they can get a decision maker with relevant specialized knowledge. Can hospitals and other healthcare facilities generally enforce pre-dispute arbitration agreements that preclude injured patients from obtaining redress in the courts?

A. No, such contracts violate public policy (*Tunkl*)
B. No, such contracts are unenforceable, because arbitration lacks the procedural safeguards and evidentiary rules of litigation
C. No, because the 7th Amendment to the U.S. Constitution provides that "Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved."
D. Yes

15. In November 2019, several U.S. District Courts issued injunctions, staying federal conscience-based objection regulations that were scheduled to become effective. If these stays are later lifted, then:

A. Objecting clinicians can exempt themselves from the actual provision of procedures like sterilization and abortion.
B. Objecting clinicians can also exempt themselves when their work has "any articulable connection" to a procedure to which they object.
C. Objecting clinicians can even decline to refer a patient to a provider that does not object.
D. A and B only
E. All the above

16. In October 2019, *JAMA Internal Medicine* reported that there is an escalation in openly racist and homophobic conduct by patients toward today's increasingly diverse healthcare workforce. Suppose a patient newly arrived in the ED yelled "I do not want that f*$!% doctor touching me." But the doctor in question is the only one available.

A. The doctor should examine the patient anyway, because EMTALA requires a screening.
B. The doctor should examine the patient anyway, because the ADA requires uniform treatment and the screening may reveal a disability.
C. The doctor may decline to treat this patient, so long as the doctor apprises the patient of the risks of waiting for another doctor.
D. The hospital should reassign the doctor, even if that makes the hospital complicit in furthering the patient's racism.

17. Which of the following are typically under the control of STATE government?

A. NPDB reports
B. Nursing board sanctions
C. Disqualification by a n ABMS specialty board
D. Adverse credentialing actions
E. None of the above

18. There is no evidence that aesthetic surgeon Dr. K was employed by Lake Health or that Lake Health exercised much control over Dr. K. Patient selected Dr. K to provide her care. She saw Dr. K outside the hospital. The hospital played no role in the formation of the relationship. If patient is negligently injured by Dr. K during surgery at Lake Health, patient can probably hold Lake Health:

A. Vicariously liable under respondeat superior
B. Vicarious liable under ostensible agency
C. Either A or B
D. Neither A nor B

19. Patient was injured by an independent contractor ED clinician in a state that does not recognize the non-delegable duty doctrine. Assume the patient failed to secure a qualified expert witness to testify against the ED clinician. Consequently, the court granted summary judgment in favor of the clinician. Should the court also grant summary judgment in favor of the hospital, if the plaintiff's theory against the hospital is vicarious liability?

A. Yes, the vicarious liability issue is moot.
B. No, the vicarious liability issue is not moot, because of ostensible agency.
C. No, the vicarious liability issue is not moot, because there may have been negligent credentialing.
D. Both B and C

20. Hospital ran an EEG on a child patient. The EEG showed a gross abnormality which required immediate treatment. But the hospital did not read the EEG for four days, thereby delaying treatment of the devastating condition. For an EMTALA screening claim in Virginia, the plaintiff's MOST important evidence is probably:

A. The standard of care in the United States
B. The standard of care in Virginia
C. That the hospital read other EEGs more promptly
D. That reasonable, prudent, comparable hospitals read EEGs more promptly

21. Which of the following is NOT an appropriate use of *res ipsa*?

A. Burn on patient's calf after a cesarean
B. Amputation of the wrong toe on the wrong foot
C. A case where the expert cannot pinpoint an act of negligence, yet testifies that damage to the nerve does not ordinarily happen without negligence
D. A or B
E. These are all probably appropriate uses

22. For an EMTALA claim for damages, the plaintiff must establish:

A. A violation of the statute
B. Injury/harm
C. Causation
D. All the above

23. The EMTALA statute says that it applies to any individual who "comes to" the emergency department. Plaintiff alleges that language means "the act of going to, approaching." If plaintiff is in an Uber heading toward the hospital about 1 mile away, does EMTALA apply?

A. Yes
B. Yes, but only if the patient has an emergency medical condition
C. Maybe. The statute is ambiguous, and the court can interpret the language.
D. No. The agency has construed the statutory meaning of hospital property, and courts generally defer to agency interpretation.

24. Unlike Minnesota, some states regulate informed consent by statute. For example, Arkansas provides: "plaintiff shall have the burden of proving that . . . the medical care provider did not supply that type of information regarding the treatment, procedure, or surgery as would customarily have been given to a patient in the position of the injured person . . . by other medical care providers with similar training and experience at the time of the treatment, procedure, or surgery."

A. This is the same disclosure standard as Minnesota and DC
B. This is the same disclosure standard as Wisconsin and Indiana
C. This disclosure standard does not fit or map onto the two leading disclosure standards in the United States
D. This is a more demanding disclosure standard than in most states

25. Molly and Bob delivered a baby in Saint Paul. But the baby later died from a serious disease that the clinician negligently failed to identify. Molly and Bob brought an informed consent claim against the clinician but, when confronted with their pro-life Catholic social media history, admitted that they would not have terminated the pregnancy even if they knew about the disease.

A. The claim fails, because the clinician has no duty to disclose information (like the existence or risks of the serious disease) about which she is actually unaware.
B. The claim fails, because there is no causation.
C. Both A and B
D. Neither A nor B

26. Dr. Furrow is employed as a claims-reviewer for Aetna in Iowa. He reviewed a treatment authorization request from Stacy's physician, Dr. Schwartz, yet decided to deny Stacy coverage for an important therapy that she needed. Because Stacy could not otherwise afford the therapy, she was injured as a result. Stacy's lawyer obtained an expert who reviewed Dr. Furrow's notes. Stacy's expert can clearly establish that Dr. Furrow did not use the correct guidelines and otherwise deviated from the standard of care in assessing Stacy's claim.

A. Stacy has a plausible medical malpractice claim against Dr. Furrow.
B. Stacy has a plausible claim against Aetna, since it is vicariously liable for Dr. Furrow's malpractice.
C. Both A and B
D. Neither A nor B

27. On the facts in Question 26, if Stacy had a direct liability claim against Aetna, it would likely be preempted by ERISA. If it were, Stacy could still recover:

A. The value of the denied therapy
B. Tort damages for personal injuries caused by the wrongful denial
C. Punitive damages, if the denial were willful or reckless
D. More than one of the above
E. All the above

28. Which of the following are clear indicators of the existence of a treatment relationship?

A. Prescribing medication to patient
B. Ordering tests for patient
C. Receiving payment for services from patient
D. Emailing patient that you agree to examine their knee
E. Texting patient that you agree to examine their knee
F. A, B, and C
G. A, B, C, and D
H. All the above

29. Colleen, a Jehovah's Witness, explicitly disclaimed the use of any blood products during her labor or thereafter. Following a c-section delivery, her blood pressure dropped. Ultimately, clinicians determined that Colleen's blood would simply not clot unless blood transfusions were administered. Clinicians did not administer blood transfusions, and Colleen died in the hospital. It was the standard of care to administer blood transfusions. That would have probably prevented Colleen's death. Her family brought a malpractice claim. That claim will PROBABLY:

A. Succeed, because the plaintiff can establish duty, breach, injury, and causation
B. Succeed, because of the emergency exception to informed consent
C. Both A and B
D. Fail

30. Spine surgery entails significant medical malpractice risk. 80% of surgeons will face at least one claim by the time they are 45 years old. In which of the following types of complaints is the plaintiff LEAST likely to need an expert witness:

A. Nerve injury
B. Lack of informed consent
C. Foreign body after surgery
D. Technical or judgment

PART TWO
Essay Question

- 1 Question worth 40 points.
- Please use the Exam Statutory Appendix when it is relevant. Otherwise, Minnesota common law applies.
- Please limit your response to 2500 words.

Your Role

Your firm has been retained by a nursing home operator, Symphony Square Systems (SSS), to provide legal advice in three areas:

(1) What is SSS's outstanding exposure both to civil liability and to regulatory sanctions based on past conduct?
(2) What actions should SSS take **immediately** to mitigate additional legal or financial risk? For example, what should SSS stop or start doing now?
(3) What other actions should SSS take **as soon as possible** to eliminate or mitigate additional (less serious) legal risk?

General Background on Nursing Homes

Each day in the United States, roughly 1.5 million individuals receive care from approximately 16,000 nursing homes. These individuals have high levels of physical and cognitive impairment and often lack family support and financial resources. As such, these are among the frailest and most vulnerable individuals in the U.S. health care system. We spend roughly $170 billion on nursing home care annually. This sector is heavily regulated at the state and federal levels. Yet, serious quality issues persist.

As the saying goes, "you get what you pay for." Due in part to the exclusion of long-stay nursing home services from the Medicare benefit, Medicaid is the dominant payer of nursing home services. Unfortunately, Medicaid payment rates are typically just 75% of private-pay prices. In many states, the average "margins" for Medicaid residents are negative, meaning that the cost of treating Medicaid residents exceeds the amount that Medicaid reimburses for their care. Low or negative margins for a substantial portion of a nursing home's population strongly incentivizes facilities to economize to lower the costs of care.

Despite the Medicaid reimbursement challenge, nursing homes can remain economically viable because their overall payment mix also includes private payers and Medicare. While most nursing homes deliver chronic care services for long-stay residents (reimbursed primarily by Medicaid), they

also care for post-acute patients following a hospital stay.[1] Post-acute Medicare payments and non-public insurer payments keep facilities afloat financially, especially in the context of parsimonious Medicaid payments.

Labor is the dominant input into the production of nursing home care, accounting for roughly two-thirds of nursing home expenditures. Nursing homes staffs are comprised mostly with registered nurses (RNs),[2] licensed practical nurses (LPNs),[3] and certified nurse aides (CNAs).[4] Higher nursing home staffing is associated with better quality of care. Conversely, nursing homes with low staffing levels, especially low RN levels, tend to have higher rates of poor resident outcomes such as pressure ulcers, catheterization, lost ability to perform daily living activities, and depression.

Higher staffing levels may also improve working conditions, which would increase job satisfaction and reduce nursing turnover and burnout. Nursing home staff, especially CNAs, have very high turnover. Commonly, nursing homes have their entire set of CNAs change multiple times within a single calendar year. Research has found that nursing homes with higher staff turnover have worse quality.

Factual Investigation Findings

SSS runs seven nursing homes with nearly 900 beds, including Alzheimer's Acres (AA) and Bedpan Alley (BA). Each facility has a license and an on-site administrator. These administrators are employed by and report to the SSS executive management team. Total operating revenue is $45 to $50 million. While for-profit companies own 70% of U.S. nursing homes, SSS is a non-religious, nonprofit organization. Each of its seven facilities receives about 55% of its revenue from Medicaid, 20% from Medicare, and 25% from private and other payers.

SSS recently acquired these two nursing homes (AA and BA) from another operator. The due diligence (conducted by a different law firm) during the acquisition process was incomplete. SSS only discovered this, two months ago, when it hired a new compliance officer to review current and past practices at AA and BA. After conducting some interviews and after reviewing records, the compliance officer discovered the following.

1. Business Practices at AA, BA, and Other Facilities

Like about 90% of nursing homes in the United States, SSS requires patients to sign a pre-dispute arbitration clause as part of their application. The relevant language provides: "any and all claims or controversies arising out of or in any way relating to . . . Resident's stay at [facility] . . . will be

[1] Medicare.gov, *Skilled Nursing Facility (SNF) Care*, https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
[2] An RN typically has completed, at minimum, a two-year degree or three-year diploma. Many RNs have four-year college degrees.
[3] LPNs have about a year of nursing education, often culminating in a certificate.
[4] Nurse aides do not have a license to practice professional or practical nursing. They may assist with meal delivery, mobility, providing support, using bathroom facilities, etc. They must pass a basic examination on five nurse aide skills.

resolved through binding arbitration rather than a lawsuit." If a nursing home applicant refuses to sign the arbitration agreement, then their application for residency in the nursing home is denied automatically. Fortunately, most residents fail to even notice the arbitration agreement in the rather thick stack of pre-admission paperwork.

Under the Obama administration, CMS prohibited nursing homes from either demanding pre-dispute arbitration clauses or requiring arbitration as a term of admission. CMS determined that such practices were "fundamentally unfair" and that it "is almost impossible for residents or their decision-makers to give fully informed and voluntary consent to arbitration before a dispute has arisen." *American Health Care Association v. Burwell*, No. 3:16–CV–00233 (N.D. Miss. Nov. 7, 2016).[5] Nevertheless, it is unlikely that this rule ever affected SSS. Nursing home trade organizations almost immediately filed suit and obtained a preliminary injunction. Then, in 2017, the Trump Administration issued a new rule, revoking the Obama ban.

Already, experts believe that more than a million nursing home residents are bound by mandatory arbitration clauses. Studies suggest that when nursing homes arbitrate a claim, the claim costs about 10% less than a civil lawsuit and takes three months less to resolve. Under the Federal Arbitration Act pre-dispute arbitration clauses are "valid, irrevocable, and enforceable." 9 U.S.C. § 2. The U.S. Supreme Court has interpreted the FAA as articulating a strong federal policy favoring the arbitration of disputes. *Southland Corp. v. Keating*, 465 U.S. 1 (1984).

2. AA and George King

From 2012 to 2018, AA employed George King (now 73 years old) as a nursing assistant. Between 2012 and 2017, AA had suspended King four times while county government officials investigated accusations of sexual abuse. Each time, officials ultimately decided not to file charges, and King resumed working for AA. However, on December 14, 2018, at around 4:00AM, a fellow caregiver saw King in the room of Sonya Fisher, a 98-year-old dementia patient. The caregiver saw King thrusting back and forth and knew that a sexual assault was occurring.

AA immediately terminated King's employment. Furthermore, because of the credible eyewitness testimony, King pleaded guilty to a second-degree criminal sexual contact with a mentally impaired or helpless victim. The judge sentenced King to nine years in prison. The SSS compliance officer's notes state: "It seems unlikely that the time King was caught and convicted (for the assault on Sonya Fisher) was the first time that he sexually assaulted a female resident."

During the criminal proceedings, particularly at the sentencing stage, prosecutors discovered that King had a long history of both domestic violence and violence of a sexual nature, including on his wife and daughter. This history spanned from 1986 to 1994. The U.S. Coast Guard had also discharged King for sexual misconduct that constituted a serious offense.

[5] In contrast, nobody opposes voluntary arbitration ***after*** a dispute. While some plaintiffs may want their day in court, others may choose arbitration as a means of reducing the cost and increasing the speed of a remedy.

Many of these prior incidents were public records that an employer would have readily discovered in a standard background check. The SSS compliance officer could find no record that AA ever ran one on King. To save on HR costs, AA had transitioned to a $10 online tool from its previous $85 "full service" background check that had included misdemeanor and felony criminal records searches at the county, state and national levels.

Finally, as part of the effort toward nursing home transparency and improvement, section 6121 of the 2010 Patient Protection and Affordable Care Act (ACA) requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff. The Secretary of the Department of Health and Human Services has discretion to require ongoing training programs for dementia management and abuse prevention if determined to be appropriate. While that mandatory training provision became effective at least by 2016, The SSS compliance officer could find no record that AA ever conducted such training.[6]

3. BA and Wesley Wilkinson

Wesley Wilkinson admitted his wife to BA, in 2015, when her dementia had progressed to a point that her care needs exceeded what he could offer at home. Wilkinson has written letters to the BA administrator complaining that when he visits his wife, he often roams the halls looking for an aide to help her. Everyone is so busy. He observes that all the on-site nurses and aides are "scrambling" to deliver meals, ferry bedbound residents to the bathroom, and answer calls for pain medication.

Notably, the aides perform a wide range of tasks. For example, they must help residents get dressed, bathe, and eat. There is confirmation for Wilkinson's observations. The SSS compliance officer's review revealed wide variability in BA staffing levels. On its best-staffed days, BA had one aide for every eight residents. On its lowest-staffed days, the ratio was 1 to 19. Payroll records show that on at least one day during each of the last six months, BA had no registered nurses at work.[7]

Wilkinson is distressed. Further, because he has been speaking to the Resident's Council, others likely share his views.[8] Wilkinson claims that because the nurses and aides are so busy, they overlook or seriously delay essential medical tasks such as repositioning a patient like his wife to avert bedsores. Consequently, Wilkinson contends that his wife has been hospitalized twice, even though both hospitalizations were avoidable.[9]

Apparently, Wilkinson's wife was not the only resident who failed to receive timely attention. The local hospital (to which BA typically transfers residents) has documented scores of BA residents

[6] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R168SOMA.pdf.
[7] On its best-staffed days, BA has a nurse to resident ratio of 1 to 16. On its worst days, the ratio was 1 to 27.
[8] https://theconsumervoice.org/issues/recipients/nursing-home-residents/resident-council-center.
[9] Wilkinson's letters and complaints focuses on medical risks. Yet, if these are delayed, then it is likely that feeding, bathing, and other tasks are also delayed or overlooked. As Wilkinson observes, nursing home Conditions of Participation impose duties to respect a range of resident rights.
https://www.medicare.gov/NursingHomeCompare/Resources/Resident-Rights.html.

who suffered from untreated bedsores, inadequate medical care, malnutrition, dehydration, preventable accidents, and inadequate sanitation and hygiene.

4. BA and Marlene Mino

As described above, BA had widely varying staffing levels. The low pay for aides (starting around $14.00 per hour) has made it difficult to recruit and retain staff. When staffing levels got too critically low, BA used a staffing agency to hire temporary independent contractor aides and nurses. One of these "temps" was Marlene Mino. BA tried to recruit Mino for a permanent position, but she found another job. BA wanted Mino, because, during her two months at BA, management perceived her as a miracle worker. She was able to accomplish so much, because she was so efficient by using labor saving practices.

For example, managing incontinence is labor-intensive, because it requires regularly scheduled toileting and bladder rehabilitation. It saves substantial staff time to use urethral catheterization. This entails inserting a tube (latex, polyurethane, or silicone) known as a urinary catheter into a patient's bladder via the urethra. Catheterization allows the patient's urine to drain freely from the bladder for collection. Incontinence is not the only labor-intensive task. It also takes a long time to hand feed residents with dementia. It is far more efficient to connect a feeding tube. Mino undertook both these measures with a number of BA residents.

Unfortunately, both these interventions are typically associated with a greater risk of morbidity and mortality. Urethral catheterization places the resident at greater risk for urinary tract infection and long-term complications (such as bladder and renal stones, abcesses, and renal failure). Similarly, feeding tubes can result in complications (such as self-extubation, infections, aspiration, misplacement of the tube, and pain). Furthermore, there is no record of the family's consent to these interventions. Almost none of these residents had decision-making capacity to consent on their own behalf. On the other hand, at least these residents did not experience delays like Wilkinson's wife. They did not have to wait for aides to toilet or to feed them.

5. AA, BA, and Other SSS Facilities

While 75% of SSS revenue comes from public payers, most of the other 25% is from private payers. SSS has been having difficulty collecting from some of these insurance companies. Therefore, SSS has received "assignments of benefits" from residents with employer-sponsored health and disability plans.[10] SSS has exhausted internal appeals processes with these insurers. These claims average $30,000 each for 33 residents.

[10] While the resident may not be the employee, they may still be a beneficiary under a spouse's or family member's plan. Allowing the Assignment of Benefits (AOB) allows healthcare providers "derivative standing" to deal directly with insurance companies. They "step into the shoes" of the beneficiary and assert claims on their behalf. This not only saves the ill or injured patient from dealing with overwhelming administrative processes but also prevents financial constraints from interfering in the treatment relationship.

The insurance companies claim that the residents engaged in illegal activity (like abusing opioids, drunk driving, or street violence) that resulted in the disabilities necessitating their nursing home care. Indeed, the residents' policies have exclusions for injuries resulting from drug or alcohol use, felonies, self-inflicted trauma, and "hazardous" behavior. But while these residents were arrested for such conduct, none were criminally charged or convicted.

Since the outstanding bills approach $1 million, SSS is eager to pursue reimbursement form these insurance companies. Furthermore, if SSS cannot secure coverage for these residents, then it must discharge them. The individual facility administrators plan to fill their beds with a "paying" resident.

Statutory Appendix

Exam Stat. 100

This state of rejects the existence of any "limited" treatment relationship as has been recognized in some jurisdictions, *e.g. Bazakos v. Lewis* (N.Y. 2009). Physicians either are in a treatment relationship with an individual, or they are not in a treatment relationship with that individual.

Exam Stat. 200

An action for health care liability must be brought within one year of when the cause of action accrues. Such action does not accrue until there has been either (a) discovery of the facts constituting the health care liability or (b) discovery of the facts that are sufficient to put a person of ordinary intelligence and prudence on an inquiry which would lead to such discovery.

Exam Stat. 300

A claimant must bring a health care liability claim not later than four years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within four years or they are time barred.

Exam Stat. 400

Punitive damages shall be allowed in civil actions only upon clear and convincing evidence that the acts of the defendant show deliberate disregard for the rights or safety of others. The court shall specifically review the punitive damages award and shall make specific findings.

Exam Stat. 500

The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

(a) Such failure was a proximate cause of the injury or death; or

(b) The health care provider's failure to follow the accepted standard of care deprived the patient of a chance of recovery or increased the risk of harm to the patient which was a substantial factor in bringing about the ultimate injury to the patient, the plaintiff must also prove, to a reasonable degree of medical probability, that following the accepted standard of care would have resulted in a greater than twenty-five percent chance that the patient would have had an improved recovery or would have survived.

Exam Stat. 700

In a civil action for damages, the plaintiff's contributory negligence, if any, which is 50% or less of the total proximate cause of the injury or damage for which recovery is sought, does not bar his recovery. However, the total amount of damages to which he would otherwise be entitled is reduced in proportion to the amount of his negligence. This is known as comparative negligence. If the plaintiff's contributory negligence is more than 50% of the total proximate cause of the injury or damage for which recovery is sought, the defendant[s] shall be found not liable.

Exam Stat. 800

In any case, claim or action for damages due to injury to or death of any person, brought against any physician and surgeon or other provider of health care, including, without limitation, any dentist, physicians' assistant, nurse practitioner, registered nurse, licensed practical nurse, nurse anesthetist, medical technologist, physical therapist, hospital or nursing home, or any person vicariously liable for the negligence of them or any of them, on account of the provision of or failure to provide health care or on account of any matter incidental or related thereto, such claimant or plaintiff must, as an essential part of his or her case in chief, affirmatively prove by direct expert testimony and by a preponderance of all the competent evidence, that such defendant then and there negligently failed to meet the applicable standard of health care practice of the community or a community substantially similar to the one in which such care allegedly was or should have been provided, as such standard existed at the time and place of the alleged negligence of such physician and surgeon, hospital or other such health care provider and as such standard then and there existed with respect to the class of health care provider that such defendant then and there belonged to and in which capacity he, she or it was functioning.

Exam Stat. 900

In contract or tort actions based on breach of contract, courts shall apply the doctrine of *contra proferentum*. Where a promise, agreement or term is ambiguous; the preferred meaning should be the one that works against the interests of the party who provided the wording.

END OF EXAM