White and Williams LLP

A Framework For Mitigating Liability Claims For Eldercare Facilities

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Introduction

The COVID-19 pandemic presents unique challenges to all aspects of the healthcare system, but particularly to eldercare facilities[1] that are composed of older, more vulnerable populations. White and Williams's healthcare attorneys have prepared a framework for developing strategies to best mitigate potential future liability claims.

The first section provides a broad overview of **civil immunity** in Delaware, New Jersey, New York and Pennsylvania. These statutes provide a roadmap for the categories of entities/providers and scope of actions that will potentially be immune from liability claims. Primary consideration should be given to ensuring that COVID-19 responsive policies, procedures and actions are consistent with, and encompass in word or spirit, the immunized conduct (*e.g.* "Purpose: COVID-19 hand washing policy in support of Pennsylvania's public health emergency response efforts").

Next, we outline the **immediate actions** that need to be taken to comply with state reporting and notification requirements with respect to eldercare facilities. The following section cites and summarizes the most recent federal and state **guidance for planning and treatment** of COVID-19 patients/residents in these types of facilities.

The last section of this framework synthesizes this information and provides **pre-litigation strategies** to best position facilities to defend future claims. We have included recommendations for new policies to comply with guidance on best practices; suggestions on how to avoid potential liability when allocating scarce resources; an analysis of the applicability of a crisis standard of care defense to eldercare facilities; and ways to create and preserve good evidence.

White and Williams has previously published alerts for eldercare facilities[2]. For more information, or if you have any questions, please contact any of the authors listed at the end of this document.

[1] For ease of reference, "eldercare facilities" encompasses Personal Care Facilities (PC), Assisted Living Facilities (ALF), Skilled Nursing Facilities (SNF) and other long-term care facilities.

[2] *See* "Coronavirus – Preparedness For Senior Living Communities And Nursing Homes" (3/17/2020) and "Nursing Homes and Long-Term Care Facilities: The Next Front Line" (4/9/2020)

Section I: Civil Immunity

The threshold question for future COVID-19 litigation will be whether eldercare facilities can claim immunity for alleged acts of negligence. At this time, there is no federal immunity for providers in eldercare facilities treating COVID-19 patients[3]. A bill is currently circulating in the U.S. Senate ("Facilitating Innovation to Fight Coronavirus Act") that would limit liability for actions taken by healthcare providers to combat COVID-19. As drafted, the legislation would shield healthcare providers from federal and state civil liability under certain circumstances, including testing and treatment of coronavirus patients; using a medical device for an unapproved use; practicing outside of a provider's specialty, but under the instruction of an individual who is licensed in that specialty; and providing care proved outside of the premises of a standard healthcare facility.

The applicable state immunities for Delaware, New Jersey, New York and Pennsylvania are outlined below. These immunities are untested in the courts, but the analysis is two-fold: (1) is the provider/entity included or contemplated by the class description? and (2) does the alleged negligent act/omission fall within the scope of immunized action? None of the state statutes immunize gross negligence, reckless or willful or wanton conduct.

Jurisdiction	Authority	Applicable to (Providers/Entities)	Covered Actions
Delaware	Emergency Health Powers Act Del.Code Ann. 20 § 3131 et. seq. Emergency Declaration (3.12.20)	"any private person, firm or corporation or employee or agent of such [. . .] who renders assistance or advice at the request of the State [. . .] under the provisions of this subchapter [. . .]" See Del.Code Ann. 20 § 3144.	"Facilities serving older adults, including skilled nursing facilities, assisted living facilities, hospice providers, and rehabilitation facilities with older patients should [. . .]" followed by list (a-k) of COVID-19 precautions and recommendations to be implemented See, Emer. Dec, para. 8.
New Jersey	S-2333/A-3910	"a health care professional" and "health care facility or a health care system that owns or operates more than one health care facility"	"injury or death alleged to have been sustained as a result of an act or omission by the health care professional in the course of providing medical services in support of the State's response to the outbreak of coronavirus disease during the public health emergency and state of emergency declared by the

[3] There are federal immunities related to administrations of vaccines and use of medical devices approved for treatment of COVID-19 patients. It is unlikely that either of these protections would be applicable to other forms of care in a residential or long-term eldercare setting.

Jurisdiction	Authority	Applicable to (Providers/Entities)	Covered Actions
			Governor in Executive Order 103 of 2020" and "a health care facility or a health care system that owns or operates more than one health care facility . . . for injury or death"
New Jersey	Executive Order 112 (3.9.20)	*"Healthcare facilities"* – any non-federal institution, [. . .] that is used, operated or designed to provide health services, [. . .] nursing, rehabilitative, or preventive care to any person. [. . .] including [. . .] long term care facilities [. . .]. See, N.J.S.A. 26:13-2.	"[. . .] act or omission undertaken in good faith in the course of providing services in support of the State's COVID-19 response [. . .]. See, EO 112, para. 9.
New York	Public Health Law Article 30-D (Emergency or Disaster Treatment Protection Act)	Healthcare professionals and healthcare facilities. The term 'healthcare facility' means a "hospital, nursing home, or other facility licensed or authorized to provide health care services for any individual under article twenty-eight of this chapter, article sixteen and article thirty-one of the mental hygiene law or under a COVID-19 emergency rule." Public Health Law 3801	"any health care facility or health care professional shall have immunity from any liability, civil or criminal, for any harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services" immunity "shall not apply if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care professional providing health care services" Public Health Law 3802
New York	Executive Order 202.10 (3.23.20 – 4.22.20)	All [. . .] licensed registered professional nurses and licensed practical nurses, who provide medical services in support of the State's response to the COVID-19 outbreak.	Civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional. Includes immunity from record keeping requirements as

Jurisdiction	Authority	Applicable to (Providers/Entities)	Covered Actions
		See, EO 202.10.	necessary to respond to emergency. See, EO 202.10.
Pennsylvania	Emergency Management Services Code 35 Pa.C.S. §7101, et. seq.	"[. . .] any person, firm, corporation or an agent or employee of any of them engaged in disaster services activities, while complying with or attempting to comply with this part or any rule or regulation [. . .]" See 35 Pa.C.S. §7704.	*"Emergency services."* —The preparation for and the carrying out of functions [. . .] include, without limitation, [. . .] medical and health services, [. . .] emergency welfare services, [. . .]. See 35 Pa.C.S. §7102.

Section II: Immediate Actions

COVID-19 Reporting Guidelines for ALFs

Jurisdiction	Reporting Obligation
Federal	**Required** to report to state and local health departments; forthcoming requirement to report to the Centers for Disease Control and Prevention (CDC) and to notify residents and their representatives
Delaware	**Required** reporting to the Division of Long Term Care Residents Protection
New Jersey	**Required** reporting to the Department of Health and local officials
New York	**Recommended** reporting to the Department of Health
Pennsylvania	**Recommended** reporting to the Department of Health

1. Federal: REQUIRED

Current Centers for Medicare & Medicaid Services (CMS) regulations and CDC guidance recommendations specify that a nursing home must notify state and local health departments about residents or staff with suspected or confirmed COVID-19 cases. See, *e.g.*, 42 CFR 483.30. On Sunday, April 19, 2020, CMS issued a notification that it will soon require reporting of both confirmed COVID-19 cases, as well as instances of Persons Under Investigation. CMS anticipates issuing specific direction on standard formatting and frequency for reporting this kind of COVID-19 information through the CDC's National Health Safety Network system.

Additionally, the April 19, 2020 CMS announcement advises that it will soon be requiring skilled nursing facilities to notify residents and their representatives about COVID-19 conditions at the facility. When the forthcoming requirements are in place, nursing homes will be required to inform residents and their representatives within 12 hours of the occurrence of a single confirmed infection of COVID-19. They will also have to notify residents and representatives if three (3) or more residents or staff with new-onset of respiratory symptoms arise within 72 hours. Further, the future regulation will require weekly updates to residents and their representatives. Facilities will be required to report information on what the facility is doing to prevent, mitigate and otherwise reduce the risk of transmission, including any alterations of normal operations within the facility.

2. Delaware: REQUIRED

Under Title 16 of the Administrative Code (Health and Safety), all "reportable incidents" must be reported to the Division of Long Term Care Residents Protection within 8 hours of the occurrence of the incident. (See, CDR 16-3000-3225 section 19.5.6.) Reportable incidents, according to section 19.7.10, include epidemic outbreaks or quarantines (defined as occurrence in persons of a defined area "of cases of an illness of similar nature clearly in excess of normal expectancy" in CDR 16-4000-4202 section 1.0).

3. New Jersey: REQUIRED

Assisted living facilities have a duty to report any cases of COVID-19. Under NJSA 26:13-4(b), a healthcare provider "shall report to the department and to the local health official all cases of persons who harbor or are suspected of harboring any illness or health condition that may be reasonably believed to be potential causes of a public health emergency." The report shall include the specific illness or health condition that is the subject of the report and a case number assigned to the report that is linked to the patient file in possession of the healthcare provider or medical examiner, along with the name and address of the healthcare provider or medical examiner. NJSA 26:13-4(d).

Assisted living facilities are **required to notify residents, families, visitors and staff** of an outbreak of a contagious disease at the facility. Under NJSA 26:2H-12.87, each long-term care facility is required to develop an outbreak response plan that includes the protocol for informing such people of an outbreak.

4. New York: RECOMMENDED

New York requires physicians "to report to the city, county, or district health officer…the full name, age and address of every person with a suspected or confirmed case of a communicable disease" or any outbreak of a communicable disease, including COVID-19. Further, any cases that occur in a facility licensed under Article 28 of the Public Health Law must be reported to the state Department of Health. ALFs are specifically excluded from Article 28 by New York's Public Health Department, which states that an ALF is not a residential healthcare facility or general hospital licensed under Article 28.

ALFs are required to report the death of a resident to the Department of Health. There is no obligation to report an infectious or communicable disease absent a death. Consistent with the broader goal of assisting in the State's pandemic response efforts, we recommend ALFs report such instances to the Department of Health consistent with the process described above under the Public Health Law.

5. Pennsylvania: RECOMMENDED

COVID-19 is a reportable condition in Pennsylvania. All "healthcare practitioners" and "healthcare facilities" must report suspected COVID-19 cases within 24 hours. See, 28 Pa. Code. § 27.21a. Skilled nursing facilities fit within the regulatory definition of a "healthcare facility." Arguably, PCHs and ALFs are not so enumerated, but the non-exhaustive definition of healthcare facilities is broad enough to encompass PCHs and ALFs. We recommend PCHs and ALFs report COVID-19 patients to the Department of Health consistent with goals described in the Commonwealth's emergency proclamation; the Emergency Management Services Code; and recent guidance published by the Office of Long Term Living.

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Section III: COVID-19 Planning and Treatment Guidance

Federal agencies and states have promulgated guidance on planning and implementation of best practices for eldercare facilities. We have not seen divergence in the recommendations. The central issues addressed in these publications are: **symptom surveillance**, **infection control** and **reporting/notification**.

A. Federal Agencies

Agency	Title	Key Provisions
Centers for Disease Control and Prevention (**CDC**)	Long-Term, Home Health, and Hospice Care Planning Guide for Public Health Emergencies (2.1.16)	Topics: • situational awareness; • continuity of operations; • facility or agency operations; • **crisis standards of care**; • staffing; and • fatality management.
Centers for Medicare and Medicaid Services (**CMS**)	Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes (3.13.20)	Guidance: • **restrict visitation** of visitors and non-essential healthcare personnel except compassionate care situations; • cancel **communal activities**, meals; • screen residents and staff for fever and respiratory symptoms; and • advise any persons exiting the facility to isolate at home and **notify** the facility if they develop symptoms in 14 days. **Hospital transfers** not required for residents with suspected/ confirmed infection if: (1) resident does not require a higher level of care; and (2) facility can adhere to infection protocols.
Centers for Disease Control and Prevention (**CDC**)	Guidance for Retirement Communities and Independent Living (3.20.20)	Recommendations: • **communicate** signs and symptoms; • clean surfaces that are frequently touched; and • **assess risk-level** of community members. During an outbreak: • **inform** individuals who have been exposed and • connect with **local health department**.
Centers for Medicare and Medicaid Services (**CMS**) and Centers for Disease Control and Prevention (**CDC**)	COVID-19 Long-Term Care Facility Guidance (4.2.20)	Recommendations: • comply with CMS/CDC guidance related to **infection control**; • implement **symptom screening** for all; • ensure all staff are using appropriate **PPE** to the extent available; and

Agency	Title	Key Provisions
		• utilize separate **staffing teams** for COVID-19 positive residents and designate s**eparate facilities or units** to separate negative, positive and unknown status residents.
Centers for Disease Control and Prevention (**CDC**)	Key Strategies for Long-Term Care Facilities (4.15.20)	Concepts: • Keep COVID-19 from entering your facility by **restricting all visitors** and non-essential healthcare personnel and implementing symptom screening for all persons entering the facility; • identify infections early by **screening residents** regularly and **notify state and local health department** within 24 hours of any individuals with suspected or confirmed COVID-19; • prevent spread by cancelling group activities and ensuring residents where a **cloth face covering** whenever they leave their rooms; • if COVID-19 is identified in the facility, **restrict all residents to their rooms** and have healthcare personnel wear recommended **PPE for care of all residents**, including N95 or higher-level respirator/face mask, eye protection, gloves and gown; • **train staff** with putting on and taking off **PPE**; • **optimize current PPE** supply if shortages are anticipated including extended use; and • identify and manage severe illness for residents with suspected or confirmed COVID-19 including **isolation** in designated areas.

B. State Agencies

Jurisdiction/Agency	Title	Key Provisions
Delaware	Emergency Declaration (3.12.20)	Facilities serving older adults (SNF, ALF, hospice, rehab): • **screen and restrict** access of sick and exposed visitors; • practice hand hygiene for all persons; • make online methods of **face-to face communication** and phone calls available; • restrict **international travel** for staff; • monitor staff if exposed or recent out of state travel; • **monitor** symptomatic staff; • staff who develop symptoms should immediately stop working, put on a face mask and self-isolate at home; • staff who develop symptoms should inform the infection preventionist, their primary care doctor and the Division of Public Health;

Jurisdiction/Agency	Title	Key Provisions
		• **increase availability of alcohol-based hand sanitizers**, tissues, no-touch receptacles for disposal and facemasks at entrances, waiting rooms, and resident check-ins; • increase **signage** for vigilant infection prevention; and • clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
Delaware	Executive Order (4.15.20)	Modifies the State of Emergency Declaration to include Home Health Agencies and Personal Assistance Service Agencies to the list of regulated facilities. All nursing facilities, ALFs, and rest-residential facilities shall: • **check** the Division of Public Health **guidance** daily and adjust policies, procedures and protocols accordingly; • establish a cohort of staff assigned to care for residents with known or suspected COVID-19; • designate an observation area for newly admitted and readmitted residents for 14 days; and • designate an area for residents with known or suspected COVID-19. All staff must complete trainings developed by the Public Health Authority by **April 20, 2020**. All medical directors for Long-Term Care Facilities (LTFCs) must complete additional trainings developed by the Public Health Authority by **April 27, 2020**.
New Jersey	NJ Human Services Works to Protect & Help Maintain Continued Benefits Amid COVID-19 Outbreak (3.18.20)	Supporting Older Adults: • mobilizing nurse care managers at Medicaid health plans to **call high risk populations** to identify and address their critical needs including supplies such as durable medical equipment and food; • allowing older residents receiving prescription drugs through Medicaid or the state prescription drug assistance program (PAAD and Senior Gold) to refill their prescriptions early and receive **90-day supplies of maintenance medications**; • working with New Jersey county partners to ensure that those receiving **home-delivered** meals continue to have access to food; • partnering with counties to **end congregate dining** in senior centers while helping to ensure that participants continue to have access to food; • qorking with counties to support telephone outreach to seniors known to be socially isolated; • encouraging healthcare providers to use **telehealth** for routine visits, as appropriate; • working closely with community and institutional providers to ensure resident needs are met; and

Jurisdiction/Agency	Title	Key Provisions
		• conducting telephonic outreach for our most vulnerable residents seeking enrollment in social service benefits.
Pennsylvania/DHS Office of Long-term Living (OLTL)	"Coronavirus Disease 2019 (COVID-19) Operations Recc. for LTSS Providers"	Recommendations: • **exercise** and promote **hygienic** practices; • review your agency back-up plan and infection control procedures; • **report all suspected cases** of COVID-19 to the Department of Health and/or the participant's CHC-MCO; and • Contact OLTL before making changes to business practice whenever possible (*e.g.* restricting visitors)

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Section IV: Pre-Litigation Strategies

A. COVID-19 Policy Recommendations

Facility Type(s)	Targeted Compliance	Recommendations
PC/ALF, LTCF	Symptom Surveillance	• Educate/encourage visitors to stay away if sick and to practice strong hand cleansing practices. • Develop symptom and travel questionnaire to use at front desk for visitors.
LTCF	Symptom Surveillance	• Initiate and log daily temperature screening for all residents. • Develop protocol and process for results over 100 degrees.
PC/ALF	Infection Control	• Post signage re: good hand hygiene. • Develop/Maintain housekeeping schedule that includes increased attention to high touch surfaces.
LTCF	Infection Control	• Audit hand hygiene for all healthcare employees. • Develop/Maintain housekeeping schedule that includes increased attention to high touch surfaces and ensures that all symptomatic resident rooms are on a deep clean schedule. • Ensure housekeeping products are antiviral. • Create isolation unit for symptomatic residents with pending or positive COVID-19 testing. • Provide hand hygiene demonstration for non-clinical departments (admin, dining, housekeeping). • Post signage re: good hand hygiene.
ALT, LTCF	Infection Control	• Expand telehealth practices and ensure facilities have interactive audio and video telecommunications systems in place to limit the number of trips residents make to outside healthcare providers
ALT, LTCF	Communication/Reporting	• Develop plan to communicate any known infections to resident/patient populations, staff and family/visitors.
ALT, LTCF	Staff Safety	• Increase PAR of PPE • Provide hand hygiene demonstration for non-clinical departments (admin, dining, housekeeping).

B. Potential Liability: Federal Discrimination Claims

The majority of state and federal guidance on the liability of COVID-19 care contemplates the scope of immunity. One exception is a Health and Human Services (HHS) Bulletin from the Office of Civil Rights published on 3/28/20. The Bulletin was prepared, at least in part, in response to disability discrimination complaints filed by Alabama and Washington over proposed COVID-19 treatment rationing. The states complained that the proposed rationing plans discriminate against people with disabilities in violation of

federal law. The HHS Bulletin is provided "to ensure entities covered by civil rights authorities keep in mind their obligations under laws and regulations that prohibit discrimination on the basis of race, color, national origin, **disability**, **age**, sex, and exercise of conscience and religion in HHS-funded programs." The inclusion of age as a protected class has raised concerns that it may be difficult to untangle prognosis from age when distributing limited resources to COVID-19 patients. We recommend that any existing or proposed policies that address the allocation of scarce resources be carefully reviewed to ensure they are ethical, objective and non-discriminatory.

C. Potential Defense: Crisis Standard of Care

The COVID-19 pandemic has the potential to generate demand for healthcare resources that exceed available supply. When healthcare systems are unable to meet patients' needs at the level normally expected of a modern healthcare delivery system, providers may need to transition from prioritizing optimum care to every patient, and reallocate resources with the objective of doing the most good for the most people. This latter concept is known as a "crisis standard of care." The crisis standard of care is well-described in medical literature, but has never been tested in American courts.

Federal agency guidelines (*e.g.* CDC, FDA, etc.) and academic research, nearly all of which explicitly advocate for the adoption of a crisis standard of care when allocating scarce healthcare resources, typically contemplate ventilator shortages in the ICU. However, this alternative standard of care also applies to a broader category of healthcare shortages, including PPE, staffing and medicine. The Long-Term, Home Health, and Hospice Care Planning Guide promulgated by the CDC in 2016 defines crisis standard of care as follows:

> "[. . .] a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations."

See, *Long-Term, Home Health, and Hospice Care Panning Guide for Public Health Emergencies*, U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, February 2016, at p. 94.

The CDC Planning Guide recommends facilities develop management crisis standards of care to address the: reprioritization of medical resources; allocation, storing and restocking of medical resources; reprioritization of non-medical resources; and allocation, storing and restocking of non-medical resources. The CDC also recommends development of policies to address shortages of human resources (*i.e.* staff), the allocation of care and security plans to address unrest from residents/patients or family members if care has been denied.

If/when a transition to crisis care is necessary, facilities should have a plan to swiftly communicate the change to residents/patients and their families.

1. Civil Litigation

Many personal injury claims arising from healthcare provided during the pandemic may be barred by state immunity protections. Cases involving more extreme types of negligence (*i.e.* gross negligence, reckless, willful and wanton conduct, etc.) will not be afforded immunity under any of the existing state and federal statutes. In those cases, the "crisis standard of care" may provide a defense if the alleged negligence was the result of the scarcity of medical resources.

It is always risky to predict how courts will rule on a novel issue. Our preliminary review of litigation surrounding prior public health disasters (*e.g.* 9/11, Hurricane Katrina, BP oil spill, etc.) did not locate any readily analogous arguments. There was one New York trial court opinion that pushes back on broad (federal) statutory immunity in the context of H1N1 vaccinations. The New York plaintiff brought wrongful death claims against healthcare providers for failing to administer an H1N1 vaccine to an inpatient who eventually contracted the virus. See *Casabianca v. Mt. Sinai Med. Ctr.*, 2014 N.Y. Misc. LEXIS 5998*; 2014 NY Slip Op 33583(U). Defendants attempted to invoke immunity under the Public Readiness and Emergency Preparedness Act (PREP Act), which provides vaccine manufacturers, distributors and administers with immunity from tort liability during a public health emergency. The court denied immunity from suit, holding that the malpractice claim, *i.e.* failure to administer the vaccine, was discrete and separable from any injury related to receiving the vaccine, and "a cause of action in no way covered by PREP."

The H1N1 case is distinguishable because it occurred outside of an ongoing declared health emergency, but it demonstrates the potential for courts to reject a broad immunity in favor of separating incidents that occurred during an emergency from those that occurred *because of* the emergency. For instance, we would not expect courts to immunize claims that occur during the pandemic, but appear unrelated to supply shortages (*e.g.* premise liability or elopements). Incidents that are not directly related to COVID-19 infections, but may be impacted by staffing shortages (*e.g.* pressure wounds or unwitnessed falls) are more of a gray area. We suggest eldercare facilities keep detailed records of daily supply and staffing shortages caused by the pandemic in the event this defense needs to be raised. Understanding the externalities and articulating their impact on daily operations will be critical to mounting a crisis standard of care liability defense.

2. Regulatory Compliance

The pandemic is expected to create supply shortages that, generally, would be grounds for deficiency citations from state and federal surveyors. CMS's COVID-19 guidance contemplates the potential for scarcity of supplies in eldercare facilities and directs surveyors not to reflexively cite facilities for PPE supply shortages (*e.g.* gowns, N95 respirators, surgical masks and hand sanitizers) if the facilities are having difficulty obtaining these supplies for reasons outside of their

control. Surveyors who believe a supply shortage citation is appropriate are directed to contact the local CMS Branch Office before issuing such a citation.

CMS does expect facilities to take actions to mitigate any resource shortages and demonstrate efforts to obtain the necessary supplies as soon as possible. "For example, if there is a shortage of [alcohol based hand sanitizer], we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents." See CMS COVID-19 Guidance for Nursing Homes (3.13.20). We recommend detailed record keeping of all efforts to maintain sufficient quantities of necessary supplies.

Negligent staffing claims are common in nursing home litigation and staffing shortages are reasonably anticipated during the COVID-19 pandemic. As noted above, state and federal guidance for eldercare facilities unequivocally encourages sick workers to be sent home to isolate for two weeks. A staffing shortage attributable to the pandemic, like a supply shortage, implicates a transition to the crisis standard of care. Accordingly, we recommend detailed record keeping, including the cause for any missed shifts, in the event a crisis standard of care defense needs to be developed.

D. Creating Good Evidence

During the coronavirus crisis, it may well be impossible for some organizations to maintain strict compliance with the high standards of performance which, outside of the pandemic, were regularly maintained and adhered to. In some instances, shortages of space, supplies, equipment, personnel or capital liquidity may require prioritizing choices that were unimaginable a few weeks ago. The phrase, "*We're doing the best we can*," has become a common summation within organizations that have otherwise been long accustomed to upholding the highest hallmarks of excellence.

1. The Need to Memorialize "Best Efforts"

Within the kind of organizations that have long been the target of adverse attorneys – particularly, healthcare providers and healthcare product manufacturers – there are concerns that the shortcuts which may become absolutely necessary to do "the best we can" during these unbearable times may someday be assailed by attorneys advocating on behalf of grieving families, employees, vendors, customers or patients whose needs the organization is currently straining to meet during the COVID-19 outbreak. Even in the midst of the fatigue and frustration of the crisis – in fact, especially in the midst of this crisis – there are steps your organization can take today to preserve proof of your best efforts – steps that will put your organization in a better position tomorrow.

The goal is to preserve enough information today so that months or years down the line, when you or your colleagues may be called upon to explain why something "was" or "was not" done, you will have sufficient notes to remind you or refresh what otherwise might be fading recollections.

Organizations will want to be able to tell the honest, accurate story of how they faced shortages, challenges, shortcomings and even impossibilities while they gave their very best effort to do their jobs during the coronavirus pandemic. Organizations should take steps today to memorialize the details of what will eventually become the important account of overcoming the crisis as best as possible. Through notes, daily logs and regular communications to the person to whom you directly report, the organization can begin to paint the picture of the heroic efforts that its people are making at all levels of the organizational chart.

2. What to Memorialize

Most high-level performers are loathe to "make excuses" or "throw someone under the bus." Still, when coping with the COVID-19 situation, even the highest-level performers may need to document shortcomings caused by the virus or the precautions being taken to avoid it. The point of memorializing is not to point the finger of accusation or make the coronavirus the culprit for every organizational shortcoming, but rather the goal is to accurately record what the people, the shift, the department, the division – even the entire company – are doing to face real problems and overcome them.

For example:

- if your company is facing supply shortages, make a note to remind yourself of all the efforts you exhausted in trying to find new suppliers;
- if you are short-staffed or cannot backfill vacant positions, keep notes about all the efforts you have made to get the right number of qualified people; or
- if you have redeployed workers from non-essential duties to essential tasks on short notice, memorialize the steps you are taking to minimize the risk of any harm that could be occasioned by a someone performing new or unfamiliar tasks.

Beyond memorializing "why" a pre-coronavirus standard may have had to bend during the crunch, also keep track of the "above-and-beyond" performances in your company. The organizations most affected by the coronavirus and the social distancing necessary to overcome it are also the enterprises within which the most inspiring and heroic stories are beginning to grow. Who went the extra mile today? Who inspired someone else? Who helped a colleague swamped by work or overwhelmed by concerns at home? Who worked a double shift to fill in for someone who is quarantined at home? These are the kind of stories that need to be preserved. They are part and parcel of the bigger picture that needs to be preserved so that when people look back at what we are now going through, they will see that despite despicable circumstances, your organization did its best to do the right thing at each step of the way.

3. Use of the Attorney-Client Privilege

While the specific nuances of the scope of the attorney-client privilege and its exceptions and waivers differ among jurisdictions, generally speaking, communications to an attorney by a client asking for guidance or advice are privileged. Communications to your in-house counsel are just as

privileged as those to an outside attorney. When you seek an attorney's counsel after describing the details of your dilemma, your communication is privileged. An otherwise discoverable document does not become privileged merely by forwarding it to an attorney, but your specific communication – your email or memo – is privileged. That privilege can allow the writer to be more expansive and detailed with respect to the facts of their coronavirus conundrum.

Conclusion

Someday, almost certainly, you will be confronted by someone who will believe that your organization did not do enough. It may be a governmental department survey, a licensing agency, an accreditation bureau, a labor lawyer or a personal injury attorney. It may be someone who is well-intentioned, or it may be an avaricious exploitation of the times in which we live. Those organizations who plan for that day will fare much better when it comes.

Authors

Edward F. Beitz
Philadelphia, PA | Partner
beitze@whiteandwilliams.com
215.864.6277

Ed Beitz focuses his practice on medical malpractice defense. He defends doctors, nurses, physicians assistants and hospitals at the trial and appellate levels, as well as in general liability matters. Ed also handles excess insurance coverage matters.

Kevin C. Cottone
Philadelphia, PA | Partner
cottonek@whiteandwilliams.com
215.864.7108

Kevin Cottone, Chair of the firm's Healthcare Group, is an accomplished trial attorney with a practice devoted to defending catastrophic injury cases. Kevin's focus is representing medical, long-term and personal care providers in professional liability matters, as well as companies in toxic tort claims.

William D. Kennedy
Philadelphia, PA | Partner
kennedyw@whiteandwilliams.com
215.864.6816

As a trial and appellate litigator, Bill Kennedy defends a wide range of clients including healthcare provider professionals, senior care providers, manufacturers, pharmaceutical companies, real estate developers, lessors and lessees, supply chain companies, restaurants, bars and social hosts.

Beyond litigation, Bill has extensive experience in the senior housing industry. He has served on the Boards of Directors of non-profits that provide independent living, personal care, assisted living and skilled nursing around the country.

Patricia L. Luczak
Philadelphia, PA | Associate
luczakp@whiteandwilliams.com
215.864.6801

Patti Luczak focuses her practice on medical malpractice litigation and general liability matters. She represents hospitals, physicians, nurses and other healthcare practitioners against professional liability claims at the trial and appellate court levels.

Shaun Martinez
New York, NY | Associate
martinezs@whiteandwilliams.com
212.868.4831

Shaun Martinez represents corporations, insurance agencies and individuals in matters including negligence actions and contract disputes.

Stephen J. Milewski
Wilmington, DE | Partner
milewskis@whiteandwilliams.com
302.467.4502

Steve Milewski is an experienced trial lawyer who has been defending institutions, individuals and insurers in Delaware for over 10 years. He has had the opportunity to represent a wide array of clients, including hospitals and physicians in medical malpractice cases; high profile insurers in breach of contract, bad faith, and coverage disputes; educational institutions in premises liability and personal injury cases; and matters involving catastrophic injuries and death.

Dana P. Petrillo
Philadelphia, PA | Counsel
petrillod@whiteandwilliams.com
215.864.7017

Dana Petrillo advises and represents healthcare entities, including hospitals, health systems, physician practices, long-term care providers and payers, in a wide variety of complex regulatory, compliance and litigation matters.

Dana's experience includes ensuring clients' compliance with federal and multi-state healthcare laws and regulations including, Medicare, Medicaid, HIPAA, Stark, Anti-Kickback and False Claims Act laws and regulations. She has also represented numerous healthcare entities in investigations, audits, disputes and litigation related to compliance issues, medical necessity, coverage and reimbursement.

Roopa Sabesan
Wilmington, DE | Associate
sabesanr@whiteandwilliams.com
302.467.4538

Roopa Sabesan handles complex civil litigation, including the defense of physicians, other medical professionals and healthcare facilities in claims of medical and professional negligence. She also represents healthcare providers before the Delaware Board of Medical Licensure and Discipline, the Delaware Board of Nursing and other state boards and agencies.

Rafael Vergara
New York, NY | Partner
vergarar@whiteandwilliams.com
212.631.4416

Rafael Vergara's litigation practice focuses on defending insurance companies and other entities in lawsuits. Primarily, Rafael handles commercial disputes, insurance coverage issues, life insurance matters and representation in incidents at assisted living facilities or nursing homes. He also has experience in litigating cases involving individual disability insurance, ERISA, products liability, asbestos, and insurance broker liability.

Robert Wright
Newark, NJ | Partner
wrightr@whiteandwilliams.com
212.631.4402

Bob Wright has been a trial attorney for more than 30 years and has extensive jury trial experience in the areas of disability law, insurance coverage, medical malpractice, commercial disputes, healthcare, insurance fraud and general litigation. Bob also has significant experience in assisted living and nursing home regulatory and crisis management arising out of allegations of elder abuse.