The COVID-19 pandemic and resulting litigation present an existential threat to the long-term care (LTC) profession in the absence of enforceable immunity statutes and the insertion of COVID-19 exclusions in insurance policies.

LTC facilities remain on the front line of the fight against this deadly illness, caring for vulnerable residents while also striving to shield them from the novel virus. While the prevention and mitigation of infection spread remain the priority, COVID-19 litigation and the threat of it should be a part of the collective consciousness within the LTC industry. Facilities should be mindful of the steps they can take now to prepare for future litigation.

Here, we’ll examine the scope of COVID-19 litigation to date and address the steps companies can take in anticipation of future litigation.

Case Study
Mr. X was 91 years old with a complex medical history and diagnoses of dementia, atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. He was admitted to the skilled nursing facility (SNF) from the hospital in early February 2020.

Mr. X was a sociable resident, and he enjoyed group activities, walking in the hallways, and talking to other residents and staff. He often exhibited resistiveness to care and required frequent redirection and reassurance.

Due to the pandemic, the facility implemented a visitation restriction policy and ceased all group activities on March 14, 2020, with written communication to the facility members of its residents. The facility also began screening all staff and essential visitors who came to the facility per Centers for Disease Control and Prevention guidelines. It also initiated screening of all residents for COVID-19 signs and symptoms.

On April 1, Patients Y and Z became symptomatic, with elevated temperatures and productive coughs. Both cases were reported to the local department of public health, and both patients were placed in isolation with strict droplet precautions. The facility’s clinical leadership requested facility-wide COVID-19 testing, but they were advised by the local public health department that there were test kit shortages, and only symptomatic residents could be tested. Tests were administered on April 2, 2020, but due to a laboratory backlog the results did not come back until April 7, by which time an additional 29 residents and 16 staff were exhibiting symptoms — including Mr. X.

Staff illness and associated fear of the virus resulted in staffing challenges. Mr. X consistently refused to wear a cloth mask and continued to walk the hallways, despite frequent redirection and care planning to address his lack of adherence to the facility’s infection control protocols due to his dementia. He received a COVID-19 test on April 8, was confirmed positive on April 10, and had a desaturation episode on April 13, 2020. He was sent to the hospital, where he died on April 21. His death certificate lists acute respiratory failure and COVID-19 as the primary causes of death.

Mr. X’s children filed a lawsuit against the SNF, asserting causes of action for wrongful death, elder neglect, negligence, and willful misconduct. They allege that the facility failed to implement proper infection control protocols and procedures to prevent the entry of COVID-19 into the building and mitigate its spread thereafter. They also allege the facility was understaffed in April 2020, and this understaffing resulted in a failure to assess Mr. X’s deterioration and transfer him to a hospital sooner.

Status of Litigation
Countless lawsuits have been filed nationally; they generally claim facilities failed to implement a proper infection control program and failed to follow the applicable public health guidance, resulting in the entrance and subsequent spread of COVID-19 in the building.

Specific claims include alleged failures to use personal protective equipment (PPE) and implement testing, failures to cohort infectious residents, and failures to properly screen staff and residents. The lawsuits allege these failures resulted in the patients’ contraction of COVID-19 and subsequent death.

Immunity and the PREP Act
There is no carte blanche federal immunity for any and all COVID-19 claims against LTC facilities. Although some states have legislated for immunity, the extent of protection afforded is variable, and the majority of states have not.

However, there is specific immunity protection afforded under the federal Public Readiness and Emergency Preparedness Act (PREP Act).

Defenses Available
The central battleground in litigation to date has focused on the immunity offered under the PREP Act. The defendants argue there is immunity from suits afforded under the PREP Act because the facilities were “covered persons” engaged in “recommended activities” for “covered countermeasures” (including but not limited to the use of PPE and testing) during the COVID-19 global pandemic and national emergency. As such, the defendants argue they are immune from suits relating to the distribution, administration, and use of covered countermeasures.

The PREP Act provides a limited exception to its immunity protections: where defendants have engaged in “acts or omissions” that meet the specified definition of “willful misconduct.” In such cases, the plaintiffs must seek relief through a federal emergency fund or before a federal court in the District of Columbia.

In addition to the PREP Act, there are excellent causation defenses available in these cases. Asymptomatic and pre-symptomatic spread were not contemplated in the federal and state regulations implemented at the onset of the pandemic. Thus, irrespective of the infection control protocols implemented, it was virtually impossible to prevent the asymptomatic spread of infection in LTC facilities. Furthermore, various studies have shown that the presence and spread of infection among the greater community is a better indicator of the likelihood of facility spread than, for example, a history of prior deficiencies or omissions that meet the specified definition of “willful misconduct.”

Facilities should consider documenting a timeline of what they did and when (before, during, and after their COVID-19 outbreaks). Finally, many of the claims asserted by plaintiffs contain a higher burden of proof (elder neglect, willful misconduct, etc.). It will be difficult to overcome these burdens of proof, particularly in cases where dedicated health care workers put their own lives and the lives of their families at risk by coming to work every day and often working double shifts in an effort to care for the most vulnerable population in our country.

Insurance Coverage
Most insurance policies now include COVID-19 endorsements/exclusions. This will result in the denial of insurance coverage in most COVID-19 cases, so facilities will be uninsured and responsible for paying the costs to defend these cases, as well as paying the cost of any ultimate jury award or settlement. As such, this financial exposure could be significant.

Best Practices in Anticipation of Litigation
Communication and documentation are key. Facilities should consider documenting a timeline, at the request of their legal counsel, to outline what they did and when (before, during, and after their COVID-19 outbreaks). This is important because documentation during emergency operations may not be as robust as before, and things can be forgotten with the passage of time before a lawsuit is filed.

Everything relating to infection control should be documented and retained (in-service training, public health survey findings, PPE inventories and orders, etc.). All communication with local county and state public health departments should be retained centrally. Furthermore, where we have faced challenges — such as PPE, testing kit, or staffing shortages — the efforts taken to address these challenges should be clearly documented and retained.

Finally, transparent communication with residents, their families, and your staff is paramount. Maintaining open lines of regular communication may prove decisive when a family is considering litigation in future.

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Kim Cruz contributed to this story.