COVID-19: Legal Liability and Related Issues

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I. An Overview

Daily news reports on the Covid-19 virus leave no room for doubt that it has had a catastrophic impact on residents in Long Term Care Facilities ("LCTFs") and their families.[1] These individuals have suffered a far higher proportion of disability and death from the disease than the population at large, often as a result of the failure of these facilities to develop and implement adequate protective measures. These tragic outcomes among the most vulnerable members of our society at the hands of health care facilities which are often chronically understaffed and noncompliant with applicable standards and regulations will inevitably result in litigation.

Many states, including Virginia and Maryland, have responded by enacted statutes which provide immunity protections for nursing homes. Given significant expert costs, problematic causation issues, and evolving immunity protections, attorneys who take on Covid-19 cases will be confronted with many obstacles in pursuing such cases. Based on early research, the higher rates of infection are present in many of the larger, private nursing home chains with large Medicaid populations. While jurors may be willing to give healthcare providers a pass on Covid-19 infections that were unavoidable, nursing homes or assisted living facilities that failed to follow minimum regulatory standards or agency guidelines and allowed a large percentage of their residents to become infected will face significant liability.

II. The Demographics

At the present time, approximately 1.5 Americans reside in the nation's approximately 16,000 SNFs. Another 800,000 to 1 million additional Americans reside in ALFs and other senior residential communities.

As the pandemic is still unfolding, it is impossible to state with any accuracy how many deaths it has caused in LTCFs. Many nursing facilities have withheld their infection rates from the government and their own residents and family members. On April 19, 2020, the federal Centers for Medicare and Medicaid Services ("CMS") mandated that LTCFs provide information about the incidence of Covid-19 infections to the government and to their residents and family members.

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[1] The term "Long Term Care Facilities" is one used by the Centers for Disease Control and Prevention ("CDC") to refer to Skilled Nursing Facilities ("SNFs"), Assisted Living Facilities ("ALFs") and other senior residential care facilities.

Studies of prior virus contaminations have consistently shown that that infection rates in skilled nursing facilities are typically much higher than the standard population, with one study before Covid-19 showing a 28% exposure rate of influenza A, despite prior influenza vaccinations.[2] The Washington Post has created a data base tracking nursing facilities with Covid-19 cases.[3] The CDC conducted a study of an early, highly-publicized infection in a SNF operated in Washington State by Life Care Centers of America, which operates some 28 facilities nationwide, which revealed that the infection spread to 81 residents, 34 staff members with 23 deaths.[4] Based on the total number of residents, 121, the infection rate was 67%.

In the six states currently reporting deaths from Covid-19 in LTCFs, those deaths account for 50% of all of the virus-related deaths in those states. Other states have reported infection rates in nursing homes as high as 25%. In Virginia, nursing homes make up more than half of the total Covid-19 deaths in Northern Virginia. In Virginia, at least 50 patients have died at the Canterbury Rehabilitation and Healthcare Center in Henrico County, a 190-bed facility with a documented infection rate approaching 70%.[5] Other facilities throughout Virginia have high infection rates.[6]

CMS has promised to track data for nursing home infection rates, which can be viewed at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.'

III. Protecting the Rights of Your Clients – Early opt Out

In September 2016, the Obama administration added a regulatory requirement that LTCFs could not use mandatory arbitration provisions as a condition of admission to a SNF. 42 C.F.R. 483.70 (n). It should be noted that this regulation did not prevent the use of "voluntary" arbitration agreements, when not being used as a condition of admission. As a practical matter, most consumers in this context will sign whatever is put in front of them. Effective July 2019, this regulation was repealed by the Trump administration, which also decreased regulatory fines against nursing homes. In light of the U.S. Supreme Court's ruling in *Marmet Health Care Center Inc. v. Brown*, 565 U.S. 530, 132 S. Ct. 1201 (2012), the argument that these agreements are against public policy is no longer viable.

Most of the large chain nursing homes and assisted living facilities are making use of mandatory arbitration provisions. Not surprisingly, those larger chains have some of the highest

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[2] Infectious Disease Outbreaks in Nursing Homes, an Unappreciated hazard for Frail Elderly Persons https://academic.oup.com/cid/article/36/7/870/318878. The frequency and severity of infectious disease outbreaks in nursing homes often go unrecognized and unappreciated, even though these facilities provide an ideal environment for acquisition and spread of infection: susceptible residents who share sources of air, food, water, and health care in a crowded institutional setting

[3] https://wpinvestigative.github.io/nursing_homes_covid19/index.html

[4] https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm

[5] The *Washington Post* recently posted a listing of Covid-19 deaths in Maryland nursing homes with the highest number being at Sagepoint Nursing and Rehabilitation Center in La Plata, Maryland. As of May 7, 2020, that 165-bed facility had suffered 129 infections (a rate of 78%) and 34 resident deaths (a rate of 20%).

[6] Annandale Healthcare Center reported 27 patient deaths and one staff death due to COVID-19. The center has admitted 57 patients with the virus. Birmingham Green in Manassas has reported 20 deaths, with 41 total confirmed and suspected cases and some 28 infected staff members. Leewood Healthcare Center in Annandale has reported 17 deaths, but also had 3 admissions of Covid-19 patients. The Virginian in Fairfax has reported 10 deaths, although it admitted 13 patients with the Virus.

infection rates in the county. Patients or their legal counsel must evaluate the need to opt out of these agreements, especially if they practice in an opt out state like Virginia.

In Virginia, residents who suffer injury can also opt out of these jury trial waivers if done within 60 days of injury, or where injury causes death, within 60 days of the qualification of an executor of the estate. Va. Code §8.01-581.12.

IV. Securing an Accurate Death Certification

There have been anecdotal reports of inaccurate death certifications, effectively underreporting Covid-19 deaths in nursing facilities and elsewhere. In cases reviewed by counsel, some doctors have been reporting the cause of death as "suspected Covid-19 exposure." This creates an issue as to whether a proper determination was even made in the first instance.

If your loved one expired in a nursing home after testing positive for Covid-19, you need to make sure that the death certificate accurately reflects the cause of death. Where the patient died of respiratory complications and tested positive for Covid-19, the death certificate should reflect Covid-19 as the cause of death. It is important that the doctor completing the death certificate understand that someone is looking over his or her shoulder during this process.

Virginia residents have the right to request a private autopsy, but they will have to front the cost unless they can convince the medical examiner to become involved. The funeral director can be a great resource for the family. The following statutes in Virginia govern death certification and examinations by the medical examiner.

Under Va. Code §32.1-263 (effective Jan 1, 2020),

> 263(C) The medical certification shall be completed and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System *within 24 hours* after death *by the physician in charge of the patient's care for the illness or condition which resulted in death* except when inquiry or investigation by the Office of the Chief Medical Examiner is required by §32.1-283 or 32.1-285.1, or by the physician that pronounces death pursuant to §54.1-2972. If the death occurred while under the care of a hospice provider, the medical certification shall be completed by the decedent's health care provider and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System for completion of the death certificate.
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> 263 (D) When inquiry or investigation by the Office of the Chief Medical Examiner is required by §32.1-283 or 32.1-285.1, the Chief Medical Examiner shall cause an investigation of the cause of death to be made and the medical certification portion of the death certificate to be completed and signed within 24 hours after being notified of the death. If the Office of the Chief Medical Examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate.

Under Va. Code §32.1-283,

> A. Upon the death of any person from trauma, injury, violence, poisoning, accident, suicide or homicide, or suddenly when in apparent good health, or when unattended by a physician, or in jail, prison, other correctional institution or in police custody, or who is an individual receiving services in a state hospital or training center operated by the Department of Behavioral Health and Developmental Services, or suddenly as an apparent result of fire, or in any suspicious, unusual or unnatural manner, or the sudden death of any infant the *Office of the Chief Medical Examiner shall be notified by the physician in attendance, hospital, law-enforcement officer, funeral director, or any other person having knowledge of such death* . . . (emphasis added)
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> B. Upon being notified of a death as provided in subsection A, the Office of the Chief Medical Examiner shall take charge of the dead body and the Chief Medical Examiner shall cause an investigation into the cause and manner of death to be made and a full report, which shall include written findings, to be prepared. In order to facilitate the investigation, the Office of the Chief Medical Examiner is authorized to inspect and copy the pertinent medical records of the decedent whose death is the subject of the investigation. Full directions as to the nature, character, and extent of the investigation to be made in such cases shall be furnished each medical examiner appointed pursuant to §32.1-282 by the Office of the Chief Medical Examiner, together with appropriate forms for the required reports and instructions for their use.

As Va. Code § 32.1-283 makes clear, the Office of the Chief Medical Examiner *shall be notified* of any death from trauma, violence, injury, poisoning, accident, suicide, homicide, or sudden death when the patient is in apparent good health. While infectious diseases are not listed as a category, death by Covid-19 could be considered death by an unusual manner. While the Medical Examiner has discretion to decide whether to intervene in a cause of death analysis, he or she may be willing to get involved in cases where there is a concern that the physician is not accurately reporting a death caused from Covid-19.

Many doctors who oversee nursing facilities are assuming if their patients tested positive for Covid-19 and died soon thereafter, that the death is related to Covid-19. They are not undertaking autopsies to make that determination, as it is simply unnecessary. In nursing homes, medical directors routinely sign the death certificates without ever examining the body.

If you believe a death related to Covid-19 (a/k/a the Corona Virus) has been inaccurately certified (as some cause unrelated to Covid-19), you should contact legal counsel or the medical examiner's office to make sure that inaccuracy is properly challenged.

V. <u>The Basis for Legal Liability</u>

Negligence represents the potentially strongest theory of recovery against nursing homes other long-term care providers. Even before this pandemic nursing homes and hospitals were supposed to be equipped to handle infectious disease outbreaks.

Under federal regulations which set minimum standards of care for LTCFs, a facility "must establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection." 42 C.F.R. §65. The provider must establish an infection control program which investigates, controls and prevents infections in the facility. *Id.* Such a program may include isolation of residents. "*The facility must prohibit an employee with communicable disease or infected skin lesions from direct contact with residents* or their food, if direct contact will transmit the disease." *Id*. As 70% of elders in LTCFs have been documented as possessing some level of cognitive impairment, they have limited safety awareness and cannot be relied upon to engage in social distancing. Accordingly, infected staff members must be exceedingly diligent in their efforts to avoid resident contact.

CDC guidelines updated on a daily basis will be one source of the standard of care. Based on initial reports, high death rates have been attributed to staff spreading the virus to residents because they had little or no protective equipment. For example, a highly publicized report in the *New York Times* described one particular SNF in New Jersey, Andover Subacute and Rehabilitation Center, as being chronically short of staff and masks, and as having residents crowded three to a room.[7]

Based on anecdotal reports, many nursing facilities failed to provide protective gear to their staff and failed to timely test their staff members. Availability of testing in a particular locale will be one potential obstacle in proving that theory, but the fact remains that many nursing homes have been able to test all staff members quickly even early on in the outbreak.[8]

Some facilities may face liability for failing to inform residents or their families that the virus was spreading in their facilities. Residents have the right to access critical health care information and the number of infected staff or residents can be and has been disclosed without violating federal or state privacy laws.

State surveyors are visiting all nursing homes to assess their compliance with state and federal regulations. Those assessments should provide useful evidence in the form of regulatory violations, which will help establish breaches in the standard of care for specific facilities. This information will also be readily available through public information requests. When issuing records requests, you should also include a paragraph specifying documents that the nursing home should retain for litigation purposes. That should include all government directives or guidelines,

[7] https://www.nytimes.com/2020/04/19/nyregion/coronavirus-nj-andover-nursing-home-deaths.html?referringSource=articleShare

[8] Co-author Downey's mother is now in isolation in an assisted living facility in a hot spot in Suffolk County, N.Y. He get daily updates on the status of the facility and what is being done to address the virus. After implementing staff testing, prohibiting visitors and implementing widespread use of protective equipment, they have not had a single resident infection. Nursing homes that followed the guidelines and had zero infections rates will provide a sharp contrast to the facilities that failed to implement timely precautions and caused widespread infection. These facilities will also be subject to punitive damages in the states that still allow such recoveries.

CDC or other communications regarding Covid-19, internal communications or emails regarding Covid-19 issues, testing data of staff and residents, inventory records of personal protective equipment and other supplies, staffing records, any documents evidencing attempts by the facility to hire staff or acquire personal protective equipment ("PPE") during the pandemic, licensure investigations, plans of correction, and patient and family member communications relating to Covid-19 or the Corona virus.

Health care unions representing nurse aides have already come out against nursing facilities for exposing low paid workers to the virus without providing proper protective equipment.[9] These employees may also have claims against their employers for exposure.

VI. Immunity and Related Issues

A. Virginia Immunity – Executive Order 60

The federal government is threatening to pass statutes granting immunity to healthcare providers for Covid-19 infections. Virginia's governor has already issued an executive order designed to give protections to Virginia nursing homes and hospitals, effectively requiring proof of gross negligence.[10] The order states, in relevant part, that

> In the absence of gross negligence or willful misconduct, any health care provider who responds to a disaster shall not be liable for any injury or wrongful death of any person arising from the delivery or withholding of health care when (i) a state or local emergency has been or is subsequently declared in response to such disaster, and (ii) *the emergency and subsequent conditions caused a lack of resources, attributable to the disaster, rendering the health care provider unable to provide the level or manner of care that otherwise would have been required in the absence of the emergency* and which resulted in the injury or wrongful death at issue. (Appendix A).[11]

[9] Milly Silva, executive vice president of 1199 SEIU United Healthcare Workers East, which represents health care workers, said in a statement that much of the fault for the rapid spread of coronavirus in LTCs across the state lies not with workers, but rather with some facility operators. "In light of continued obfuscation by some nursing home owners and delays in informing family members and workers about positive cases, the Murphy administration has taken strong, decisive action," Silva said. The union remains concerned about a "significant under-counting of resident deaths," Silva said, specifically of those who passed away without being tested or who died after being taken to a hospital.

[10] The executive order takes advantage of a statute on the books that provides immunity from simple negligence in cases where a healthcare provider is responding to a declared disaster. Va. Code §8.01-225.01. https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-60-Clarification-of-Certain-Immunity-From-Liability-For-Healthcare-Providers-in-Response-to-Novel-Coronavirus-(COVID-19).pdf, Appendix A

[11] Although the focus of this article is on Virginia law, it should be noted that both the District of Columbia and the State of Maryland also have issued emergency acts to limit the civil liability of health care providers who are servicing Covid-19 patients. D.C. Act 23-299 amends D.C. Code §7-2304 to add a new paragraph 3A(A)(i) to "[e]xempt from liability in a civil action a healthcare provider, first responder, or volunteer who renders care or treatment to a potential, suspected, or diagnosed individual with COVID-19 for damages resulting from such care or treatment of COVID-19, or from any act or failure to act in providing or arranging medical treatment for COVID-19 during a declared public health emergency." The protection does not extend to "[a]cts or omissions that constitute a crime, actual fraud, actual malice, reckless breach of contract, gross negligence, or willful misconduct." *Id.* at 3A(C)(i). A Proclamation issued by Maryland Governor Larry Hogan on May 6, 2020 extends the immunity

This executive order will be subject to legal challenge on the grounds that it exceeds the authority that the Governor has to limit liability for healthcare providers. Historically in Virginia, limits on liability for healthcare providers have occurred only through legislation passed through the General Assembly. Governor Northam will argue that this authority was granted to him under Va. Code §44-146.17, which grants broad powers to the Governor in times of national emergencies. However, nothing in this authorizing legislation confers the Governor with power to limit liability of tortfeasors.

The Virginia Supreme Court has not hesitated to reign in the power of governors to issue executive orders that encroach upon the traditional law-making role of the legislature. For example, in *Howell v. McAuliffe*, 788 S.E.2d 706 (Va. 2016), the Supreme Court invalidated an executive order of Governor McAuliffe that sought to restore the right to vote for 206,000 Virginians who had completed their prison terms, which order was contrary to the Virginia Constitution. As the Court stated,

> In sum, Governor McAuliffe's Executive Order has the attributes of an an *ultra vires* assertion of the suspending power that has been forbidden by our constitution since 1776.

Id., 788 S.E.2d at 724.

Executive Order 60 may not apply in situations where the nursing home failed to test and screens staff members before allowing them to interact with residents. Even if the facility alleges lack of adequate testing availability, the facility should have been able to take the temperatures for all staff and exclude those staff who showed any signs of infection. Many facilities who excluded visitors and diligently tested staff were able to achieve low or zero infection rates throughout the pandemic.

In addition, nursing homes and hospital are supposed to be set up to handle the isolation of highly infectious patients. If a nursing facility failed to properly quarantine patients, this could be another basis for liability that would not be impacted by Executive Order 60. In discovery, plaintiffs should focus on availably of empty rooms and options that nursing homes had to transport infected patients to other locations. Facilities that followed CDC guidelines and sought to separate early infection cases had significantly lower overall infection rates.

B. Establishing Gross Negligence or Willful and Wanton Conduct

To get around immunity protections for simple negligence (assuming their constitutionality), attorneys in Virginia should also plead gross negligence and willful and wanton conduct where the facts support such allegations. Courts in Virginia have routinely overruled

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provisions of §14-3A-06 of the Public Safety Article of the Maryland Code to grant immunity to "[h]ealth care providers who act in good faith under this catastrophic emergency proclamation." Https://governor.maryland.gov/wp-content/uploads/2020/05/3rd-Renewal-of-State-of-Emergency-5.6.20.pdf. It is unclear whether the immunity would extend to care provided to non-Covid-19 patients in facilities where the provision of care to infected patients directly impacts the provision of care to the non-infected patients.

demurrers in nursing home cases where the plaintiff has pled a reckless disregard of the patient's rights. If a plaintiff is able to meet the pleading threshold necessary to provide punitive damages, then he or she has already exceeded the pleading requirement for gross negligence.

In *Booth v. Robertson,* the Virginia Supreme Court held that punitive damages are warranted not only by malicious conduct, but also by "negligence which is so willful or wanton as to evince a conscious disregard of the rights of others." 236 Va. 269, 273, 374 S.E.2d 1, 3 (1988) (emphasis added). "Willful and wanton negligence is acting consciously in disregard of another person's rights or acting with reckless indifference to the consequences, with the defendant aware, from his knowledge of existing circumstances and conditions, that his conduct probably would cause injury to another." *Infant C. v. Boy Scouts of America, Inc.*, 239 Va. 572, 581–82, 391 S.E.2d 322, 327 (1990) (emphasis added). Whether an action rises to a level deemed willful or wanton is largely a fact-specific inquiry. *Alfonso v. Robinson,* 257 Va. 540, 545, 514 S.E.2d 615 (1999). If reasonable persons, upon the facts presented, could differ regarding whether the Defendant's conducts show a conscious disregard of the rights of others, a jury question is presented. *Huffman v. Love,* 245 Va. 311, 314 427 S.E.2d 357, 360 (1993).

If nursing homes exposed their patients to other infected patients or potentially infected staff members, the threshold for gross negligence or even punitive damages should be met. Various Virginia Courts have allowed punitive damages under circumstances arguably less egregious, including the following:

- *Hirsch v. CSP Nova*, 2018 WL 3231467, 98 Va. Cir. 286 (2018) (allowing punitive damages in fall case where plaintiff alleged defendant consistently failed to answer a demented resident's call lights despite knowledge that she might try to go to the bathroom by herself);

- *Hamilton Development Co. v. Broad Rock Club Inc*., 248 Va. 40, 445 S.E.2d 140 (1994) (punitive damages supported by defendants' reckless seizing of plaintiff's land, clearing and grading it for their own use);

- *Larsen v. Cannon/Hearthwood, L.P. et. al*., 65 Va. Cir. 505 (2004) (punitive claim survived demurrer where the tenant was injured as a result of the landlord's placement of a defective ladder and the landlord's failure to warn of the dangerous condition of the ladder);

- *Rice v. Safford Dodge Inc.,* 43 Va. Cir. 578 (1997) (punitive damages allowed where defendant knowingly sold as a demonstrator model a damaged car that had been repaired);

- *Kaufmann v. Abramson,* 363 F.2d 865 (4th Cir. 1966) (punitive damages award sustained for a landlord's cutting off a elderly lessee's electricity despite his awareness of lessee's frail health);

- *Crouse v. Medical Facilities of America*, XLVIII, 86 Va. Cir. 168 (Roanoke 2013), *cert denied,* Record No. 130838 (Va. Oct. 2, 2013), *reh. denied* (Va. Jan. 21, 2014)

(knowledge of prior bed alarms problems in other nursing facility within the MFA chain and lack of training supported punitive damage award);

- *Guilliams v. Wray*, 79 Va. Cir. 244, 255 (Roanoke 2009) (alleged intentional misrepresentations regarding post-op complications supported punitive damages claim).

Defendants will rely on the *Elliot v. Carter*, 292 Va. 618 (2016), a gross negligence case in which the Supreme Court held that the conduct of a troop leader in failing to prevent a boy scout from drowning did not meet the gross negligence standard. The standard defense argument on gross negligence is that *if any care was provided,* no matter how slight, Plaintiff cannot make out a claim for gross negligence.[12] While that language appears in the holding of *Elliot*, the Virginia Model Jury Instruction does not incorporate that language into the definition of gross negligence.[13]

The defense bar had been relying on *Elliot v. Carter* to argue that if some care was provided in a nursing home (*i.e.*, a resident was turned once a shift as opposed to every two hours in order to avoid a pressure wound), that Plaintiff could not establish a claim for punitive damages. While some Circuit Courts bought into that flawed argument, the Supreme Court arguably put that issue to rest in the recent case of *Curtis v. Highfill*, Rec. No. 190117 (April 2020) where it found that the trial court had erred in dismissing a punitive damage claim against a physician who was alleged to have over-prescribed opioids. Plaintiff claimed that Dr. Highfill had prescribed large amounts of clinically unwarranted, highly addictive pain medications to a patient with a history of alcoholism and bipolar disorder without ever examining or seeing the patient for a period of fourteen months. The Court noted that unlike gross or ordinary negligence, willful and wanton negligence required an actual or constructive knowledge that injury would result from the act or omission. The hallmark of this tort is "the defendant's consciousness of his act, his awareness of the dangers or probably consequences and his reckless decision to proceed notwithstanding that awareness." *Id.*, quoting *Infant C. v. Boy Scouts of America Inc*., 239 Va. 572 (1990).

One case often cited by Plaintiffs in arguing gross negligence standards is *Chapman v. City of Virginia Beach*, 252 Va. 186, 475 S.E.2d 709 (1996) where the Supreme Court reversed a trial court's decision in setting aside a verdict for the plaintiff in a wrongful death action arising from an accident on the boardwalk. There, a child died after becoming entangled in a swinging gate made of metal bars which provided access to the beach from the boardwalk. City employees had been notified on at least three occasions prior to the incident that the gate was broken, but the gate was not repaired. A supervisor in charge of maintaining the gate made a "deliberate decision" not to order the gate repaired or secured at the time the reports were made in the fall because most of the city's maintenance on the boardwalk "`is done in the spring prior to the tourist season.'" *Id.* at 191, 475 S.E.2d at 801. In discussing the standard of care, the Supreme Court stated, "[d]eliberate conduct is important evidence on the question of gross

[12] As Justices McCullough and Mims noted in their dissent in *Elliot*, "the purported acts of slight care, *separated in time and place from the gross negligence*, do not take the issue away from the jury." *Elliot*, 791 S.E.2d 733 (emphasis added). While *Elliot* was arguably a single incident case, this dissenting argument is even more persuasive when the neglect involves a continuum of conduct over a long period of time

[13] VMJI 4.030 defines gross negligence as "that degree of negligence which shows such indifference to others as constitutes an utter disregard of caution amounting to a complete neglect of the safety of another person. It is such negligence as would shock fair-minded people, although it is something less than willful recklessness."

negligence." *Id.* at 190, 475 S.E.2d at 801 The Court noted that under the city's own operating procedures, the gates were to be closed unless city employees were performing maintenance functions. Despite repeated notices by its own employee, the city did not take any action. The decision not to take any action was deliberate." *Id.* at 191, 475 S.E.2d at 801. The Supreme Court concluded that reasonable minds could differ as to the "cumulative effect of these circumstances constitutes a form of recklessness or a total disregard of all precautions, an absence of diligence or lack of even slight care." *Id*.

Given the well-known risk and lethal nature of Covid-19 virus to vulnerable nursing home patient populations, it should not be difficult to effectively plead both a gross negligence and willful and wanton negligence case where there is evidence that the facility failed to implement minimum regulatory standards or CDC guidelines.[14] Situations where the facility housed Covid-19 patients with patients who were not yet infected, should be sufficient to meet gross negligence standards.

Additionally, staff members who were put at risk because the facility was not properly prepared to confront this virus have come forward to report dangerous practices and will likely be compelling witnesses. While juries may be reluctant to give awards against the heroic doctors and nurses who stepped up to deal with this crisis, those kind feelings may not extend to institutions that breached basic standards of infection control during this crisis.

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SEO Tags: death from sepsis, death from coronavirus, corona virus, COVID-19 attorney, Corona attorney, respiratory disease, respiratory failure, covid-19 claim, covid-19 case, nursing home negligence, sepsis negligence, nursing home neglect, deficient infection control, negligent infection control, contact isolation, sepsis malpractice, negligent infection, infected pressure wound, infection control, pressure ulceration, bedsore, pressure sore, infected bed sore, infected decubitus ulcer, nursing home infection, infection control, assisted living facility, Corona lawyer, Corona legal claim, assisted living attorney, Sepsis, Blood poisoning, immune system, infection, tissues, organ, Mclean nursing home attorney, Virginia Nursing Home attorney, Virginia malpractice attorney, Maryland malpractice attorney, District of Columbia malpractice attorney, DC nursing home attorney, DC assisted living attorney, wrongful death, Fairfax assisted living facilities, assisted living lawyer, abuse and neglect, wrongful death attorney, assisted living neglect, assisted living negligence, assisted living abuse

[14] CDC Guidelines for LTCFs are set forth at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html and are periodically updated.