



WHAT YOU NEED TO KNOW ABOUT NURSING HOME CARE LIABILITY

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The cases and materials presented here are in summary and outline form. To be certain of their applicability and use for specific claims, we recommend the entire opinions and statutes be read and counsel consulted.

WHAT YOU NEED TO KNOW ABOUT NURSING HOME CARE LIABILITY

I. INTRODUCTION

Nursing home litigation is on the rise in Illinois and across the country and has been for more than a decade. Nursing homes and long term care facilities now face an ever increasing risk of liability claims, and as people live longer due to advances in medicine, it is expected that residence in a long term care facility near the end of life will be the norm for many people. Many communities have one or more nursing homes, and these facilities run the gamut in size, type of ownership, level of care, age/upkeep of grounds and facilities and the manner in which they are staffed. While nursing homes present some similarities to hospitals, it should be recognized that in hospitals, physicians are generally ultimately responsible for patient care in an acute situation. In nursing home cases, the day to day medical care and assessment is provided by nurses, therapists or aides with the consultation of physicians at certain intervals or in acute circumstances. Additionally, recordkeeping, regulations and the standard of care itself is generally different in a hospital environment than it is in a long term care facility.

Oftentimes, residents are placed in a long term care facility because they cannot be cared for properly at home, or because they have significant medical conditions and require day to day monitoring. Residents include people with end stage diseases, mobility issues, dementia or numerous other serious physical and mental disabilities or diseases. Therefore, many residents in nursing home environments are much more susceptible to injury or accident than the average person. These circumstances all combine to create complicated risk management and reduction environments in these facilities.

II. STATE AND FEDERAL REGULATION OF LONG TERM CARE FACILITIES

In Illinois, nursing homes are generally subject to complex, interrelated and often overlapping federal and state regulations. Generally speaking, these regulations provide a framework for the day to day operation of nursing homes. The primary regulatory scheme in Illinois is the Nursing Home Care Act, 210 ILCS 45/1-101 *et seq.* There are also a multitude of federal regulations that may be applicable to a nursing home, and these regulations are found in the Nursing Home Reform Amendments, enacted as part of the Omnibus Budget Reconciliation Act of 1987. Pub.L. No. 100-203, 101 Stat. 1330 (1987). Many attorneys and claims professionals well versed in litigating these claims simply refer to these as the OBRA regulations. The Illinois regulations are enforced by the Illinois Department of Public Health, which is the same agency that licenses long term care facilities. The federal enforcement agency for the OBRA regulations is the Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). Each of these regulatory schemes and the agencies that enforce them is important to keep in mind when defending nursing home claims.

The Illinois Nursing Home Care Act was passed in 1979 “amid concern over reports of ‘inadequate, improper and degrading treatment of patients [sic] in nursing homes.’” *Eads v. Heritage Enterprises*, 204 Ill. 2d 92 (2003). Through this Act, the Illinois legislature provided the Illinois Department of Public Health with the authority to regulate long term care facilities and to enforce those regulations. The Act provides for civil and criminal penalties in some circumstances. The Nursing Home Care Act casts a wide net over the regulation of long term care facilities, and a detailed discussion of it exceeds the scope of this paper. However, it should be noted that the Act generally applies to sheltered care, intermediate care and skilled care facilities. The Act excludes certain types of facilities such as hospitals, certain “supportive living facilities” and other less common long term facilities. For a lengthy description of the excluded facilities, see 210 ILCS 45/1-113. Certain aspects of the Act are essential to acknowledge in analyzing and defending any nursing home claim.

The Nursing Home Care Act provides that an owner, licensee, administrator, employee or agent of a long term care facility shall not neglect a resident of the facility. 210 ILCS 45/2-107. Neglect is then defined in the Act as a failure to provide adequate medical or personal care or maintenance that results in physical or mental injury to the resident or a deterioration in the resident’s physical or mental condition. Under the Act, an owner and licensee are liable to a resident for any intentional or negligent act or omission by their agents or employees that injures a resident. 210 ILCS 45/3-601. Since the owner and licensee are liable for the intentional acts of agents or employees, a facility may not typically avoid liability under the Act by arguing that conduct was outside the scope of employment. These basic principles provide the foundation for a private right of action by a resident against a facility under the Act separate and apart from a common law negligence claim.

Perhaps the most important and onerous provision of the Nursing Home Care Act within the context of litigation is the fee shifting provision:

The licensee shall pay the actual damages and costs and attorney's fees to a facility resident whose rights, as specified in Part 1 of Article II of this Act, are violated.

210 ILCS 45/3-602.

If a plaintiff successfully proves allegations of neglect under the Act, the licensee must of course pay damages assessed by the finder of fact, which is typical of any defendant in any ordinary negligence suit. However, under the Act, the licensee-defendant must also pay a successful plaintiff’s costs and attorney’s fees. In these circumstances, the attorney for the plaintiff typically claims an hourly rate multiplied by the number of hours worked on the case and then submits a fee petition to the court. Plaintiffs also claim costs – which depending on the judge, might include the costs of retaining expert witnesses – under this fee shifting provision. While the defendant does have an opportunity to object to portions of the fee petitions by submitting evidence of lower prevailing local hourly rates or by disputing time entries, the fee award to the plaintiff can be substantial. Further, the provision lessens the financial deterrent to bringing

claims under the Act. Anyone evaluating a claim brought under the Nursing Home Care Act must include these costs and fees in the analysis.

A. Liability for Owner/Licensee

As noted above, in claims brought under the Act, the only liable parties are the owner or licensee. Therefore, a Nursing Home Care Act claim brought against other entities such as individual nurses, administrators, or corporate members should be challenged accordingly. However, plaintiffs typically file a count under the Act and a count based on principles of ordinary negligence. The common law claims against non-owners and non-licensees would not be barred *per se*, but should still be challenged on any other available basis.

B. Arbitration

The legislature fully intended for the provisions of the Act to have the effect of encouraging actions and complaints against facilities, as seen above with the fee shifting provision. Additionally, the Act makes it illegal for a facility to transfer, discharge, evict, harass, dismiss or retaliate against a resident, a resident's representative or an agent or employee who makes a report, files a complaint or brings a legal action against a facility. See 210 ILCS 45/3-608. Furthermore, the Act goes so far as to nullify any "waiver" of a resident's right to sue or a right to a jury trial. See 210 ILCS 45/3-606, 607.

However, there are limited circumstances where a facility may enforce an arbitration agreement or arbitration clause against a resident, resulting in the dismissal of the case from the traditional court system. This area of nursing home litigation has evolved significantly over the past several years. In *Fosler v. Midwest Care Center II, Inc.*, 398 Ill. App. 3d 563 (2d Dist. 2010) (*modified upon denial of rehearing*, March 1, 2010) the appellate court found that the "antiwaiver" portion of the Act (noted above) was preempted by provisions of a federal statute known as the Federal Arbitration Act. In other words, the court found that an otherwise valid arbitration clause in a contract such as a nursing home admission agreement could be enforced against a resident notwithstanding the antiwaiver sections of the Nursing Home Care Act. That holding was reinforced by the Illinois Supreme Court in *Carter v. SSC Odin Operating Co., LLC.*, 237 Ill. 2d 30 (2010).

However, the enforcement of arbitration agreements is not without limitation. In *Curto v. Illini Manors, Inc.*, 405 Ill. App. 3d 888 (3d Dist. 2010), the appellate court held that a spouse's execution of an arbitration agreement did not bind a nursing home resident, or even the spouse herself, in subsequent litigation against the facility. In 2007, Marilee Curto contracted with a residential long term care facility for the placement and residence of her husband, Charles. The contract identified Charles as the "resident" and Marilee as "Guardian/Responsible Party." Marilee signed the contract on a preprinted signature line which identified her as "Legal Representative." *Id.* Curto, 405 Ill. App. 3d at 890. The parties also executed a separate arbitration agreement which directed that any dispute arising from Charles' residence be submitted to binding arbitration. Charles did not sign the agreement; Marilee signed it above a

signature line that read "Signature of Resident Representative." *Id.* Charles died at the facility and Marilee brought suit under the Nursing Home Care Act, the Wrongful Death Act and the Survival Act. The facility moved to dismiss the case pursuant to the arbitration agreement, arguing that Charles' estate was bound by the arbitration agreement.

The trial court denied the motion, finding that Marilee was not acting as Charles' agent when she signed the arbitration documents. The appellate court agreed, finding initially that a nonsignatory nursing home resident may only be bound by an arbitration agreement if the signatory had the actual authority to sign the agreement as the resident's agent. *Id.* at 891. There was no evidence that Charles gave Marilee express authority to act on his behalf, and there was no written agreement or power of attorney granting her such authority. *Id.* at 892. The court further found no evidence to support an apparent agency argument. The court wrote that Charles did nothing to indicate to the facility that Marilee was acting as his agent. Of course, Marilee signed the admission documents and Charles then accepted residence in the facility for a period of time, suggesting that he agreed with the terms of the admission and his wife's authority to agree to it on his behalf. However, the appellate court refused to assign knowledge of the existence of the arbitration agreement to Charles without some indication in the record that he was aware of it and consented to his wife's agreement that he be bound by it. *Id.* at 893.

Furthermore, the current state of the law in Illinois renders it impossible for a facility to enforce an arbitration agreement against a representative plaintiff in a wrongful death case. While it may be possible to enforce an arbitration provision involving a survival claim under the Nursing Home Care Act, the appellate court has determined that a representative party in a wrongful death claim cannot, as a matter of law, waive her right to a jury trial by executing an arbitration agreement on behalf of a yet-to-be deceased resident, nor can that resident waive the next of kin's right to a jury trial by executing the same document himself. *Carter v. SSC Odin Operating Co., LLC*, 2012 IL 113204. A wrongful death action does not accrue until death and is not brought for the benefit of the decedent's estate, but for the next of kin who are the true parties in interest. A personal representative in a wrongful-death case is merely a nominal party, effectively filing suit as a statutory trustee on behalf of the next of kin. Since those representatives are not "prosecuting the wrongful death claim on behalf of" the decedent, they are not bound by the decedent's signature on an arbitration agreement. Therefore, a facility cannot compel arbitration of a claim brought pursuant to the Wrongful Death Act.

C. Surveys (Complaint and Annual)

The Nursing Home Care Act also gives the Illinois Department of Public Health the power to license facilities. The IDPH licenses facilities by reviewing written applications and by physically inspecting nursing homes on a periodic basis. The "annual survey" is typically done once every 12-15 months. The facility is not told about the survey beforehand, and the unannounced survey can take several days. It usually involves interviews with administration, staff and residents as well as physical inspection of the premises and an audit of resident charts. The facility's licensure status will be determined, in part, by the findings at this annual survey.

However, the IDPH also has the authority to conduct a “complaint survey.” A complaint survey can be triggered by any report of an alleged violation of the Nursing Home Care Act. The Act empowers anyone – residents, their families, friends, members of the community and even facility employees – to contact the IDPH via phone, email, written communication or even on a walk-in basis to complain of an alleged violation of the Act. Any report then requires a focused investigation at the nursing home by an IDPH surveyor which, again, is unannounced and typically initiated and completed without the presence or counsel of a lawyer for the facility. Prior to exiting the facility, the surveyor then prepares a report which is provided to the facility administrator and licensee and to the IDPH regional supervisor. The report indicates whether evidence exists to suggest that a violation of the Act or applicable regulations was evident.

Based on the report findings, the IDPH has several options if it is determined that the findings in the report in fact constitute a violation. The report includes a detailed description of the circumstances of the violation(s) and any impact on nursing home residents on a form known as Form 2567. These “2567’s” are available online for each facility at the IDPH webpage for a specific facility. See <http://www.idph.state.il.us/healthca/nursinghometestjava.htm>

The IDPH can (a) require the facility to submit a plan of correction (basically describing the methods the facility will take to prevent a future violation), (b) place the facility on a quarterly list of violators, (c) assess a financial penalty, (d) issue a conditional license to the licensee or (e) suspend, revoke or refuse to renew the licensee’s current license.

The IDPH uses a ranking system used by CMS and many other states in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. Each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Violations in categories A, B, or C are those that pose no risk to residents, and homes with these violations only are considered to be in “substantial compliance” with the law. Violations in categories D, E, or F are those that have the potential to cause “more than minimal harm” to residents. Violations in categories G, H, or I are those that cause “actual harm” to residents. And violations in categories J, K, or L, also known as “immediate jeopardy” violations, are those that cause or have the potential to cause death or serious injury to residents. These findings are usually referred to as deficiencies or deficiency findings.

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is Not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

Plaintiffs usually attempt to use these survey results and findings as evidence of neglect or abuse. Defense counsel should take the position that these findings are inadmissible as evidence in a civil trial. The surveys are by definition full of hearsay (as well as hearsay within hearsay) and lack any of the formality or foundational requirements of admissible evidence. Furthermore, current federal law arguably prevents the state surveyors from giving testimony about the survey they performed. In other words, the author of the survey in most cases is not permitted to testify, depriving the parties to the civil suit the opportunity to depose that person and question them regarding the facts, opinions and conclusions included in the survey.

The current federal law with respect to state surveyors giving testimony or producing documents is as follows:

No employee or former employee of the DHHS may provide testimony or produce documents in any proceedings to which this part applies concerning information acquired in the course of performing official duties or because of the person's official relationship with the Department unless authorized by the Agency head pursuant to this part based on a determination by the Agency head, after consultation with the Office of the General Counsel, that compliance with the request would promote the objectives of the Department.

45 CFR 2.3.

According to another federal regulation, if the state surveyor is enforcing the policy of the Department of Health and Human Services (which they arguably are while surveying a nursing home that accepts Medicare/Medicaid residents), then that person – even though not employed by the federal government – is considered “an employee” of the DHHS and subject to the above-referenced prohibition on testimony. Under the law, “employee” of the DHHS includes:

Employees of a contractor, subcontractor, or state agency performing survey, certification, or enforcement functions under title XVIII of the Social Security Act or Section 353 of the Public Health Service Act but only to the extent the requested information was acquired in the course of performing those functions and regardless of whether documents are also relevant to the state's activities.

45 CFR 2.2(3).

It should be noted that some DHHS regions in the country will permit state surveyors to testify, but many will not.

D. Damages

As noted above, the typical economic and non-economic damages available to any successful plaintiff in an ordinary negligence case are available to plaintiffs in nursing home cases, including survival claim damages and wrongful death damages. If a claim is brought pursuant to the Nursing Home Care Act, a successful plaintiff is also entitled to attorney's fees and costs.

The Act does allow residents to recover common law punitive damages if willful and wanton conduct on the part of the defendant is proven. *Eads v. Heritage Enterprises*, 204 Ill. 2d 92 (2003). However, the resident's right to common law punitive damages expires when the resident dies. *Vincent v. Alden-Park Strathmoor, Inc.*, 241 Ill. 2d 495 (2011).

E. Certificates of Merit Under 735 ILCS 5/2-622

An action under the Nursing Home Care Act is not considered an action “for healing art malpractice” within the meaning of 735 ILCS 5/2-622. Therefore, a plaintiff who asserts a private right of action under the Act is not required to support a complaint with an affidavit of counsel and certificate of merit from a physician or other health care provider. *Eads*, 304 Ill. 2d at 94. However, common law claims of medical or nursing malpractice brought separate from the Act must be supported with the appropriate material outlined in section 2-622. If the common law claim is non-medical in nature, i.e., does not involve the use of professional, medical judgment and decision-making, compliance with section 2-622 is still not required. However, if the common law negligence claim attempts to state a case for nursing malpractice, compliance with section 2-622 is required. In the situation where a plaintiff alleges negligence under the Act, and then mirrors those allegations in a common law count, the defendant facility should insist on compliance with section 2-622 and make all available challenges to the pleadings.

III. STANDARD OF CARE

The standard of care to which a nursing home defendant is held is that of reasonable, ordinary care. *Graves v. Rosewood Care Center, Inc.*, 2012 IL App (5th) 100033. In a case brought pursuant to the Nursing Home Care Act, that standard is otherwise referred to as “adequate” care (see below). This reasonable care standard is seemingly at odds with much of the language of the state or federal regulations for long term care facilities, which is one basis for seeking to exclude those regulations as evidence of the standard of care in any nursing home case.

IV. JURY INSTRUCTIONS

In July 2014, the Supreme Court Committee on Jury Instructions in Civil Cases approved pattern jury instructions for use in cases alleging liability under the Nursing Home Care Act. Any facility facing a litigated claim under the Act should expect these jury instructions to be proposed by plaintiff’s counsel. Furthermore, it is expected that in ordinary negligence cases involving nursing home claims (such as wrongful death cases not brought pursuant to the Act), plaintiff’s counsel will also propose these instructions as non-IPI instructions. Of note, the IPI instructions define “neglect” for the jury as:

Neglect means a facility’s failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that are necessary to avoid physical harm, mental anguish, or mental illness of a resident.

I.P.I. Civil (2014) 190.05.

Under this instruction, defense counsel should be prepared to argue that the care was “adequate” for the resident, even if a good result did not occur.

It should also be noted that the “issues” instruction approved for use in Nursing Home Care Act cases alludes to the inclusion in the instruction of violations of state or federal “regulations”

*[Set forth in simple form without undue emphasis or repetition those allegations of the complaint asserting abuse or neglect **under the Act or violations of federal or state regulations** that have not been withdrawn or ruled out by the court and are supported by the evidence.]*

I.P.I. Civil (2014) 190.02[3] (emphasis added).

While plaintiffs will argue that this instruction permits citation to the state and federal regulations, the instruction clearly indicates that these regulations may only appear in the jury instruction if they are supported by the evidence and not ruled out by the court. Depending on

the case, there are a multitude of reasons as to why state and certainly federal regulations should not be the basis of an issues instruction in a jury trial, and defense counsel should maintain consistent positions in opposition to such citations so that there is a basis to exclude reference to them in the jury instructions.

V. COMMON RECORDS ISSUES

It is imperative in defending any nursing home case to obtain a full complement of medical records for the resident. As soon as notice of a claim is received, all of the resident's records in the facility's possession should be immediately isolated. This will prevent anyone from later claiming that someone attempted to alter, modify or "fix" any of the records. Nursing homes do not keep the same types of records that hospitals keep, so it is not unusual to see less than daily charting for an otherwise stable or healthy resident. Furthermore, the "resident chart" may not contain all of the important records in the case. Flow sheets, shower forms, CNA assessments and other records might be placed in a central location as opposed to within individual resident charts.

A resident chart should include some of the same information that would be included in a hospital chart, including nursing notes, physician progress notes and orders, medication administration records (MARs), lab results, social services and therapy notes, nutrition records, vital signs notes and other consultations. A nursing home chart should also include written care plans and "minimum data set" (MDS) documentation.

A care plan is literally a plan of care for the resident and for each problem that might be facing a resident. Facilities are required to keep written care plans for their residents and to update the care plan routinely or when there is a substantial change in the resident's condition, such as a fall, severe weight loss, serious illness or hospitalization.

The MDS is a form required by CMS/Medicare/Medicaid that includes basic information about the resident and the resident's relevant medical conditions. These should be updated regularly and should accurately confirm the overall condition of the resident at the time they are generated. Inaccurate MDS documentation or incomplete care plans can make it very difficult to defend claims, as it may tend to show either a systemic or specific failure to assess and adequately care for a resident.

VI. COMMON TYPES OF CLAIMS

A. Falls

Falls are one of the most common types of injuries found in nursing home claims. These cases can be frustrating because nearly all long term care facilities are now "restraint free" facilities in

accordance with certain laws or best practices regarding the treatment of diseases in elderly patients.

Many different types of residents may pose a risk for falls. Residents who are experiencing a decline in mobility and physical movement may be at an increased risk for falls; on the other hand, residents who are recovering from an injury or making progress toward independent ambulation present a risk for falls. Residents suffering from a stroke or cerebrovascular accident (CVA), Parkinson's, incontinence, dizziness, vertigo, impaired balance while sitting or standing, or even someone with hearing or vision problems might present an increased risk for suffering a fall. It is not uncommon for a fall to cause a bone fracture in an elderly resident, and in some cases, an elderly resident has a difficult time recovering from a fall. Many times, a nursing home complainant will allege that a fall caused the resident's death, even if the death does not occur immediately after the fall.

In any fall case, it is imperative to determine whether a fall assessment was performed and a corresponding care plan initiated and updated on a regular basis. Fall precautions typically include a call light, chair or bed alarm, a low mattress or lowering the resident's bed, proper redirection to the resident, physical and occupational therapy and conferencing with the resident's family and physician as to the risk for falls. All falls cannot be prevented, but to defend a liability claim involving a fall, a facility must show that it was aware of the resident's risk for falls and made every effort to limit the possibility that the resident would suffer a fall.

B. Pressure Sores

Pressure sore or wound cases are common and in the absence of regular and accurate charting, can be difficult to defend in light of applicable nursing home regulations. In Illinois, nursing homes are required to provide generalized nursing care that includes:

A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

77 Ill. Adm. Code 300.1210(d)(5).

Plaintiffs' experts routinely define "unavoidable" to mean that the resident developed a pressure sore or ulcer even though the facility had previously evaluated the resident's clinical condition and pressure ulcer risk factors, implemented interventions designed to address the resident's needs, monitored the impact of the interventions and revised or updated the interventions as necessary. In other words, it will be important in defending a pressure sore case to gather evidence to show that the facility assessed the resident, developed an appropriate plan to

prevent or treat skin breakdown, implemented the plan, and then updated the plan as conditions changed. If this evidence is not gathered via the resident chart or through eyewitness testimony, merely arguing that the development of an ulcer or failure of a pressure ulcer to heal was “unavoidable” will not be persuasive.

C. Other Types of Claims

Other typical nursing home claims involve dehydration and/or malnutrition or choking events. Elderly residents, especially those who suffer from degenerative, progressive mental maladies including Alzheimer’s or Parkinson’s disease can easily become dehydrated or malnourished. Care must be taken to properly assess a resident so that an appropriate dietary plan can be put in place, and staff must ensure that the resident is taking in enough food and water to maintain a healthy weight and nutritional status. Of course, the record must be charted accordingly so that any changes in weight or trends with respect to the eating habits of a resident can be discovered and treated appropriately.

Other less common but problematic claims include elopement claims, in which a resident is able to leave a facility without supervision or permission. Resident elopement can lead to accidental injuries, falls, and even death due to exposure or traumatic means. Care must be taken to safely and respectfully control ingress and egress to a facility.

Along those same lines, facilities may also face claims of sexual abuse or assault of residents. These claims have been reported where the offender is (a) an employee of the facility, (b) a resident of the facility or (c) a visitor or intruder to the facility. These cases can present difficult obstacles for the facility and defense counsel and can draw the attention of the media. Again, properly controlling access to the facility is imperative, as is conducting necessary and proper background checks of employees and residents.



Michael J. Denning

- Partner

Mike concentrates his practice in civil defense litigation, including medical malpractice and nursing home litigation and general auto and trucking litigation. In addition to defending physicians and long term care facilities in malpractice litigation and personal injury claims, Mike also handles a myriad of administrative issues for long term care facilities, including involuntary discharge proceedings, licensure issues, fraud and abuse claims, and other litigation.

Mike has represented the firm's clients in jury trials, high-exposure mediations and settlement conferences. He has represented physicians as well as Fortune 500 companies, local businesses, professionals and insurance companies in a variety of cases. Mike has also defended the firm's clients and their interests at depositions, including those of plaintiffs, co-defendants, witnesses, treating physicians, and expert witnesses. He has presented physicians, nurses and nursing assistants for deposition in numerous professional liability cases. Mike is periodically contacted immediately after a catastrophic trucking accident to visit an accident scene and work with the client to help develop the facts and evidence, and prepare the case strategy with an eye toward a successful result once litigation is filed.

Significant Cases

- Obtained directed verdict in jury trial on behalf of general surgeon who was alleged to have improperly operated on a patient suffering from apparent bile leak and associated symptoms caused by a retained gallbladder following cholecystectomy performed by another surgeon.
- Obtained a defense verdict for defendant surgeon after a jury trial in which plaintiff alleged that the surgeon failed to entirely remove her gallbladder during a cholecystectomy.
- Represented defendant orthopedic surgeon at jury trial in the successful defense of allegations that the doctor improperly casted plaintiff's both-bone forearm fracture, allegedly causing permanent deformity and loss of motion.

- Represented OB-GYN physician at jury trial in the successful defense of plaintiff's allegations of bowel injury during closure of surgical wound after performance of tubal ligation.
- Represented a radiation oncologist at trial in the successful defense of plaintiff's claims that in treating her cancer, the oncologist administered too much radiation, causing insufficiency fractures in her bones and resulting in her death.
- *Eckburg v. Presbytery of Blackhawk of Presbyterian Church (USA)*, 396 Ill. App. 3d 164, 918 N.E.2d 1184 (2d Dist. 2009) - Represented rural landowner in the appeal of a case alleging serious injury and wrongful death to plaintiffs, a motorcycle rider and his passenger wife, resulting from a tree falling onto state highway. The court affirmed the lower court's dismissal of the case. In a second appeal, (*Eckburg v. Presbytery of Blackhawk of Presbyterian Church (USA)*, 2011 IL App (2d) 110284-U, Not Reported in N.E.2d, the appellate court ruled that the landowner could not be held liable for damage caused by falling branches or trees that abut private property that are physically located on state's Right of Way and exclusively under state's control.
- *Lorenz ex rel. Lorenz v. Herrera*, 362 Ill. App. 3d 1171 (2d Dist. 2006) - Represented defendants/appellants Sheriff and Sheriff's Department in an appellate case that established that the proper venue for personal injury action against deputy sheriff is county in which sheriff's office is located, not plaintiff's county of residence.

Publications

- "Survey of Civil Practice Cases," Illinois Association of Defense Trial Counsel's 2013 Survey of Law (2014)
- "Liquor Liability: Social Hosts and Other Issues," 26th Annual Claims Handling Seminar (2011)
- "Illinois Courts Expand, Then Narrow Validity of Arbitration Agreements in Nursing Home Litigation," *IDC Defense Update*, Vol. 12, No. 14 (2011)

Public Speaking

- *"How to Handle the Midnight Call and The Building Blocks of an Effective Defense"*
Heyl Royster 29th Annual Claims Handling Seminar (2014)
- *"Civil Procedure Update"*
Illinois Association of Defense Trial Counsel (2013)
- *"You've Been Served: How to Help Your Organization Understand and Defend a Lawsuit"*
St. Mary's Occupational Health & Streator Chamber of Commerce (2013)

Professional Recognition

- Martindale-Hubbell AV Preeminent
- Named one of "40 Under Forty" attorneys to watch in Illinois by the Law Bulletin Publishing Company. This honor recognizes exceptional lawyering skills, significant contributions to the legal profession and substantial involvement in local community.
- Named to the Illinois Super Lawyers Rising Stars list (2012-2015). The Super Lawyers Rising Stars selection process is based on peer recognition and professional achievement. Only 2.5 percent of Illinois lawyers under the age of 40 or who have been practicing 10 years or less earn this designation.

Professional Associations

- Federation of Defense & Corporate Counsel (Vice Chair, Professional Liability Section; Editor, Professional Liability Section Newsletter)
- Professional Liability Defense Federation
- Winnebago County Bar Association
- Illinois State Bar Association
- Illinois Association of Defense Trial Counsel
- Defense Research Institute
- American Bar Association
- State Bar of Wisconsin

Court Admissions

- State Courts of Illinois and Wisconsin
- United States District Court, Northern District of Illinois and Eastern and Western Districts of Wisconsin
- United States Supreme Court

Education

- Juris Doctor (cum laude), Northern Illinois University College of Law, 2002
- Bachelor of Science-Business Administration, Bradley University, 1999