*Editor's Note: Lawsuits can be won or lost based upon demonstrative evidence. Juries often react strongly to video evidence of alleged bad acts. In this article, the authors analyze California Statutes governing the use of video monitoring and surveillance equipment and explain how statutory requirements and technology intersect in the courtroom.*

## WHO'S WATCHING? STRATEGIC, LEGAL AND OPERATIONAL ISSUES FOR LONG TERM CARE FACILITIES CONSIDERING VIDEO SURVEILLANCE MONITORING

**By Nathaniel M. Lacktman and Jonathon E. Cohn**[1]

### 1. INTRODUCTION

As regulatory scrutiny and elder abuse verdicts mount, more nursing facility operators are utilizing video surveillance to monitor common areas of the facility.

The use of video surveillance monitoring equipment is completely voluntary. Although many states explicitly permit video surveillance, which includes cameras installed by the facility in common areas and cameras installed by residents in their rooms (aka granny cams), no state requires it.

Many long term care providers, particularly those with records of high-quality care, believe the proactive use of video surveillance monitoring equipment can supplement record keeping, improve quality assurance efforts, maintain employee productivity and compliance and enable greater oversight by facility management. There are plenty of anecdotal stories about the employee caught sleeping in the lounge or the allegedly "abused" resident who actually drove his or her own wheelchair into a corridor wall.

But along with its advantages, video monitoring raises several difficult and complicated issues providers must first consider when determining whether video surveillance is appropriate for their facility. If a facility installs equipment should it operate the system and monitor the facility 24 hours a day? Should the facility employ someone full time, if need be, to view the imagery? Does the recorded footage constitute medical records? Should the recorded footage be stored and for how long? Can (or should) the facility make subjective determinations about which images to keep and which to destroy? Is the video footage protected from disclosure to plaintiffs' attorneys and/or state and federal regulators? How can video surveillance improve a poor performing facility? These issues are addressed in this article.

### 2. STRATEGIC ADVANTAGES OF VIDEO SURVEILLANCE

Video surveillance of common areas of a skilled nursing facility offers several strategic advantages. First and foremost, it is a method to safeguard against abuse because people are less likely to act abusively if they know they are being filmed. It provides general deterrence to ensure compliance by employees with their job duties.

Video surveillance can also assure state and federal regulators that the facility has an active interest in maintaining the safety and well-being of its residents and always is on watch for potential deficiencies or violations. The footage can be used for training programs and in-services to demonstrate proper employee work habits.

Video surveillance footage also is documentary evidence that can provide a defense against false allegations of elder abuse. It can exonerate facility staff by

showing, for example, that suspicious bruises sustained by a resident were actually due to a simple slip and fall, rather than abuse.

## 3. OBTAINING PROPER CONSENT UNDER HIPAA AND STATE PRIVACY LAWS

Videotape surveillance of residents, even if limited to common areas, raises privacy and consent issues. The issues differ depending on the intended use of the video footage. Consent to the video surveillance and recording, appropriate to the intended use of the video footage, should be obtained from the resident or the resident's authorized legal representative. Video footage of a resident may be taken for several different purposes, including patient education, marketing, professional education, research or law enforcement. Photographs and video footage are treated identically for consent and privacy issues.

Publication of video footage taken without a patient's consent may give rise to an action for damages.[2] Even without publication, the mere act of video recording without obtaining consent may, in some circumstances, be actionable.[3]

### A. Develop A Policy For Video Surveillance And Sign A Hipaa Business Associate Agreement With The Surveillance Vendor

Each facility should develop a policy regarding which residents may be video recorded and when, how and by whom. If video footage of a patient (or part of a patient's body) allows the viewer to identify the patient, then the disclosure of that video footage constitutes the release of medical information. Because the video surveillance company will have access to the footage, the company should sign a HIPAA business associate agreement with each facility, agreeing to use the information only in the manner consented to by the resident and in accordance with facility policies, California privacy rights, the California Medical Information Act (CMIA) and HIPAA regulations.

It is important to note that, California and federal medical confidentiality laws do not prohibit the use of video footage of a resident for purposes of diagnosis and treatment, or for the facility's own operational purposes ("health care operations").[4] "Health care operations" as defined, include, among other things, conducting quality assessment and improvement activities, reviewing the competence and qualifications of health care professionals, conducting training programs, licensing and certification activities, and general administrative activities such as resolution of internal grievances. Although a facility is not required to obtain resident consent to use the footage for "health care operations," it is both prudent and considerate for the facility to disclose that it conducts video surveillance and the facility should seek to obtain consent.

### B. Disclose The Surveillance In The Admission Agreement

The admission agreement is an effective and practical tool to alert a future resident that the facility uses video surveillance. To that end, the admission agreement can contain a brief paragraph that discloses the video surveillance and obtains the patient's consent to the filming and use of the video footage. Consider adding the following language to the admission agreement:

**I acknowledge that the facility uses video surveillance in common areas as part of its quality assessment and improvement**

**activities and health care operations as defined by 45 CFR §§164.501 and 164.506. I acknowledge and consent to the video recording, with the understanding that the images from such recording may be used only for facility health care operations and will not be disclosed except as required or permitted by law.**

California's Standard Admission Agreement contains similar disclosure language and a consent to photograph form.[5] In addition to the "health care operations" exception noted above, under California law a facility may disclose video footage without a patient's authorization if the disclosure is otherwise permitted by law (e.g., mandatory reporting obligations, court order or permitted disclosures to law enforcement agencies).[6] If a resident refuses consent, however, the facility should ensure that any video footage of that resident is limited to use of "health care operations" only.

## 4. TACTICAL CONSIDERATIONS AND HURDLES

Employing video surveillance at a health care facility carries certain risks. Along with recording potentially exonerating footage, cameras can capture potentially incriminating footage that could expose a facility to lawsuits or penalties for regulatory violations. Prior to installing cameras, a facility needs to create policies and procedures for retention and destruction of recordings, patient consent, and disclosure of footage. The facility and its staff also risk criminal liability for destroying recordings of suspected abuse. Video footage is sometimes difficult to admit as evidence in defense of a lawsuit, and certain precautions should be employed to ensure the admissibility of such evidence. These issues are each addressed below.

### A. Criminal Liability For Destruction Of Evidence

In many states, it is a criminal offense to destroy or conceal evidence.[7] In California, the crime is codified under Penal Code section 135, which provides:

"Every person who, knowing that any book, paper, record, instrument in writing, or other matter or thing, is about to be produced in evidence upon any trial, inquiry, or investigation whatever, authorized by law, willfully destroys or conceals the same, with intent thereby to prevent it from being produced, is guilty of a misdemeanor."

Most employees in California nursing facilities are required to report suspected elder abuse within two days to DHS and the Bureau of Medicare Fraud and Elder Abuse (BMFEA).[8] These employees are known as "mandated reporters." When a mandated reporter files a report of suspected elder abuse, the facility should be aware that the corresponding agency (e.g., DHS or BMFEA) will commence an investigation or inquiry into the suspected abuse. Although the reporting statutes do not require the facility to provide documentary or physical evidence of the suspected abuse with the initial report, there are fields on the standard reporting form where the mandated reporter should identify the sources of information upon which he or she bases a report of suspected elder abuse.

If a facility has a video surveillance system, the footage from that surveillance is important documentary evidence of suspected abuse. Although the mandated reporter statutes do not explicitly require a facility to preserve evidence of suspected elder abuse, after a report is filed, the provisions of Penal Code section 135 would likely be triggered because an investigation

will soon commence. It could therefore be a criminal act if the facility knowingly destroyed or concealed evidence of the suspected abuse (including video footage) before investigators can inspect it.

For that same reason, destroying or selectively deleting (i.e., editing) video footage that constituted evidence of elder abuse could be criminal under Penal Code section 135 because the prohibition on destroying evidence is not limited to writings or written documents. An abuse report investigation by DHS or BMFEA falls within the reach of Penal Code section 135 because the Section is not limited to cases where formal legal proceedings are pending. The Section applies, for example, to evidence seized in the course of a police investigation.[9]

### B. Civil Liability For Destruction Of Evidence

Under California law, intentional loss or destruction of evidence in a civil lawsuit (spoliation of evidence) is not an actionable tort.[10] A facility cannot be sued for destroying or editing video footage. However, there are several nontort remedies that punish and deter spoliation of evidence. For example, a plaintiff can ask the jury to draw a negative inference against the facility because it willfully destroyed videotape footage.[11] There are also discovery, monetary and contempt sanctions for spoliation of evidence, available when a party destroys evidence in response to a discovery request after litigation has commenced or has destroyed evidence in anticipation of a discovery request.[12] Disciplinary sanctions can also be imposed against an attorney who participates in spoliation or suppression of evidence.

### C. Access To Video Footage By State And Federal Regulators

With regard to whether or not state or federal regulators can obtain the video recordings, the answer is unclear. Regulators contend they have authority to access such footage because it is part of the survey process and necessary to evaluate the facility for compliance with licensing or certification requirements. Facilities would seek to withhold such footage from production under the quality assurance privilege guaranteed by Title 42.[13] Although the facility would have a good argument, it is likely the facility would ultimately be required to produce the video footage on the grounds that the footage (i.e., the records sought to be withheld) was not a record created by the quality assurance committee. Furthermore, it would be exceedingly difficult for a facility operator to tell patients that the video footage is used for health care operations and simultaneously tell regulators that the footage is useless to evaluate quality assurance and compliance.

If there is a possibility of criminal prosecution, the facility could withhold the video footage under a Fifth Amendment claim. Regulators would not be able to access it absent a court order. Therein lies an inherent risk of video surveillance: it records the incriminating along with the exculpatory.

## 5. DEVELOP A POLICY FOR VIDEO RECORDING RETENTION AND DESTRUCTION

A facility needs to address the retention and destruction of video recordings in its policies and procedures. Because modern video recordings are stored in electronic format, a facility may easily and inexpensively store all the data on back-up

hard drives or DVDs. Retaining all data provides a facility with the full spectrum of events and offer unfettered access to review video footage from any particular date. But at the same time, the data permits regulators and plaintiffs the same access.

Another option for a facility is to periodically review footage and destroy it (e.g., every two weeks). This allows a facility to review the footage but not incur the storage costs and risks of preserving all the historical activities. If a facility elects to periodically destroy the footage, it still must preserve evidence of any suspected elder abuse which prompted a mandatory report.

A third approach is for a facility to review video footage and maintain events depicting suspected abuse and events that might be used as exonerating evidence in defense of a lawsuit. Other footage would be destroyed. This approach is risky, however, because it gives significant discretion to the video footage reviewer to decide what footage is deleted.

Ultimately, whatever record retention and destruction approach a facility employs, it should be addressed and reflected in its policies and procedures and comply with state and federal law.

## 6. EVIDENTIARY ISSUES

If a facility wants to use video surveillance footage at trial in defense of a lawsuit, it will need to satisfy the legal requirements for admitting video recordings into evidence. Under California law, video recordings require authentication by witness testimony that the recording is an accurate representation of what it purports to show. The authenticating witness need not be the videographer, but may be anyone present at the scene of the event depicted.[14] If the video footage has been edited, facility (as the party seeking to introduce that evidence) has a much higher burden, and must establish that the editing did not distort the meaning of the facts depicted.[15] For this reason, a facility should carefully consider whether it should edit its video surveillance footage, and the most prudent course of action is most often, not to edit the footage.

Courts are aware that video evidence can be distorted and that the careful editing of visual recordings may alter the facts depicted in the recordings. For these reasons, courts adopt a cautious approach to admission of video evidence.[16] A facility must establish that there has been no distortion of the video footage.[17] If a facility were to extensively edit its video footage (even if done pursuant to its policies and procedures), such editing could make the footage difficult to introduce into evidence. If a facility wants to retain a recorded event, it should consider retaining all footage from that day. This might make it easier to introduce the footage at trial.

## 7. CONCLUSION

There will always be a tension between the privacy rights of the residents at a long term care facility and the interests of the facility operators to ensure quality care. As video surveillance technology advances and becomes more affordable and widespread, its use in the long term care setting should only increase. Video surveillance can be a powerful tool to increase productivity, improve the quality of patient care, and provide exculpatory evidence in litigation. Facility operators should appraise themselves of the risks and benefits before installing a surveillance system. Facilities that currently have such systems installed should assess their policies and procedures to verify compliance with applicable state and federal laws. When counsel is experienced in these issues, the facility can

establish a comprehensive plan to properly implement a video surveillance system.

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[2] *Miller v. NBC*, 187 Cal. App. 3d 1463 (1986) (publication of photographs).

[3] *Estate of Berthiaume v. Pratt*, 365 A.2d 792 (Me. 1976) (physician held liable for invasion of patient's privacy for taking pictures for medical research purposes over patient's objections).

[4] 45 CFR §§164.501 and 164.506; California Civil Code §56.10(c)(14).

[5] California became the first state to prohibit long term care facilities from writing and using their own customized admission agreements. R-05-01; Title 22 of California Code of Regulations §72516. The regulation became effective on January 2, 2006 and applies to all residents admitted since January 1, 2000. In *Parkside Special Care Center, Inc. v. Sandra Shewry* (Cal. Sup. Court, San Diego County, Case No. GIC 860574, 2006), California's Standard Admission Agreement was challenged on the grounds that several of its provisions are invalid and inconsistent with existing law. It remains under revision by DHS.

[6] Civ. Code § 56.10(c)(14).

[7] *People v. Superior Court of Santa Clara County*, 53 Cal. App. 3d 341 (1980).

[8] *See* California Wel. & Inst. Code §§ 15630, *et seq.*

[9] *People v. Fields*, 105 Cal. App. 3d 341 (1980).

[10] *Cedars-Sinai Medical Center v. Superior Court*, 18 Cal.4th 1, 17-18 (1998).

[11] Cal. Evid. Code §413.

[12] Cal. Code Civ. Pro. §2023.030.

[13] *See* 42 U.S.C.§ 1395i-3(b)(1)(B), which provides: "A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph." The same language is applied to nursing facilities by 42 U.S.C. § 1396r(b)(1)(B).

[14] *People v. Bowley*, 59 Cal.2d 855, 859 (1963).

[15] *Fashion 21 v. Coalition for Human Immigrant Rights of Los Angeles*, 117 Cal. App. 4th 1138, 1146-47 (2004) (edited videotape was admitted for purposes of SLAPP suit motion to strike in determining plaintiffs' reasonable probability of success on libel claim, but had the videotape been offered at trial, its lack of authentication may have been an evidentiary bar).

[16] *Harmon v. San Joaquin Light & Power Corp.*, 37 Cal. App. 2d 169, 174 (1940).

[17] *Fashion 21, supra*, at 1146-47 ("[T]he party offering an edited videotape into evidence at trial bears the burden (under Evid. Code §1402) of showing the editing did not distort the 'meaning' of the activities depicted in the tape.").