
CORPORATE HEALTHCARE LITIGATION

From Boardroom to Bedside

Tracing an Ownership Decision to a Patient's Injury

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

Over the last 15 years, a lot of healthcare changed hands. Physician groups, nursing homes, hospitals, hospices, and behavioral health programs were bought by private equity firms, had their buildings sold and leased back, and were handed to management companies to run. Physician practice acquisitions alone went from several hundred in 2012 to several thousand by 2021.

What that has meant for patients is still being studied, and the evidence isn't all one way. Two studies get cited constantly. Kannan, Bruch, and Song, writing in *JAMA* in December 2023, found that hospital-acquired adverse events, including falls and central line infections, rose about 25 percent after private equity bought a hospital, compared with similar hospitals that weren't bought. And Gupta, Howell, Yannelis, and Gupta, in the *Review of Financial Studies* in 2024, linked private equity ownership of nursing homes to roughly an 11 percent increase in short-term mortality among Medicare residents, along with lower staffing. Both are averages across many facilities. Neither tells you what happened to your client.

The policy response has been real. Steward Health Care, once private equity-owned and dependent on a sale-leaseback of its hospitals, went bankrupt in May 2024. Hospitals closed, and a Senate committee investigated. Massachusetts tightened oversight in January 2025, and by the end of 2025 at least seven states, including Oregon, California, Massachusetts, Indiana, New Mexico, Washington, and Maine, had passed laws expanding scrutiny of private equity and other investors in healthcare. Oregon's SB 951 goes furthest, limiting investor control over clinical decisions in physician practices. At the federal level, CMS since November 2023 has required nursing homes to disclose more about who owns and manages them, including private equity and REIT owners.

Whether a parent company, investor, or manager can be held liable, through direct corporate negligence, veil piercing, joint enterprise, or a statute, is a question for counsel, and the answer varies by state. What a clinical reviewer can do is build the chain from a decision made in an office somewhere to what happened at one patient's bedside. Without that chain, ownership is just background. With it, it can be the heart of the case.

A FICTIONAL CASE

An investment firm buys a nursing home. It sells the building to a real estate trust and leases it back. A management company tied to the investors takes over for a percentage of revenue. Over the next year, aide hours per resident drop, agency staff fill more shifts, turnover climbs, and the star rating falls. A resident with diabetes and limited mobility gets a wound on her foot that nobody notices for several days. It gets infected, and she loses part of her leg.

START AT THE BEDSIDE, AND LEAVE OWNERSHIP OUT OF IT FOR NOW

What were her risk factors: diabetes, neuropathy, poor circulation, immobility? What did the care plan say about checking her skin and feet, and how often? What does the documentation show was actually done, and by whom? When was the wound found, by whom, and what happened next?

That answer has to stand on its own. If the foot checks were charted but not done, or never charted, that's a care failure no matter who owns the building. If the checks were done properly and the wound came on fast anyway, that's a different story. Only once the bedside picture is clear does it make sense to ask what shaped it.

THEN FIND WHAT SHAPED IT

The most common links are practical ones. Maybe there weren't enough aide hours to do skin checks and turning properly; payroll-based staffing data, assignment sheets, the MDS acuity picture, and the facility's own facility assessment will show that. Maybe the people caring for her didn't know her, because agency use and turnover were high; agency invoices, turnover data (now on Care Compare), and orientation records will show that. Maybe the right mattress or wound supplies weren't there; purchasing records and refused supply requests will show that. Maybe the wound nurse position was left empty or cut, or maybe quality problems were reported upward and nothing happened; QA minutes and position records will show that.

THEN FOLLOW IT UPSTREAM

Who set the labor budget, and what targets came with it? Did the administrator ask for more staff and get told no? What did the management agreement give the manager control over: staffing, purchasing, policies, clinical operations? Who did the administrator and director of nursing

actually report to? What quality reports went up to corporate, and what came back down? Emails and messages about staffing, supplies, and survey results are often the most revealing documents in the case.

Whether you can get those documents is a legal question. The clinical reviewer's job is to tell you which conditions mattered, so discovery can aim at them instead of trying to swallow the whole company.

TWO TIMELINES, SIDE BY SIDE

One technique that helps is to build two timelines and set them next to each other. The first is the corporate one: the acquisition, the sale-leaseback, the new manager, leadership changes, budget cycles, restructurings. The second is the facility's clinical story: staffing hours, agency use, turnover, survey citations, complaints, and quality measures like pressure injuries, falls, and hospitalizations. Then drop the resident's own timeline into the middle.

A staffing drop that starts the quarter after a new budget is a different finding from one that started before the sale. A spike in pressure injuries right after a wound nurse position was cut points to a specific mechanism. None of that proves causation. It tells you where to dig.

DON'T OVERREACH

A staffing drop might reflect a regional labor shortage that hit every facility in the county; public PBJ data from nearby facilities can tell you. A management fee might have nothing to do with care. And if corporate quality staff caught a problem and made the facility fix it, that belongs in your analysis too.

Be specific: which decision, which resulting condition, which bedside failure, and what connects them. A chain with solid links persuades. A general argument that private equity is bad doesn't.

IT ISN'T JUST NURSING HOMES

The same approach works for hospitals (nurse staffing, closed service lines, deferred equipment maintenance, transfer delays after a unit shuts), physician practices (productivity quotas, 10-minute visit templates, thin support staff, how many APPs one physician supervises), hospice and home health (visit frequency, caseloads, live discharges), and behavioral health (staffing ratios, observation levels, pressure to discharge). Bedside failure, contributing condition, originating decision.

RECORDS WORTH REQUESTING

- The complete clinical record and care plans
- PBJ staffing data, assignment sheets, agency invoices, and turnover data
- Facility assessments for the relevant years

- Budgets, staffing plans, and variance reports
- Management, consulting, and lease agreements, plus organizational charts
- Corporate clinical policies and who approved them
- Quality reports and dashboards sent to corporate, and QA records (privilege may apply)
- Survey history, plans of correction, and CMPs
- Public ownership data from CMS enrollment files, Care Compare, and state filings

SOURCES

- Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. *JAMA*. 2023;330(24):2365–2375
- Gupta A, Howell ST, Yannelis C, Gupta A. Owner incentives and performance in healthcare: private equity investment in nursing homes. *Review of Financial Studies*. 2024;37(4):1029–1077
- CMS, disclosure of ownership and additional disclosable parties for SNFs and NFs, final rule (Nov. 2023)
- Stateline, “New state laws tackle private equity’s growing role in health care” (Nov. 21, 2025); Oregon SB 951 (2025)
- 42 C.F.R. §§ 483.35, 483.71

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If ownership or management decisions may be part of your case and you want the bedside failure pinned down and traced upstream, link by link, we'd welcome the conversation.

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