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California Courts Sharply Curtail the MICRA Damages Cap in Nursing Home Litigation

Aud v. RRT Enterprises, the *Holland* Framework, and a Practical Defense Playbook

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Executive Summary

On July 22, 2026, the California Court of Appeal (Second District, Division Seven) filed its partially published decision in *Aud v. RRT Enterprises, LP* (2026 Cal. App. LEXIS 449, B341254), reinstating a jury's award of **$1,837,032 in noneconomic damages** against a skilled nursing facility and reversing the trial court's reduction of that award to $250,000 under the Medical Injury Compensation Reform Act (MICRA).

The court held that the resident's injuries—repeated falls, pressure injuries, malnutrition, and dehydration—arose from the facility's failures as a **custodian and caregiver**, not as a **healthcare provider**, and that MICRA's cap on noneconomic damages therefore did not apply at all.

Aud is the first published appellate decision to apply the California Supreme Court's framework from *Holland v. Silverscreen Healthcare, Inc.* (2025) 18 Cal. 5th 364 to a full jury verdict, and it does so aggressively. Three of its holdings deserve particular attention:

1. The Care Plan Does Not Save You

- Even where the facility properly performed a clinical fall-risk assessment and identified high-risk interventions, the failure to *implement* those interventions—supervision, call-light response, toileting

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assistance, alarms, adequate staffing—is custodial neglect outside MICRA.

- Attaching the words "assessment," "care plan," or "nursing judgment" to operational failures will not convert them into professional negligence.

2. Mental State is Irrelevant to the MICRA Line

- The jury found neglect but expressly found *no* recklessness, oppression, fraud, or malice. The defense argued that ordinary (non-egregious) neglect must therefore fall under MICRA.
- The court rejected the argument: it is the **type of conduct** and the **capacity in which the facility acted**—not the defendant's culpability—that controls. A facility can now face uncapped non-economic damages on a theory of *simple negligence* in custodial care.

3. The Plaintiffs' Roadmap is Now Published

- *Holland* and *Aud* together tell the plaintiffs' bar exactly how to plead and try these cases: characterize every failure as supervision, staffing, hygiene, hydration, toileting, repositioning, or call-light response, and MICRA (and, in many cases, the resident's arbitration agreement) falls away.
- We should expect nearly every complaint filed against a California facility going forward to be drafted to this template.

The practical consequence is that **MICRA can no longer be treated as a reliable damages backstop** in California long-term care litigation. Defense of these claims must shift decisively toward:

1. operational and documentation practices that close the gap between assessment and implementation,
2. contract and arbitration architecture drafted with the custodial/medical line in mind,
3. litigation strategies that force pleading specificity and preserve MICRA, arbitration, and allocation arguments where genuinely medical conduct is at issue, and
4. claims-evaluation, reserving, and underwriting assumptions recalibrated for uncapped exposure.

Section by section, this alert traces the law, then sets out a concrete playbook for each stakeholder.

A status note: *Aud was certified for partial publication and is citable, but it is not yet final. A Court of Appeals opinion ordinarily becomes final 30 days after filing, and a petition for review to the California Supreme Court remains possible. Its status should be confirmed before it is relied upon in a filed brief.*

1. The Aud Decision

Facts and Trial Outcome

- Betsy Jentz, a former marathon runner in her 80s, was admitted to Country Villa Wilshire Convalescent Center, a skilled nursing facility operated by RRT Enterprises, LP, in late 2020 for custodial care and rehabilitation following a hip fracture. On admission, the facility's nursing staff assessed her as a **high fall risk** and recommended implementing high-risk fall interventions.

- The evidence at trial showed what followed: her call light was frequently out of reach or not working; when it did work, responses took 30 to 45 minutes; staff did not provide regular toileting assistance or meaningful supervision; no bed alarm or observation arrangement was implemented; and understaffing prevented these basic measures from being carried out. Jentz fell repeatedly.

- In her worst fall, in October 2021, she got out of bed after no one answered her call, made it to the bathroom, and fell on the way back, fracturing her humerus, pubic ramus, and ischium. She also developed pressure ulcers attributed to failures to reposition her and keep her skin clean, and evidence showed inadequate food and water, with no one assisting her to eat after she lost the use of her arm.

- The jury found elder neglect under the Elder Abuse Act and negligence, awarded **$2,342,800** in total (including $1,837,032 in noneconomic damages and $53,150 in statutory damages for 132 violations of Health & Safety Code section 1430(b)), and found the facility acted with malice, oppression, or fraud for punitive-damages purposes—but critically, the jury found **no recklessness, oppression, fraud, or malice** for purposes of the Elder Abuse Act's heightened remedies under Welfare & Institutions Code section 15657.

- The trial court granted the defendants' post-trial motions, reducing noneconomic damages to MICRA's $250,000 cap (the pre-2023 figure, because the action was filed in 2022) and reducing economic damages to $69,812.19, the amounts Medicare and Medi-Cal actually paid.

The Holding

The Court of Appeals reversed the MICRA reduction. Applying *Holland,* the court concluded that Jentz's negligence and elder abuse causes of action "arose out of Country Villa Wilshire's acts and omissions as Jentz's custodian and caregiver, not as her health care provider."

The failure to assist her from bed to bathroom, the unanswered call lights, the absence of supervision and alarms, the failure to reposition and clean her, and the failure to provide adequate food and hydration were all "paradigmatic" custodial failures. Civil Code section 3333.2, therefore, did not limit her recovery, and the full $1,837,032 noneconomic award was reinstated.

The Arguments the Court Rejected—and Why They Matter

"The gravamen was a negligent fall-prevention care plan."

The defendants argued that fall-risk assessment and fall-avoidance planning necessarily implicate nursing expertise and judgment, placing the claim on the medical side. The court, quoting *Holland,* held this argument "sweeps too broadly." A claim *may* sound in professional negligence when it challenges the clinical judgment embodied in prescribing or executing a plan to address a resident's medical needs.

But Jentz never claimed the nursing staff mis-assessed her risk—the assessment was correct. Her claim was that the facility "lacked the staff and custodial resources to implement the plan, and it was that failure that caused [her] injuries." Even her expert's testimony about "individualizing" the care plan concerned custodial tasks: learning when the resident typically needed the bathroom, building a toileting schedule around it, and finding activities outside her room so staff could watch her.

"She was admitted with a medical condition."

The fact that the resident arrived post-surgery with a fractured hip did not transform custodial failures into medical care. The resident's medical fragility, the existence of a clinical care plan, and the involvement of licensed staff do not control the analysis; the nature of the specific duty and the act that caused injury do.

"No egregious abuse means MICRA applies."

Because the jury declined to find recklessness, oppression, fraud, or malice under section 15657, the defendants argued (relying on language in *Delaney v. Baker* (1999) 20 Cal. 4th 23) that any "ambiguity" had to be resolved in favor of professional negligence and the cap. The court squarely rejected this.

After *Holland,* the controlling consideration is the type of conduct and the capacity in which the defendant acted —not whether the plaintiff proved a heightened mental state. **Ordinary negligent custodial care is outside MICRA, even where the plaintiff cannot establish the culpability required for Elder Abuse Act enhanced remedies.** This is arguably the single most consequential holding in *Aud,* because it detaches uncapped noneconomic exposure from any requirement of egregious conduct.

Flores v. Presbyterian distinguished.

The defendants invoked *Flores v. Presbyterian Intercommunity Hospital* (2016) 63 Cal. 4th 75, where a negligently maintained bed rail—raised pursuant to a clinical order—was professional negligence. The *Aud* court distinguished it in one sentence: "Jentz's injuries … were not caused by anything a health care professional ordered." The lesson: where a specific clinical order or undertaking is the causal mechanism, MICRA remains available; where the causal mechanism is the absence of routine assistance, it is not.

What the Defense Won

Aud was not a total loss for the defense, and the unpublished portions carry practical value. The court **affirmed** the reduction of economic damages from $452,618 to $69,812.19—the amounts Medicare and Medi-Cal actually paid—reinforcing that paid-versus-billed principles remain a powerful tool against inflated economic claims.

The court also affirmed judgment notwithstanding the verdict for the management and consulting entities (Rockport and Boardwalk) on the **joint venture** theory, and affirmed a new trial on **alter ego,** confirming that alter ego is an equitable issue for the court, not the jury.

The plaintiffs' efforts to reach related entities and individual principals remain subject to meaningful proof requirements—a point of real significance for structured operator/management-company organizations.

2. How We Got Here: The Doctrinal Path from *Flores* to *Aud*

The custodial/medical distinction did not appear overnight. Understanding its lineage matters because each case in the chain supplies arguments—for both sides—that will now be deployed in every California long-term care case.

Flores v. Natividad Medical Center (1987) 192 Cal. App.3d 1106.

An inmate suffering a hypertensive crisis went untreated; the State was held liable for **failure to summon medical care** under Government Code section 845.6. The Court of Appeals held MICRA's cap did not limit the award against the State because the gravamen of that claim was the failure to *provide access* to care, not negligence in *rendering* professional services.

Flores also applied the hybrid-theory rule of *Waters v. Bourhis* (1985) 40 Cal. 3d 424: **where a plaintiff proceeds on both MICRA and non-MICRA theories and the recovery may rest on the non-MICRA theory, MICRA's limitations do not apply.** That rule is now a live threat in every mixed custodial/medical case—and the reason defense counsel must insist on allocation in verdict forms (see Section 6).

Delaney v. Baker (1999) 20 Cal. 4th 23 and Covenant Care, Inc. v. Superior Court (2004) 32 Cal. 4th 771.

The Supreme Court held that the Elder Abuse Act's heightened remedies reach reckless custodial neglect by healthcare providers, and that "health care provider" and "elder custodian" are conceptually distinct capacities. *Covenant Care* described neglect as "the failure of those responsible for attending to the basic needs and comforts of elderly or dependent adults … to carry out their custodial obligations"—language *Aud* quotes directly.

Flores v. Presbyterian Intercommunity Hospital (2016) 63 Cal. 4th 75.

The counterweight: negligence in carrying out a measure that a healthcare professional *ordered* to accommodate a patient's condition (the raised bed rail) is professional negligence. This remains the anchor authority for keeping genuinely clinical conduct inside MICRA.

Avila, Valentine, and Hearden (2018–2024).

A line of Court of Appeals decisions in the arbitration context asked whether the "primary basis" of a wrongful death claim sounds in medical malpractice or custodial neglect, holding that heirs' wrongful death claims premised on custodial neglect are not captured by Code of Civil Procedure section 1295 arbitration agreements under *Ruiz v. Podolsky.*

Holland v. Silverscreen Healthcare, Inc. (2025) 18 Cal. 5th 364.

The Supreme Court unified the doctrine. A skilled nursing facility "wears multiple hats": it renders services as a professional medical provider and as the resident's day-to-day custodian. Only acts or omissions in the facility's capacity **as a healthcare provider** constitute professional negligence.

Paradigmatic custodial duties include assistance with hygiene, food, hydration, and clothing; a habitable living space; protection from routine safety hazards; attending to and monitoring residents; assistance with daily activities; and helping the resident obtain medical attention (*a failure to summon* care is custodial; a negligent *undertaking* of care is medical).

The court expressly rejected the argument that fall protection and infection control are inherently medical, while acknowledging that claims challenging the clinical content of a treatment plan remain grounded in professional negligence. Notably, *Holland* also confirmed that opaque pleading will not be rewarded: where the complaint does not connect the causal mechanism to the injury, the remedy is leave to amend and specificity—a point defense counsel should exploit (Section 6).

Faiaipau v. THC-Orange County, LLC (2025) 117 Cal. App. 5th 292 and Frankland v. Etehad (2025) 113 Cal. App. 5th 503.

Two post-*Holland* decisions preserving the medical side of the line:

- **In *Faiaipau,*** a hospital's failure to monitor and reconnect a ventilator it had undertaken to provide was professional negligence — the negligent performance of an ongoing medical service.
- **In *Frankland,*** a physician's inadequate examinations, failures to follow up on tests and orders, and inadequate treatment of infection were professional medical services; the physician did not become the patient's custodian merely by treating her inside a skilled nursing facility.

These cases are the defense's best templates for characterization arguments.

Aud v. RRT Enterprises, LP (2026).

The capstone: *Holland* applied to a tried verdict, with the care-plan and mental-state escape routes closed.

3. The Statutory Framework: What "Custodial Care" Actually Means

MICRA nowhere defines "custodial care." It defines **professional negligence,** and the courts identify custodial care by contrast.

Civil Code section 3333.2 (and, in materially identical terms, Code of Civil Procedure sections 340.5 and 1295) defines professional negligence as a negligent act or omission by a healthcare provider **in the rendering of professional services,** proximately causing personal injury or wrongful death, where the services are within the scope of the provider's license. The statutory focus is on the rendering of medical services—not on whether the defendant happens to hold a license, and not on where the injury occurred.

The closest statutory description of the custodial function comes from the Elder Abuse Act. Welfare & Institutions Code section 15610.57 defines "neglect" as the negligent failure of any person **having the care or custody** of an elder or dependent adult to exercise the degree of care a reasonable person in a like position would exercise, and enumerates the paradigm custodial obligations: assistance with **personal hygiene;** provision of **food, clothing, and shelter; obtaining or providing access to medical care; protection from health and safety hazards;** and **prevention of malnutrition and dehydration.**

Section 15657.2 completes the architecture: claims against a provider that *are based on professional negligence* are governed by the law applicable to professional negligence actions—including MICRA's protections. The custodial relationship itself requires a robust caretaking relationship in which the defendant has assumed responsibility for basic needs an able-bodied, competent adult could ordinarily manage alone; a physician's episodic treatment relationship generally does not qualify (*Frankland*).

The Current Cap Amounts — and Which Cases Get Which Cap

For actions filed (or arbitrations demanded) **before January 1, 2023,** the historic **$250,000** cap applies where the claim is based on professional negligence, which is why the *Aud* trial court applied $250,000 to a 2022 filing. For actions filed **on or after January 1, 2023** (AB 35), the caps started at $350,000 for personal injury and $500,000 for wrongful death and escalate annually by $40,000 and $50,000, respectively.

During 2026, the amounts are $470,000 (personal injury) and $650,000 (wrongful death) per statutory category, with the amount in effect at judgment, award, or settlement—not filing—controlling. The amended

statute recognizes up to three separate category caps: healthcare providers collectively, healthcare institutions collectively, and unaffiliated providers or institutions responsible for separate and independent professional negligence. The cap reaches only non-economic damages; economic damages are never capped.

Two Wrinkles that are Easy to Miss

1. The section 15657(b) survival-damages ceiling

When a plaintiff *does* establish reckless, oppressive, fraudulent, or malicious neglect under section 15657, the Elder Abuse Act permits recovery of the decedent's pre- death pain and suffering in a survival action—but section 15657(b) independently caps those damages by reference to Civil Code section 3333.2(b).

So in wrongful death/survival cases, even a *custodial theory* can encounter a statutory ceiling on the pre-death pain-and-suffering component—not because MICRA applies to the claim, but because the Elder Abuse Act incorporates the ceiling for that remedy.

Defense counsel should not concede this point, and claims professionals should account for it when valuing death cases versus living-plaintiff cases. (Living plaintiffs like Ms. Jentz, by contrast, face no such ceiling on a custodial theory—which is precisely why living- resident fall and pressure-injury cases now carry the greatest uncapped exposure.)

2. Skilled nursing versus assisted living/RCFE

A skilled nursing facility is a "health facility" under Health & Safety Code section 1250(c) and thus a MICRA "health care institution"—though, as *Holland* and *Aud* teach, that status does not medicalize its custodial operations. Assisted living and RCFE operators are generally **not** MICRA institutions (*Kotler v. Alma Lodge* (1998) 63 Cal. App.4th 1381), even when they store medications, assist with self-administration, or arrange medical appointments.

For AL/RCFE portfolios, MICRA was never a meaningful shield, and *Aud* changes little—but the plaintiffs' custodial-neglect playbook applies with full force, and the operational recommendations below apply equally.

4. Where the Line Falls: A Working Map

Synthesizing *Holland, Aud, Faiaipau, Frankland,* and *Flores v. Presbyterian,* the characterization of the most common injury mechanisms now looks like this:

CUSTODIAL — No MICRA Cap	MEDIC
Failure to respond to call lights (30–45 minute responses in *Aud*); call lights out of reach or broken.	Negligent clinical judgment in treatment plan.

Failure to supervise, monitor, or assist with mobility, transfers, and bathroom needs; failure to station staff or use bed alarms.	Injury caused by negligent exe (raised bed rail negligently ma
Understaffing that prevents implementation of safety measures or care plan interventions.	Negligent performance of an c undertook—e.g., ventilator mc
Failure to reposition, keep skin clean and dry, assist with eating, or provide adequate nutrition and hydration (pressure injuries, malnutrition, dehydration).	Wound assessment, staging, d clinical findings, and skilled w
Failure to notice readily observable deterioration or to summon/obtain medical attention (failure to *access* care).	Negligent diagnosis, medicati infection or deterioration once
Custodial components of care plan implementation: individualized toileting schedules, activity planning, observation arrangements.	Clinical assessment and evalu interventions, and clinical dec plan.

Two features of the map deserve emphasis:

1. First, **substance controls over labels** — in both directions. Plaintiffs cannot medicalize a claim by hiring an expert to opine about "nursing standards," and defendants cannot genuinely clinical failures. Courts examine the actual conduct alleged to have caused injury.
2. Second, the map is applied **failure by failure,** not case by case. A single resident's course can generate both custodial claims (unanswered call lights) and medical claims (negligent wound staging), and the same facility wears different hats as to each. This is why allocation—in pleading, in discovery, in expert work, and above all in the verdict form—is now the central structural battle of these cases.

5. The Plaintiffs' Roadmap—What to Expect Now

Holland and *Aud* hand the plaintiffs' bar a drafting template, and we should assume it will be used in every case. Expect the following, and prepare for it:

Custodial-only Pleading

- Complaints will allege understaffing, unanswered call lights, missed toileting and repositioning, inadequate supervision, and failures to summon care—and will studiously avoid alleging negligent clinical judgment, even where the chart shows clinical decision-making at every turn

- Claims will be styled as Elder Abuse Act neglect, negligence, and Health & Safety Code section 1430(b) violations, with wrongful death claims pled through section 377.60 "neglect" to defeat arbitration under the *Avila/Holland* line.

Strategic Dual-track Theories

- Where the facts include medical failures, expect plaintiffs to plead them but seek recovery through the custodial theory, invoking the *Waters v. Bourhis/Flores v. Natividad* hybrid rule: if the recovery may rest on the non-MICRA theory, the cap is lost entirely.

Care Plan Reframing

- Post-*Aud,* plaintiffs will concede the adequacy of assessments (as Jentz did) and attack implementation—converting the facility's own risk assessments into admissions that it knew exactly what custodial measures were required and failed to deliver them.
- Your best clinical documentation becomes the plaintiff's liability exhibit if the implementation record is thin.

Staffing Data Litigation

- Expect aggressive discovery into PBJ payroll-based journal data, staffing schedules, call-light system data, and internal audits, aimed at proving the operational impossibility of implementing care plans—the precise theory that carried *Aud.*

Section 1430(b) Stacking

- The *Aud* jury found 132 separate resident-rights violations.
- Expect per-violation statutory-damages theories to be pled alongside the uncapped noneconomic claim, plus attorney's fees exposure.

Arbitration Avoidance

- Wrongful death heirs will plead custodial neglect to stay out of section 1295 agreements under Ruiz; expect motions to compel arbitration to be met with *Avila/Hearden/Valentine/Holland* oppositions.

6. The Defense Playbook

The response cannot be a single tactic; it has to operate at four levels—contract architecture, operations and documentation, litigation strategy, and claims/underwriting posture as outlined below, organized by stakeholder.

A. Providers and Operators: Admissions Documents and Contract Architecture

The threshold caution: *Aud* holds that courts look past labels to the substance of the conduct. **No admission agreement recital will, standing alone, convert custodial failures into professional negligence.**

But contract architecture still matters enormously—for the scope of arbitration, for framing the evidentiary record, and for preserving MICRA where clinical conduct is genuinely at issue.

Adopt Dual-track Arbitration Agreements

- *Holland* contains a drafting lesson hiding in a footnote: the resident's agreement covered not only section 1295 professional-negligence disputes but *any dispute relating to his treatment and care at the facility*—and as a result, all three **survivor claims** (including the Elder Abuse Act claim) went to arbitration without appeal. Only the heirs' independent wrongful death claim escaped.
- Agreements should therefore contain:

    1. a fully section 1295-compliant medical-malpractice provision (mandatory language, article-one placement, 10-point bold red notice above the signature line), *and*

    2. a separate, broad provision covering any dispute arising from or relating to the resident's care, treatment, services, residency, or the admission agreement itself—with robust severability. The broad clause captures the resident's (and successor-in-interest's) custodial claims by ordinary contract principles even where section 1295/*Ruiz* does not.

Address Wrongful Death Claimants Directly

- Heirs are not bound by the decedent's agreement for custodial-neglect wrongful death claims (*Ruiz* extends only to professional-negligence claims).
- Where feasible, obtain signatures from spouses and adult children **in their individual capacities** agreeing to arbitrate any claims they may hold arising from the resident's care. This will not always be practical or enforceable, but where obtained, it closes the *Holland* gap.

Define the Service Model in the Admission Agreement—Accurately

- Describe supervision, fall interventions, repositioning, toileting programs, and monitoring as components of an integrated, physician- directed, nurse-assessed plan of care, ordered and modified through clinical judgment.
- Do this honestly and operationally, not as boilerplate: the value is not that the label controls (it does not), but that it shapes how the facility's witnesses, charts, and policies describe the same conduct the plaintiff will call "custodial."
- Where an intervention genuinely originates in a clinical order, the record should show it — that is the *Flores v. Presbyterian* fact pattern that keeps MICRA in play.

Negotiated Risk and Informed-choice Documentation

- For residents who decline interventions (alarms, assistance, restricted ambulation), document the offer, the clinical counseling, and the resident's or responsible party's informed refusal.
- These documents both reduce liability on causation and comparative-fault grounds and evidence that custodial measures were, in fact, offered and staffed.

B. Providers and Operators: Operations and Documentation—Closing the Assessment-to-Implementation Gap

Aud was lost in the gap between a correct assessment and absent execution. The operational mandate is to make the implementation as documented as the assessment. Priorities include:

Call-light Response

- Deploy (or fully utilize) electronic call-light systems that log activation-to-response times; set response-time standards; audit monthly; and address outliers in writing.
- In litigation, objective response-time data is either your best exhibit or the plaintiff's. Assume it will exist—make it favorable.
- Include call-light equipment checks (reach, function) in rounding protocols; in *Aud,* lights out of reach or broken were as damaging as slow responses.

Intervention Implementation Logs

- For every high-risk assessment (falls, skin, nutrition, elopement), the chart must show the loop closed: intervention identified → ordered/care-planned → assigned → delivered → audited.
- Toileting schedules, repositioning logs, restorative ambulation records, and meal-intake/feeding- assistance records should be contemporaneous, initialed, and audited for completion—not preprinted checkbox exercises vulnerable to "chart-perfect, care-absent" cross-examination.

Staffing Documentation

- Maintain and retain shift-level staffing records aligned with PBJ submissions, acuity-based assignment records, and documentation of how high-risk residents are factored into assignments.
- Where agency staff fills gaps, documents orientation, and competency. The plaintiffs' theory is operational impossibility; the answer is an operational record.

IDT Engagement After Events

- Post-fall huddles, skin-integrity reviews, and care-plan updates should reflect *clinical reasoning*—what was evaluated, what was considered and rejected, and why.
- This serves quality goals first, and secondarily builds the record that intervention selection involved professional judgment (relevant to characterization, where the plan's content is later attacked).

Do Not Over-medicalize the Chart

- Resist the reflex to relabel custodial tasks with clinical vocabulary.
- *Aud* shows courts will look through it, and inflated clinical framing can backfire—creating standard-of-care expert battles over tasks that should be defended as reasonable custodial care, and undermining witness credibility.

C. Defense Counsel: Litigation Strategy

Force Pleading Specificity at the Outset

- *Holland* itself holds that where a complaint fails to connect the causal mechanism to the injury, the proper course is amendment and specificity—the Supreme Court refused to reward "opaque pleading" but required the connection to be pled.

- Use demurrers, motions to strike, and early contention discovery to pin plaintiffs to the *specific acts or omissions* alleged to have caused each injury. Locking the theory early:

    1. frames arbitration motions,
    2. frames the MICRA characterization, and
    3. prevents late-trial theory migration.

Move to Compel Arbitration on the Broad Clause, not Just Section 1295

- Where the agreement contains a general treatment-and-care arbitration provision, survivor claims—including Elder Abuse Act claims—are compellable on ordinary contract grounds regardless of the custodial/medical characterization (*Holland,* fn. 1).
- Bifurcating the heirs' wrongful death claim into court while the survivor claims proceed in arbitration is imperfect but often still valuable.

Identify and Develop the Genuinely Medical Failures

- Where the record shows clinical orders, skilled interventions, or treatment-plan content in the causal chain, build the *Flores v. Presbyterian/Faiaipau/Frankland* characterization with evidence: who ordered the measure, what license it required, what clinical judgment it embodied.
- Physician and clinician co-defendants retain their own MICRA protections (*Frankland*) even where the facility's conduct is characterized as custodial—which affects apportionment strategy and settlement sequencing.

Demand Allocation in Special Verdict Forms

- This is now the structural key to preserving any MICRA benefit. Under *Waters v. Bourhis* and *Flores v. Natividad,* a general verdict that *may* rest on a non-MICRA theory forfeits the cap.
- Propose special verdicts and instructions that require the jury to allocate fault and damages between custodial conduct and professional negligence, and preserve the issue for appeal if refused.
- Consider the amended section 3333.2 category-cap structure (providers vs. institutions vs. unaffiliated actors) when structuring apportionment.

Attack Causation Failure-by-Failure

- Because characterization is conduct-specific, so is causation.

- Require plaintiffs to tie each claimed custodial failure to each injury; unanswered call lights that caused no fall, or missed repositioning that preceded no wound, should be excluded or minimized, not aggregated into an undifferentiated "neglect" narrative.

Contain economic and statutory damages

- *Aud* affirmed reduction of economic damages to amounts Medicare/Medi-Cal actually paid—press paid-versus-billed aggressively.
- Scrutinize section 1430(b) stacking (violation counting, the statutory cap, and duplication with the negligence recovery) and the fee exposure it drives.

Recalibrate Settlement Valuation and Section 998 Strategy Immediately

- Cases previously valued against a $250,000 (or $470,000) non-economic ceiling must be re-valued as uncapped where the operative theory is custodial.
- *Aud's* $1.8 million non-economic award for a living resident's falls and pressure injuries is the new comparator that plaintiffs will cite.
- Serve early, realistic 998 offers in custodial-theory cases; the cost- shifting leverage now runs against defendants who anchor to capped-era numbers

Check Finality Before Citing Aud—and Watch for Review

- *Aud* is citable now but not final; confirm status (and any petition for review) before briefing.
- If review is granted, the mental-state holding is the most likely candidate for further examination.

D. Insurers, Claims Professionals, and Risk Managers

Reserving

- Reserve custodial-theory California claims without a MICRA haircut.
- The characterization question should be answered—explicitly, in writing, with coverage counsel or defense counsel input—at first substantive claim review: which alleged failures are custodial, which are medical, and what does that mean for the realistic verdict range?

- Previous California LTC severity assumptions built on the cap are no longer valid.

Limits Adequacy and Program Structure

- A single adverse custodial verdict can consume primary limits that were sized for a capped environment.
- Insureds, captives, and RRGs should re-evaluate primary limits, attachment points, excess layers, and reinsurance with uncapped noneconomic exposure—plus section 1430(b) statutory damages and fee-shifting—in the model. Aggregate erosion across multi-facility programs deserves particular attention.

Underwriting and Risk Selection

- Staffing metrics, call-light system data, survey history (particularly F- tags tied to supervision, ADL care, and skin integrity), fall and pressure-injury rates, and care-plan implementation audit results are now direct proxies for uncapped-exposure risk.
- Build them into underwriting submissions and pricing. Facilities that can produce clean implementation data are objectively better risks post-*Aud,* and underwriting should say so.

Coverage Characterization

- The custodial/medical line will surface in coverage as well: professional liability forms keyed to "professional services" versus general liability coverage for custodial operations may allocate these claims differently.
- Review policy wording now—definitions of professional services, abuse-and-neglect provisions, sub-limits, and defense obligations—so the claim theory that defeats MICRA does not also generate an unintended coverage gap or dispute.

Early Resolution Discipline

- Cases with bad implementation records (missing logs, damning call-light data, staffing shortfalls) should be identified and resolved early, before the uncapped number is anchored by plaintiff experts.
- Cases with genuinely clinical causal mechanisms and strong implementation records are the ones to try. The portfolio-level skill post-*Aud* is to quickly tell those two categories apart.

Risk Managers: Audit Against the Aud Fact Pattern

- Run a facility self-audit specifically against the failures found in *Aud:* call-light reach and function on rounding; response-time data; toileting-schedule compliance; repositioning documentation; feeding

assistance for residents with limited mobility; and the paper trail connecting each high-risk assessment to delivered interventions.

- Treat the *Aud* opinion as a free plaintiff's expert report on what juries punish.

7. Conclusion

***Aud* completes what *Holland* began:** in California, MICRA now protects nursing facilities only when the causal failure is genuinely one of professional medical judgment or the negligent performance of a medical service undertaken. The everyday operational failures that generate most long-term care claims—supervision, staffing, call lights, toileting, repositioning, nutrition, hydration—carry uncapped noneconomic exposure, on a simple negligence showing, without any requirement of egregious conduct.

The plaintiffs' bar has its roadmap; the defense answer is structural: contract architecture that captures custodial claims in arbitration, operations that close and document the assessment-to-implementation loop, litigation strategy that forces specificity and allocation, and claims and underwriting assumptions rebuilt for an uncapped world.

We are available to assist with admission agreement and arbitration provision review, facility documentation audits, litigation strategy in pending matters, and program-level exposure assessments.

This alert is for informational purposes only and does not constitute legal advice. Please contact our offices to discuss how these rulings may affect your specific operations, claims portfolio, or insurance program.

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