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## THE ADELMAN ADVANTAGE by Rebecca Adelman

### Assisted Living Lawsuits: An Ounce of Prevention Is Worth a Pound of Cure



As the population across the country ages, assisted living continues to grow in popularity. Resident care litigation risk has been emerging with more frequency as the mission and vision of assisted living communities evolve. Aging in place is a central philosophical

aim of the assisted living movement and the acuity levels of residents are higher and needs increasing through the residency. As in nursing homes, accidents or clinical problems at assisted living centers can translate into liabilities. We have been experiencing an increase in lawsuits across the country against assisted living communities including against individual assisted living nurses. Plaintiff's attorneys are now targeting assisted living communities after decades of focusing attention on nursing homes. Plaintiff's attorneys have a "nursing home lawsuit" playbook in hand that they are using on the field against assisted living communities. What do you and your facility need to know? How can you be proactive with risk management and quality assurance? In this article, we will explore the characteristics of the assisted living industry that have interested Plaintiff's attorneys; provide an overview of the anatomy of an assisted living lawsuit; identify the main claims presented in the lawsuits; and present a few considerations for proactive risk prevention.

#### **Why is the Assisted Living Industry Being Targeted By Plaintiff's Attorneys?**

Plaintiff's attorneys see assisted living facilities rapidly becoming the nursing homes of the future and suited for the litigation model they developed over the past decades. According to the National Center for Assisted Living, there are over 36,000 licensed assisted living facilities nationwide with an estimated one million residents making their home in assisted living/residential care communities, including about 131,000 receiving assistance under the Medicaid program. Assisted living is the long-term care option preferred by many individuals and their families because of its emphasis on resident choice, dignity, and privacy and assisted living continues to grow while adapting to changes in consumer wants and needs.

As far as Plaintiff's attorneys view, assisted living facilities tend to

aggressively market and recruit residents, many times promising staffing levels or services that, in reality, are not available. In an attempt to compete with nursing homes, assisted living facilities are accepting patients with higher acuity including advanced Alzheimer's disease and cognitive impairment. The nursing home understaffing theory is then pursued with the argument that the assisted living facilities have staffing that is inferior to the staffing levels present in nursing homes and simply cannot meet the needs of the higher acuity residents. Plaintiff's attorneys capitalize on industry data such as the December report from the Office of Inspector General of the U.S. Department of Health and Human documenting deficiencies in meeting state and federal requirements for assisted living communities providing Medicaid services.

The assisted living industry shares many of the characteristics of nursing home industry from the early 1990's when nursing home companies were being targeted as defendants in lawsuits. Assisted living has been an untouched industry for many years and the industry is populated with large corporations. The residents' needs are higher with recent reports showing that 37% of residents were receiving assistance with three or more ADLs; 42% had Alzheimer's disease or other dementias; 39% provided skilled nursing services by RNs or LPNs and 13% of residents received these services; and 19% of residents received Medicaid funding. Statistics also show that 33% of the residents die in the assisted living facility and 59% are transferred to a long-term care facility. Overall, there is greater exposure to legal risk when an event occurs at an assisted living community similar and Plaintiff's attorneys are profiteering.

#### **What is the Anatomy of an Assisted Living Lawsuit?**

The basis for an assisted living lawsuit is whether the assisted living facility breached regulatory or community practice standards related to a specific event (fall or other incident) or set of clinical conditions (development of pressure ulcers, UTIs, decline in functional status) during the residency. The inquiry is, in most cases, whether the facility accepted the resident for admission when the resident's care needs required a higher level of care or the facility failed to properly assess the resident for changes in condition making continued placement unsuitable. As assisted living nurses, you have a multitude of responsibilities and play many roles. In the arena of litigation, the nursing

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oversight responsibility to assure timely identification of acute clinical problems and to optimally manage physical and behavioral problems becomes a focal point and serves as the basis for claims of direct liability against a nurse. A professional nurse in assisted living may have the responsibility for assessment of potential residents to determine their suitability and safety living in an assisted living environment as well as assessing change in condition to determine if a resident needs a higher level of care. Plaintiff's attorneys seek to establish that a nurse breached the duty owed to a resident by failing to fulfill these responsibilities that then resulted in an incident or development and/or decline in conditions.

Specifically in an assisted living lawsuit, a Plaintiff (the resident or the resident's representative) must establish a "prima facie case." A "prima facie case" is an action against an assisted living facility for injury to or death of a resident and must be established by proof of:

- A duty owed by the assisted living facility to the resident (and/or a specific duty owed by the assisted living nurse);
- The standard of care applicable to the assisted living facility governing its care of the resident;
- The breach of that duty by the assisted living facility (or the nurse), either by omitting to perform or by wrongly performing its duty to the resident;
- Damages (i.e., injury to or death to the resident); and
- A proximate causal relationship between the assisted living facility's breach of duty and the resident's injury or death.

There are several general defenses that are advanced by the assisted living facility, including:

- The assisted living facility (and/or nurse) conformed to the applicable standard of care;
- The resident's negligence was a factor contributing to injury or death;
- The resident assumed the risk that was the cause of the injury or death; and
- There is no proximate causal relationship between the assisted living facility's conduct and the resident's injury or death.

There are several parties that may be entitled to recover in the lawsuit including:

- A resident who suffered injury due to an assisted living facility's breach of duty;
- A resident who suffered injury due to an assisted living facility's breach of duty, through a guardian, conservator, or next friend;
- The estate of a resident who died due to an assisted

living facility's breach of duty; or

- A spouse or other person entitled to bring a loss of consortium (companionship) claim.

With respect to potential defendants who can be in the lawsuit, they include:

- The assisted living corporation or partnership;
- The owner, operator or management company of the assisted living facility;
- Individuals with ownership interest in the assisted living company; and/or
- An individual staff member whose conduct contributed to the resident's injury or death.

A lawsuit against an assisted living facility for injury or death to a resident may usually be brought in state courts of general jurisdiction and may also be brought in federal court if certain requirements are met. A lawsuit may also be brought pursuant to an enforceable arbitration agreement. The plaintiff may be required to offer proof of the assisted living facility's standard of care and its breach of that standard through expert testimony. The state regulations, while serving as some evidence of the standard of care, are the minimum required for facility licensure. Plaintiff's attorneys also look to national and community standards of practices as well as the assisted living facility's policies and procedures. We will discuss the need to evaluate current policies and procedures and revise, if necessary, to comply with state regulations and facility practices as part of risk management and prevention.

The Plaintiff in the lawsuit may recover for medical expenses, pain and suffering, and other compensatory damages generally recoverable in personal injury or wrongful death actions. The Plaintiff may recover punitive damages where the defendant's conduct evidences a wanton disregard for the rights of the resident.

There are several theories of liability against an assisted living community. Specific Plaintiff's tactics are highlighted later in this article. Generally, we see the following theories of liability alleged:

- Common Law Negligence;
- Violations of the Consumer Protection Act;
- Violations of the Adult Protection Act or Vulnerable Adult Act;
- Negligent Hiring and/or Retention;
- Violation of Residents' Rights;
- Breach of Contract;
- Violation of State Regulations;
- Loss of Consortium;
- Wrongful Death;

# Unexpected Gifts During a Directed Inservice



Directed inservices. No facility wants to be in the position of having to schedule this type of training. A directed inservice means that the facility was cited for substandard care and that as part of the plan of correction, CMS deemed that a directed inservice will help achieve compliance. I freely share that I am not a fan of inservices and seriously doubt their efficacy (as they are traditionally done). For the column I wrote on this topic, refer

to the NAL article titled, *"Inservice Time! Please Reconsider Your Strategy"* in September 2016. Having said that, inservices are a part of the reality of working in healthcare so educators need to take the lead by developing training programs that engage, teach, affirm and inspire.

A directed inservice is a unique training program and requires balancing sufficient details of what happened in the facility that resulted in the substandard citation *and* providing guidance on what to do differently. Understandably, staff are not happy to spend a portion of their day in this type of training. Sometimes, depending on the nature of the situation that precipitated the citation, staff may be angry, resentful, embarrassed, or even frightened. It's helpful to start these trainings by acknowledging, *"I understand that most of you do not want to be here right now."*

Recently, I was asked to give a directed inservice at a facility cited for abuse, a resident-to-resident altercation. After reading the 2567, the plan of correction and facility abuse policy, I developed the training and a few days later was en route to the facility. Upon arriving, I was greeted warmly by the administrator. Despite the unfavorable survey her facility had just experienced, she exuded a graciousness and openness to learning, to helping staff be successful and to making the home a better place for all residents and staff.

The top of the hour chimed; it was time to start. At the beginning, I make it very clear that the purpose of a directed inservice is never to blame or point fingers but to identify learning and improvement opportunities. Staff are invited to look critically and compassionately at what occurred in their facility and engage in productive dialogue. Despite the gravity of the situation that precipitated the deficient citation, starting a directed inservice by recognizing and acknowledging staff's desire to provide good care is key. Over several slides, I show images of the incredible array of services that the facility provides.

These are two of the slides in this sequence that I use:

The nursing home as a microcosm of an entire community.



Repair Shop



Recreation Center



Bank



Emergency Room



Doctor's Office



Meditation Room

Quiet Place



Library



Ice Cream Parlor

Whenever I show this series of slides, I get goosebumps; I, too, am reminded of all the ways we are working so hard every single day to take care of the most vulnerable people in our communities. With all the negativity portrayed about nursing homes - never anything positive although there are oodles of examples - staff can get discouraged and may lose their passion for this vital work. I do everything I can to prevent that.

One of the unexpected gifts during a directed inservice is laughter. Here's what happened in this inservice.

From the time I left my office with the slides on my flash drive to the time I popped the drive into a facility computer (suffice this part of the story to say there were HDMI compatibility troubles and I couldn't use my computer), the technology gremlins had wreaked havoc with my slides. With very limited time until the first inservice, I focused my attention on correcting the slides about abuse, info on the 2567, process improvement and the like. Thankfully, I was able to recreate most of the slides.

However, I only gave the beginning slides a perfunctory glance and since all the images were there, I assumed (incorrectly!) that the slides were fine. During the inservice, I was delighted with peals of laughter when I began showing this first series of slides with the images of services that facilities provide. The images were fine but not the text boxes! All the text boxes got rearranged. So, the ice cream parlor was in the repair shop, the botanical garden was in central supply and pet therapy was taking place in the med room. As I looked (at first in disbelief) at my messed-up slides, I found myself going with the flow and laughing right along with staff. It truly was great fun and it set a wonderful stage for learning.

Since many staff are not familiar with the nuts and bolts of the survey process, the meaning of scope and severity, the regulations involved in the citation and why in the world they had to attend this inservice, I start there. Staff from all departments know the survey didn't go well but not exactly why. They know the facility was cited for abuse, but my job is to take the citation and pull it apart to uncover the process breakdowns – not just *what* happened but *why* it happened. Assessments, care plans, care plan revisions, person-centered care, communication, critical thinking (or, as is often the case, a lack of it), regulations, facility culture and staff responsibility all come into play in most of these situations.

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- Battery; and
- Punitive Damages.

While each lawsuit is different and is based on individualized facts and state-specific regulations, they have similar characteristics. More and more, with Plaintiff's attorneys sharing information and conducting seminars on assisted living lawsuits, we are seeing the same prosecution models and playbooks used across the country.

### **What are the Most Common Claims in an Assisted Living Lawsuit?**

Understanding the most common claims in an assisted living lawsuit (which are also the most frequent resident or family complaints), allow communities to create more proactive risk management and prevention programs, additional staff training, revised policies and procedures all which serve not only to reduce litigation risks but serve to enhance the quality of care and life of residents.

The events or conditions that most often form the basis of an assisted living lawsuit relate to:

- Falls
- Inconsistent, Incomplete or Erroneous Documentation
- Abuse (Physical and Sexual)
- Understaffing/Inadequate Staffing
- Failure to Transfer or Discharge
- Elopement/Wandering
- Failure to Supervise
- Non-Compliance with Facility Policies and Procedures
- Changes in Condition
- Medication Administration Errors
- Corporate Negligence
- Wound Issues
- Wrongful Death

### **How to Take a Proactive Approach to Litigation Risk Management?**

Litigation risk management and reduction is part of a community's overall Quality Assurance and risk management programming. It is recommended that policies and procedures, admissions procedures and criteria are scrutinized then the necessary changes for compliance with state regulations and community practices be implemented. Below are some additional considerations for your community to include in proactive risk management and quality improvement plans.

*Formal Expectations Management Programs* - Most residents and families do not know what to expect at an assisted living facility and have expectations that may be unrealistic. Residents and families may be experiencing emotions such as grief, guilt,

fear and anger which set the stage for conflict. Setting realistic expectations with residents and families through formal programs at admission and continuing management of the expectations through the residency will significantly reduce the chances and opportunities of a resident or family member filing a formal lawsuit against the community. We develop and customize programs for our assisted living community providers that are easy and cost-effective and suggest you consider program objectives to be on quality of care and a sense of wellbeing through communication and family partnerships, ensuring that families fully understand the realities of assisted living life including the risk, educating staff to recognize and communicate illness trajectories and changes in condition for continued assessment related to placement.

*Consistent and Complete Documentation* – The first action a Plaintiff's attorney takes prior to filing a lawsuit is requesting and reviewing the resident's assisted living record, the administrative file and admission contracts. What he/she is hoping to find are inconsistencies between the admission assessments and level of care the resident is to receive, the resident's conditions and any changes and continued assessments (care plans) to evaluate continued suitable placement. In addition, to timely and accurately documenting care and services, it is important to document discussions with staff, physicians, residents and families. Document that labs were gathered, that results were sent timely and any new orders properly placed in the record and compliance noted. Often we are faced with incomplete MARs and TARs which makes defending the record and care more difficult. Record audits should be regularly conducted for compliance with state regulations and policies and procedures.

*Continuing Assessments to Evaluate Suitability for Placement and/or Increased Need for Services for Aging in Place* - Liability risks are compounded when residents remain in an assisted living facility that cannot provide the appropriate care. Admission criteria should be consistently applied, with resident needs reassessed regularly and documented prominently in the record and recommendations for home care, physical therapy and other ancillary services be noted. Involuntary transfer of a resident to a skilled nursing facility may otherwise result in unnecessary operational, legal and risk management problems.

*Assess and Address Changing Staffing Needs* – Most staffing levels established in state regulations are minimum only. Plaintiff's attorneys focus on understaffing for budgetary savings and lack of staffing to support corporate liability and greed. Employing staff in sufficient number, with ability and training to provide the basic resident care, assistance, and supervision required, based on the assessment of the acuity levels and residents needs is the best defense to these claims. Monitor the adequacy of staffing ratios based on residents' needs at regular intervals.

*Analyze Marketing Materials Including Internet Advertising* – Analyze marketing materials to determine if they are consistent with the level of services provided. Be certain that information on the internet is current, accurate and that organizations are properly identified. A legal review should be completed on all marketing materials including that services or statements that could present exposure.

Documentation is a key topic, specifically subjective versus objective entries and why that distinction is important. In the resident record of the gentleman involved in the altercation, there were several subjective words including rude, loud, upset, uncooperative and agitated. We discussed the importance of describing, not labeling, a person's expressions and behaviors and how to achieve person-centered documentation that accurately describes the situation.

*Side note:* Keep in mind that while reading this article, you may be incredulous that the words above would appear in anyone's documentation. Truly, hindsight is 20/20 and looking at a situation after it occurred is much easier than being in it in the moment. For any situation that didn't turn out well, it's helpful to ask, "Why did this person take that action *at the time*?" This line of inquiry invites dialogue about the circumstances and processes involved in the situation rather than blaming staff for the outcome.

A CNA in the back of the room raised her hand and waited patiently to be called on to speak. She said, "I wrote some of those words." It was clear she wanted to explain more so I encouraged her to continue. What she went on to describe was a perfect example of a process issue that was making it very difficult for staff to document properly.

The electronic medical record ("EMR") at this facility limits the number of characters in the narrative sections. (Since other EMR's also have this limitation, I'm certain that staff across the country are experiencing similar challenges.) The work-around was to use words like "rude" and "loud", not just because they are short but because staff also believed they conveyed accurate information from their perspective. So not only was the word choice incorrect but the EMR software would not allow a proper, objective description of the situation given the character limitation.

Administrative leadership was attending the inservice when this CNA shared the EMR challenge. Here, another gift. One of the most rewarding outcomes was observing them talking after the inservice, collaborating on how to solve the problem and maintain open lines of communication for other issues. Staff spoke up and leadership listened, *truly listened*.

Because this CNA was courageous enough to speak up in front of dozens of her peers and admit that she had documented words that did not fare favorably in the care of this resident or the outcome of the survey, we all learned that day. I thanked her for sharing the struggle that the EMR was posing for her and her peers. She gave voice to all the staff that document in the residents' records.

A third gift was received that day as a reminder and encouragement. Speak Up. Speak up when you're struggling with a process at work, when something isn't going well or is wasting time, or if you have a question. Speak up if you have a new idea about how to make the job easier and more fun!

I felt humbled after that inservice and incredibly grateful to the CNA that spoke up and the staff that listened. Given their openness and willingness to collaborate, I was excited to think of the possibilities of how things would improve. And, I silently thanked the technology gremlins for their surprising contributions to the day.

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*Review Admissions Agreements, House Rules and Resident Handbooks* - Review resident contracts for consistency of terms. Focus on areas such as discharge and retention policies. Expectations management programs should be included in the Admissions Agreements as well as House Rules.

*Review and Revise Policies and Procedures as Necessary* - Draft policies and procedures that address operational, business and clinical issues to promote consistency in actual practices by the staff and compliance with state regulations and "best practices". Monitor the staff for compliance of established policies and include outcomes in annual competency and performance evaluations.

*Assessment of Residents' Rights* - Liability can also arise through a violation of resident rights, as established in state resident rights statutes. Ongoing assessment of a facility's compliance with residents' rights should be an integral part of the risk management program. Document the monitoring and evaluation of a resident rights compliance program to create a strong defense. Violations related to protection of resident funds and financial matters, receipt of mail, security of personal property, and abusive staff behavior may be subject to heightened scrutiny and made part of a lawsuit.

*Implement an Arbitration Agreement and Training Program* - An arbitration agreement is a contract that requires all disputes between a resident and an assisted living facility to be resolved through binding arbitration before a neutral arbitrator as opposed to a judicial forum. Properly executed by the resident or legal representative the agreement is enforceable and reduces significantly the cost and expense of a lawsuit and the reward to a Plaintiff. Arbitration agreements are not desirable for a Plaintiff's attorney as history shows that recovery in arbitration is nearly 30%-35% less. We have successfully rolled-out arbitration programs for many assisted living providers and have seen a reduction in claims.

## Summary and Conclusion

The need for proactivity in risk management, prevention and enhanced quality assurance is accelerating in the assisted living industry with increased claims and lawsuits facing providers. The changing landscape, mission and vision of assisted living requires risk identification and awareness of problems or potential problems that may result in loss. Timely identification is the cornerstone of a successful risk management program. Hopefully understanding more about the strategies employed by Plaintiff's attorneys will help with the continued design and implementation of your community's programs.

*Rebecca's insurance defense practice includes representation of insurance companies and long-term care providers and their insurers, both regionally and nationally. She also provides consulting services and educational programming to healthcare professionals and business associates. She has active practices in the areas of general liability, professional liability, premises, and employment law. She is a listed mediator serving all areas of business and healthcare litigation.*

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