Walking the Care Continuum Tightrope: Responding to the Need for a Higher Level of Care

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A special thank you to Kathleen M. Reilly, Jessica M. DeMichiel, and Lydia H. Beebe for their preparation of ILF v. ALF v. SNF: Managing the Transitions on the Slippery Slope of Aging Services.
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I. ILF vs. ALF vs. SNF: What Are the Differences?

Independent living, assisted living and skilled nursing facilities can vary dramatically by state as each state individually defines, licenses and regulates these types of facility. In contrast to independent and assisted living facilities, skilled nursing facilities also participate in the Medicare program and are regulated at the federal level by the Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services. Consequently, there is no universally accepted “definition” of each type of facility and variations among the same type of facilities are common. The terms independent living, assisted living and skilled nursing facilities are used to characterize the different housing options, programs and services available to the residents.

Although independent living, assisted living and skilled nursing facilities must operate in compliance with the minimum standards set forth under state and federal law, each individual facility may offer unique features and services to their residents that differ among the same types of facilities. The two key factors for determining the appropriate type of facility required for an individual are the level of independence demonstrated and the level of medical care needed by that particular person. An individual’s level of independence is usually based on the ability of that person to perform essential activities of daily living such as bathing, grooming, dressing, eating, ambulating, toileting, shopping for groceries and person items, and performing household chores.

II. Independent Living Facilities

An independent living facility (ILF) is any housing arrangement designed exclusively for people ages 55 and older. The types of independent living facilities available can vary from houses set within retirement communities to senior apartments or condominiums, which offer amenities specifically geared to helping older adults. An independent living facility may offer senior-friendly floor plans and social, cultural and recreational programs. In addition to many private pay options, the U.S. Department of Housing and Urban Development (HUD) subsidizes senior housing complexes for low-income seniors. In many states, independent living facilities are neither licensed nor regulated.

An independent living facility is usually an option for individuals who need minimal or no medical care on a daily basis and can perform most or all of their own activities of daily living, but prefer a place designed to be easier for an older adult to manage and navigate. Most independent living facilities offer transportation options to access outside activities such as medical appointments or shopping centers. In addition, these types of facilities can offer socialization opportunities such as activity centers, common areas and field trips. An independent living facility may provide some personal services to the resident such as aid with meal preparation, cleaning and housework, and managing money. In addition, the residents and their families may be able to hire in-house aides, nurses, physical or occupational therapist and care givers.

Although an independent living facility may provide emergency alert and response systems within the residences, such as ‘emergency buttons’, on-site medical care is typically not available. The inability of these facilities to provide on-site medical care, with most facilities having a no-CPR policy, has become a hot topic in light of the recent incident involving an independent living facility in California. The incident involved an employee who refused to perform CPR on an elderly resident based on a facility policy and a 911 operator...
who vehemently argued with the employee to provide CPR to the resident. The incident made national headlines after authorities released the 911 call to the media. This incident has led to controversy over the limited medical care provided to residents at independent living facilities, as well as the level of understanding that residents, their families and the community have with regard to the care provided by these facilities.

Overall, independent living facilities are the least restrictive, supervised and regulated entities out of all long term care facilities. The residents in these types of facilities are usually still relatively independent and active with the ability to generally care for themselves. As independent living facilities generally do not provide any medical services to its residents, the appropriate time for a resident to transition between an independent living facility and an assisted living facility can often be difficult to determine and may instead result in the resident transitioning directly to a skilled nursing facility as his or her physical condition deteriorates. Often, individuals at independent living facilities stay much longer than they should considering the level of medical care and assistance with activities of daily living these individuals require.

A. Recent Claims Involving Independent Living Facilities

In 2015, a resident in an independent living facility in Virginia broke her clavicle and was unable to move. The facility did not check on her for four days. She took off her neck alarm and had not yet signed up for the facility provided check-in system. The facility check-in system at the time required the resident to call the front desk each morning. If the resident did not call, then a staff member was to call them. If the resident did not answer, a staff member was to check on them in person. If the resident was not in her apartment after going through the check-in process, the receptionist was to alert the business office manager. The staff were to call 911 or a family member for medical emergencies. Through a series of mistaken identity via telephone calls and observations at the facility, the staff thought the resident was out of town.

The facility was extremely apologetic to the resident and her family. They acknowledged that the system failed as a result of a variety of human errors and it was unacceptable. The incident occurred in December 2015 and by February 2016, the facility implemented an electronic check-in system. The facility was ordered to pay $900,000 by an arbitrator. Virginia does not regulate independent living facilities.

The facility acknowledged its errors and apologized to the family. An apology can be very helpful in the defense of a claim. More often than not, the failure to apologize angers family members and pushes them toward filing claims. Thirty-six states have provisions regarding apologies by medical professions. For more details on apology statutes see www.ncsl.org.

III. Assisted Living Facilities

An assisted living facility (ALF) usually includes all of the services and programs offered by an independent living facility in addition to a wide array of support services to help residents with activities of daily living and basic medical care assistance. The residents at this type of facility generally have experienced a slight decline in physical health and require assistance performing one or more activities of daily living such as bathing, grooming, dressing, eating, ambulating, toileting, performing house chores, and shopping for groceries or personal items. The residents at an assisted living facility ordinarily do not require the continuous level of medical care and supervision provided by a nursing home.

Although assisted living facilities are usually not required to have a skilled health care provider available at all times, minor health care services such as monitoring vital signs and medication reminders may still be provided on an individual basis as permitted by each state’s laws and regulations. Typically, the condition of each resident should be assessed by the staff at the time of admission to the assisted living facility and any
time there is a change in the resident's condition. The staff can then utilize the assessment to develop an individualized service plan for each resident and to monitor the condition of the resident overtime at the facility. When there is a change in condition, the staff should meet with the resident and his or her family to discuss the change, as well as to manage expectations regarding the level of care that can be provided by the assisted living facility and the possible need to transfer the resident to a skilled nursing facility as this transition is often the most difficult for many individuals.

In contrast to the lack of regulation imposed on independent living facilities under state law, most states impose regulations on assisted living facilities. These regulations generally address the mandatory services this type of facility must provide to residents, but may not set definitive standards on the maximum services that may be provided to residents at this type of facility making it difficult for staff, residents and their families alike to know the appropriate time to transition to a higher level of care. Some states regulate retention standards for when a resident must be transferred to a higher level of care, the staff within these states can often feel pressured to accept residents with a higher level of acuity then may be suitable for the level of care that facility can provide to the individual and then to keep the resident longer than appropriate under the circumstances due to the wishes of the resident their families, as well the pressure placed on staff to keep these types of facilities profitable. In addition, there is also an evident under-regulation of the quality of care provided at this type of facility as most of these facilities are not subject to the regulations promulgated under federal law.

In Virginia, there are twelve specific categories of residents who shall not be admitted or retained in an assisted living facility. Those categories include residents who are dependent on a ventilator, have stage III or IV dermal ulcers (unless a physician determines that the stage III is healing), or require intravenous therapy. Assisted living facilities may not accept or retain individuals with nasogastric tubes or gastric tubes (except where the resident can independently feed himself and care for the tube). The broader and more difficult categories of individuals who may not be admitted or retained in an assisted living facility are those who present an imminent threat to self or others, those who require continuous nursing care, and those whose needs cannot be met in the specific facility as determined by the facility. See 22VAC40-72-340. It is these final three categories that produce challenges for staff.

In 2016, the National Center for Assisted Living reported that 23 states changed regulations, statutes or policies affecting ALF. The most common policy changes were staffing, training, dementia care and medication management.

Assisted living facilities are now considered the fastest growing form of residential housing for older Americans. This type of facility has filled the space between senior housing and skilled nursing facilities, and is expanding into the market previously served exclusively by nursing homes. This loose definition of independent and assisted living facilities—and the fact that they are often unregulated or under-regulated – has contributed to the rise of the number of facilities around the country. The rise has also been precipitated by the trend of `aging in place` and providing services which allow seniors to live in their own housing and communities as long as possible.

**A. Recent Claims Involving Assisted Living Facilities**

In January 2017, a Michigan family filed suit against an assisted living facility for the wrongful death of a resident who wandered from the facility and died of hypothermia outside the facility. The resident had a history of wandering and the facility failed to perform visual checks of the resident's whereabouts. Earlier this year, a jury found that a California residential care facility specializing in dementia care was not responsible for a cervical spine fracture a brain injury suffered by a resident after she was assaulted by another resident.
Plaintiff claimed that the facility was negligent for the failure to supervise the residents, admitting a resident with a violent history, and allowing the resident with a violent history to move freely about the facility and interact with other residents. The defendant showed through expert testimony that the resident who assaulted the other resident was appropriate for the facility and did not present a known danger to other residents. Residential facilities are required to provide care in the least restrictive environment and must allow residents to socialize with others and move freely about the facility. See Curtis v. Midwest Care Sunflower, LLC, et al., Superior Court, Orange County, CA, Case No. 30-2013-00661988-CU-PO-CJC.

IV. Legal Issues Facing Independent and Assisted Living Facilities

The definition of independent and assisted living facilities as well as the spectrum of senior housing options available through these types of facilities differs from state to state. This loose definition of independent and assisted living facilities—and the fact that they are often unregulated or under-regulated—has contributed to the rise of the number of facilities around the country. The rise has also been precipitated by the trend of “aging in place,” the term that refers to the desire of older people to live in their own housing and communities as long as possible. John Pynoos, Christy Nishita, Caroline Cicero and Rachel Caraviello, Aging in Place, Housing and the Law, 16 Elder L.J. 77, 78 (2008).

At one time, aging adults moved out of independent and assisted living facilities and into skilled nursing facilities once they developed life-threatening illnesses. Now, staff at both independent and assisted living facilities often try to help residents remain as long as possible, even if the resident is a candidate for skilled nursing care or hospice care. Rudy Washington, Assisted Living vs. Hospice: Who’s in Charge? NYTimes.com (Nov. 16, 2012, 6:08 AM), http://newoldage.blogs.nytimes.com/2012/11/16/assisted-living-vs-hospice-whose-in-charge/.

Independent and assisted living facilities often offer transitional services to residents that provide more care as the senior becomes less capable of taking care of him or herself, such as moving a resident to a unit specifically designated for those suffering from certain physical or mental ailments or increasing a resident’s monthly charge in exchange for more care from staff.

While independent and assisted living facilities are attractive to seniors who do not yet require skilled nursing care and who wish to remain independent as long as possible, the low level of regulations surrounding the facilities and the minimal medical care provided can lead to a host of legal issues, including how much care and supervision a facility provides and how much care and supervision a resident needs. The supervision issues frequently arise in the context of wandering and elopement.

A. Emergency Preparedness

Another issue facing independent and assisted living facilities surrounds the protocol the staff should follow in the event of an emergency. As the facilities generally provide residents with little to no medical services, staff members are often directed to call 911 when an emergency situation arises. This can be very frustrating for both families and emergency services dispatchers, who do not understand the difference between the care provided at a skilled nursing facility and that provided at an independent or assisted living facility. As mentioned above, an event at a California assisted living facility in February 2013 sparked a national debate after an 87 year-old woman collapsed at an assisted living facility where she resided. A staff member (who was also a nurse) called 911. The dispatcher pleaded with the staff member to help the woman, but she replied that it was the facility’s policy not to perform CPR on residents. The woman later died at the hospital. Alyssa Newcomb, Elderly Woman Dies After Nurse Refuses to Give Her CPR, ABC News (Mar. 3, 2013, 1:17 PM),
The family of the woman has declined to sue, stating that they understood their mother had wanted no medical intervention in the event of an emergency. Tracie Cone, *Family of California woman who died after being denied CPR says she wanted no intervention*, NBCnews.com (Mar. 5, 2013, 8:25 PM), http://usnews.nbcnews.com/_news/2013/03/05/17199790-family-of-california-woman-who-died-after-being-denied-cpr-says-she-wanted-no-intervention?lite. However, independent or assisted living facilities should not assume that families will always be so understanding and take such a reasonable approach.

A similar situation arose in New York when a nursing supervisor failed to follow the wishes of a patient and did not perform CPR when the patient stopped breathing. The nurse was charged with falsifying business records, a felony, and willful violation of health laws, a misdemeanor. The nurse pleaded guilty, and under a plea agreement, was sentenced to a conditional discharge and required to surrender her nursing license. She was also ordered to complete 150 hours of community service. Freeman staff, *Nurse Who Let Woman Die Completes Community Service*, (October 30, 2014), http://www.oneidadispatch.com/article/OD/20141030/NEWS/141039981.

Unfortunately, emergency preparedness also includes responding to active shooters. In May, 2017, a shooting at a nursing home in Ohio left four people dead. The deceased included the police chief, two employees of the nursing home (a nurse and previous girlfriend of the shooter and a nurse's aide) and the suspected shooter. Laurel Wamsley, *4 Dead, Including Police Chief and Suspect, After Shooting at Ohio Nursing Home*, http://www.npr.org/sections/thetwo-way/2017/05/12/528136175/four-dead-including-police-chief-and-suspect-after-shooting-at-ohio-nursing-home.

As displayed by the above examples, emergency situations which put residents of independent and assisted living facilities in danger can put staff members in difficult positions. In order to minimize potential legal issues, it is important for facilities to have clear protocols and procedures for staff members to follow in emergency situations and proper training of staff members to ensure compliance with those protocols. Residents and their families need to be properly informed to lessen any anger or confusion that may arise when a facility staff member calls emergency services rather than perform life-saving procedures. See the U.S. Department of Health and Human Services website for a checklist of emergency preparedness at: http://www.cms.gov/medicare/provider-enrollment-andcertification/surveycertemergprep/downloads/sandc_epchecklist_provider.pdf.

**B. Residency No Longer Appropriate**

Another issue facing independent and assisted living facilities is how to manage transitioning individuals to a higher level of care. Determining the right time to send a resident on to another facility with a higher level of care and the manner in which the staff handles that situation with the resident and family can be complicated and present potential issues. At the other end of the spectrum, families of residents have also sued independent and assisted living facilities on claims of improperly discharging their loved ones, even in cases where the facility contends that the resident needs more care than the facility can offer.

In New York in 2009, the family of an 81-year old man sued an independent living facility for a fall that resulted in paralysis. The family alleged that the facility was negligent in allowing the man, who suffered from Alzheimer's, to become a resident and in allowing him to remain at the facility. The family reasoned that because all residents are examined prior to admission, the facility should have known that their father's mental state made him unfit to live at the facility. The court ruled for the independent living facility, stating that the man was quite happy at the facility and there was never any evidence that the man's Alzheimer's made it dangerous to live there. *Rapoport v. Cambridge Development, LLC*, 2009 N.Y. Misc. LEXIS 4288.
In New York in 2012, the family of an elderly woman sued an assisted living facility for her wrongful death, alleging that the facility was negligent in allowing the woman to be admitted, for allowing her to continue living at the facility once the facility was unable to meet her needs, and for failing to transfer her to a more skilled facility. The court ruled in favor of the facility, stating that it was up to the woman’s doctors and not solely in the discretion of the facility to decide if she should have been moved to a higher level of care. Hanley v. Engel Barn Senior Housing, 2012 N.Y. Misc. LEXIS 1246.

A case in Virginia regarding appropriate facility placement involved a resident who fell down after being struck by an automatic door to her apartment. The resident reported tripping over her walker, however, the family questioned the appropriateness of her placement at the facility. The facility retained an engineer to test the door opener and opine as to the length of time it allowed for the resident to walk through it. The resident died before trial. The favorable engineering testimony and issues with the Dead Man’s statute regarding the resident’s statement led to a favorable resolution before trial.

As displayed by the preceding examples, independent and assisted living facilities can run into problems when determining at what point to transfer a resident into a skilled nursing facility. The level of regulations surrounding the types of services the facilities offer may also make it difficult for both staff and families to determine when a resident must move on and sometimes that decision may come too late. In addition, both facility staff and family may have a desire for a long standing and well-liked resident to remain at the facility—even if the time has come for that resident to be transferred. This can result in complications and potential legal disputes. In order to prevent these problems, it is important for facilities to have clear procedures and protocol for assessing residents’ physical and mental health in light of the services offered by that facility, applying those procedures and protocols consistently and making the procedures and protocols open and transparent to residents and families to make that transition smoother.

V. Transfer and Discharge of Residents

There may come a time where the facility can no longer meet the needs of the resident. According to Federal regulations, “Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.” See 42 C.F.R. §483.12(a).

If the need to transfer a resident arises, one of the following six requirements must be met:

(i) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility;
(ii) The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility;
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.

Of course, the reason for the transfer must be documented in the medical chart. The resident’s physician must document when the reason for transfer falls under subpart (a)(2)(i), (ii) and (iv).
Unless the safety and health of other individuals in the facility is at risk, written notice of transfer must be made by the facility at least 30 days before transfer or discharge. See 42 C.F.R. §483.12(a)(5).

A. Recent Claims Involving the Discharge Process

A case out in Illinois involved the involuntary discharge of a nursing home resident. The resident was involved in a verbal dispute with a nurse and another resident. The facility administrator signed an Emergency Notice of Involuntary Transfer or Discharge because the resident posed a danger to individuals in the nursing home. The resident later sued claiming that the involuntary discharge violated the Nursing Home Reform Act. The Illinois Court dismissed the suit, and held that the Nursing Home Reform Act does not grant residents the right to sue nursing homes in federal court for alleged violations. The resident rights are enforced through government oversight and penalties, not through legal actions by individuals.

VI. Skilled Nursing Facilities

A skilled nursing facility is a residential facility that provides 24 hour medical care. Skilled nursing is often thought of as a type of service that is offered. These services include care provided by registered nurses, licensed practical nurses, certified nursing assistants and physical, speech, and occupational therapists. These services may be required for short term rehabilitation or long term care of a chronic medical condition. Some examples of skilled nursing services include wound care, intravenous (IV) therapy, injections, physical therapy, and monitoring of vital signs and medical equipment. These requirements for higher level of care lead to increase exposure for claims. In fact, liability costs are expected to increase by 6% in 2017.

According to Aon Risk Solution's 2016 Long Term Care General Liability and Professional Liability Actuarial Analysis, the claim severity has grown from $164,000 in 2006 to $214,000 in 2016. Florida, Kentucky, Tennessee and West Virginia were projected to have the highest loss rate levels for the states profiled in Aon Risk Solution's 2016 study. A copy of AON's report can be found at: http://www.aon.com/attachments/risk-services/Aon-2016-Long-Term-Care-Benchmarking-Report.pdf.

According to CNA Aging Services 2016 Claim Report based on a review of its insured aging services organizations, resident falls and pressure ulcers continue to be the most common allegations. However, claims of elopement, failure to follow a physician's order, delay in seeking medical treatment, pressure ulcers and failure to inform the physician represent the highest average total payout.

A copy of CNA Aging Services 2016 Claim Report can be found at: https://www.cna.com/web/wcm/connect/a669c765-f601-4823-b0bc-a53a021a9210/Aging-Services-2016-Claim-Report.pdf?MOD+AJPERES.

According to the Journal of Wound, Ostomy and Continence Nursing, the prevalence of facility acquired pressure injuries in long-term care facilities increased from 3.8% in 2013 to 5.4% in 2015. Former employees often serve as the source of damaging information against the nursing home. However, it is important to explore the foundation for the damaging information.

A recent wound case involved information from a former employee about the facility running out of wound dressings, and having to borrow supplies from a sister facility. This testimony did not paint the facility in a good light. However, after exploring the CNAs knowledge, it was clear that she did not know the difference between certain dressings and any alleged shortage occurred during a time period during which the resident was not prescribed such a dressing. It was important to compare the CNAs entries in the ADL chart for dates that she worked to the physician orders. Regardless, the facility nursing expert opined that a substitute dressing would have been appropriate, and the facility exceeded the standard of care by ensuring that the residents received the exact dressing ordered by the physician, rather than using a substitute dressing.
A. Recent Claims Involving Skilled Nursing Facilities

A recent lawsuit claims that a CNA at an Illinois skilled nursing facility misread a medical chart and failed to resuscitate a 52-year-old resident prior to her death. According to the resident's family, the resident signed a form stating that she wished to be resuscitated if the need arose. The lawsuit alleges that a CNA found the resident unconscious and 30 minutes later placed a call to emergency services to report the death of a resident who did not wish to be resuscitated. A subsequent call was made to emergency responders to report that the form had been misread, and requested paramedics respond to the scene. The lawsuit is ongoing. In Virginia, a 90-year-old woman was the resident of defendant nursing home. The resident was rolled off the bed onto the floor while the nurse was changing the resident's bed linens. As a result of the fall, the resident suffered a fracture of her right lower leg, right ankle, right shoulder and left leg. The resident eventually required amputation of her right leg below the knee. She also developed 13 wounds in the months after the fall. The nursing home denied liability but resolved the case through mediation before trial.

VII. Continuing Care Retirement Communities

Continuing care retirement communities (CCRC) offer a variety of housing options with different levels of services and programs in one general location. These types of communities often offer residents the ability to transition between an independent living, an assisted living and a skill nursing facility on the same site or within a campus-type setting. Continuing care retirement communities provide a comprehensive, lifetime range of services appropriate for the needs and wants of each resident as the resident ages in place. The residents can move from one level of care to the next level of care without having to transition to a completely new environment.

Typically, these types of communities require the resident to sign a contract with the provider that guarantees the resident access to each facility within the community, as needed, in exchange for an up-front entrance fee, a monthly rate or rent, and additional established costs for each type of service required as the resident declines in physical health. These contracts may even guarantee the resident the ability to remain within the community in the event the resident runs out of funds. Although individuals usually enter a continuing care retirement community with the ability to still live completely independent, this type of community provides residents ease in knowing that their needs and wants will be met as they get older and require additional services, such as a higher level of medical care or additional around-the-clock services.

Although continuing care retirement communities benefit from being able to advertise 'a complete package' of long term care to potential residents, there are often many pitfalls associated with this marketing strategy, including the questionable longevity of the community due to poor management by owners and operators, the ability of the community to provide all of the services that may be required by the resident long-term, such as mental health services for residents with dementia, and the need to have space available at the time when the resident must be transitioned to a facility within the community that provides a higher level of care.

A. Recent Claims Involving CCRCs

In South Carolina, a CCRC staff member smothered an 82-year-old resident in her sleep. The staff member was criminally prosecuted and sentenced to life in prison. The family also filed a wrongful death lawsuit that led to a settlement of $1.5 million.

In California, a CCRC agreed to a $1 million settlement in a wrongful death and elder abuse lawsuit involving the development and treatment of pressure ulcers. The family claimed that the facility withheld care for two months until the pressure ulcer became infected.
VIII. Hospice Care

Hospice care is intended for people with six months or less to live if the disease runs its normal course. An increasing number of hospice patients live in nursing homes while they receive care for progressive diseases before they die. The majority of hospice care is routine home care provided in the patient’s residence, nursing home or residential facility. The nursing home is reimbursed for room and board, while the hospice provider is reimbursed for hospice services. Because nursing homes provide similar services to hospice providers, there is a potential for overlap in services. There is also concern about referral for hospice services when they are not medically necessary.

A. Recent Claims Involving Hospice Providers

In Maryland, a 62 year old woman was admitted to a hospital for ulcers, but was mistakenly advised to get hospice care. She was given excessive doses of painkillers and died. The jury awarded her estate more than $900,000 in damages. Often, claims against hospice providers are difficult to prove because death is imminent for hospice patients. Claims may include failure to provide documented nursing services, failure to ensure availability of care, and failure to provide pain medication due to lack of staff.

IX. Certified Nurse Aides (CNAs) and Patient Sitters

Certified Nurse Aides or Certified Nursing Assistants (CNAs) play a vital role in the long term care industry. They provide personal care services, basic nursing and restorative services to residents. Although the training and licensing requirements vary from state to state, CNAs typically require a certification course to include communication and interpersonal skills, safety and emergency procedures, personal care skills, observational and reporting techniques, appropriate clinical care, skills for basic restorative services, resident rights, legal aspects to practice as a CNA, occupational health and safety measures, cultural sensitivity and conflict management.

The number of nursing assistant positions is expected to rise by 2024, making up at least 39% of the employment growth in the nursing home industry. Vacancies are on the rise because of job quality and pay. In 2012, the turnover rate among nursing assistants was 52%.

CNAs can have an enormous impact on litigation, both good and bad. In one Virginia assisted living facility case, a CNA cared for the same resident for over five years. She knew the resident’s habits and sleeping routine. The CNA also knew of the resident’s favorite activities, dolls and stuffed animals. This relationship and solid knowledge of the resident meant a lot to the family and decreased the settlement value of a fall case involving the same CNA and resident.

Often, CNAs in long-term care facilities speak to issues outside their scope of practice. This can get the facility in trouble. For example, in a recent case, a CNA did not witness a resident fall, but assumed that the resident had been pushed by another resident. This assumption was reported to emergency responders and made its way into all the hospital records, despite the fact that no one witnessed the fall. This CNA’s statement turned a routine fall case into a homicide investigation. After this incident, the facility determined which staff members may speak to emergency responders, excluding if a CNA actually witnessed the incident leading to injury.

Patient sitters (also called patient safety assistants, healthcare sitters, companions and one-to-one or constant observers) are staff or volunteers assigned to provide direct observations of patients. The role is generally undefined in both duties and qualifications. The patient sitter role did not commonly exist 20 years ago, but the use of patient sitters is on the rise. Patient sitters are often asked to observe a range of patients – those
with dementia, suicidal tendencies, disorientation, or those at risk of falls. Patient sitters often observe a vulnerable patient population, and put themselves at risk of violence, physical threats and verbal abuse. There are no national guidelines or regulations on the role of sitters.

As with any role, the use of patient sitters comes with its own set of challenges, and does not eliminate injuries. Some examples of falls even with patient sitters include the (1) sitter not within reach of patient; (2) patient tripping on item in path of walking; (3) sitter left room with no designated back up staff; and (4) patient sliding to floor while sitting on the edge of the bed.

A. Recent Claims Involving CNAs and Patient Sitters

In 2015, a CNA in Colorado was arrested on four counts of child sex assault for assaulting a 13-year-old who was volunteering in a nursing home. In 2017, a nurse at the same facility filed suit against the facility claiming that the company retaliated against her after she reported being raped at work by her supervisor.

A recent Tennessee Board of Nursing matter involved the use of a RN assigned to monitor one patient after a surgical procedure. The RN was not assigned to any other patients. The RN placed a pulse oximeter on the patient, but the oximeter only worked intermittently. She did not notify anyone of this problem or replace the device. She did not attempt to speak or rouse the patient but documented full breathing, high oxygen saturation, full consciousness, good circulation and lively activity. The RN admitted to never rousing or checking on the patient for these ratings. The RN falsely documented oxygen saturations. During her 90 minutes with the patient there were changes in his blood pressure. She did not take any action in response to the changes. After 90 minutes the RN left to get fluids. She was asked to help turn the patient upon return – his leg was blue. When turned, the patient was deeply cyanotic, apneic, and pulseless. The patient sustained a brain injury and died 2 days later. The Board noted that the RN accessed Facebook and another social media site during the time she monitored the patient. Her license was revoked and her multistate privilege was void.

In 2015, a patient sitter was charged with four felony counts of aggravated indecent assault and five counts of indecent assault at a Pennsylvania hospital.

Although the use of patient sitters is relatively new, Plaintiff’s attorneys are seeing this area as an additional cause of action against providers or a way to amplify an already existing cause of action. In an unpublished Connecticut case involving a patient fall at a facility, the Plaintiff’s attorney sought leave to file an Amended Complaint after taking a nurse’s deposition to add a count of recklessness against the facility for failing to provide a patient sitter. The Court granted leave to amend and found that the second count of recklessness amplified the negligence claim and expanded on the allegations of wrongful death. See Zoppo v. Bristol Healthcare, Inc., 2014 WL1189805.

In an effort to avoid situations like these, the facility should develop clear policies and guidelines to define the role of the private sitter and protect them. Training is essential so the patient sitter knows how to respond to a variety of events.

X. Virtual Nurses and Sitters

A new approach in healthcare includes the use of virtual nurses and sitters. Recently the neuroscience unit at Mission Hospital in Asheville, North Carolina, achieved zero unassisted inpatient falls and zero injuries during a 3-month pilot period using patient-observer technology. In addition to standard fall-prevention interventions: bed locked in low position; call light, call bell, assistive devices and personal items within reach; nonslip footwear; clutter-free room, among others, the hospital used a virtual sitter system. An algorithm was designed to identify the highest-risk patients for participation in the program. The virtual sitter
software uses an infrared camera and can monitor a patient’s movements under any ambient light. A continuous live video feed is sent across a secure wireless network to a high-definition monitor. CNAs were trained to serve as monitor technicians and trained on the software.

The patient’s movements generated a virtual sitter alert, and the monitor technician intervened using the following escalation techniques: (1) use the two-way audio to interact with the patient; (2) contact the patient’s RN or CNA; (3) contact the unit supervisor for emergency situations. The results showed that 50% of the virtual sitter interventions involved redirection alone and was highly effective in keeping the patient in his or her bed or chair. This is important because it helped decrease patient falls, but also kept nurses from being interrupted from other tasks.

A medical group in Omaha, Nebraska used a virtual sitter program in its rehabilitation unit. The sitters watch monitors for movement and either call in and remind the patient not to get up unassisted or call a floor nurse for help. The rehab unit saw a 22% reduction in falls during the virtual sitter pilot program. It is also less intrusive than placing a person in the room. The virtual sitter program is not intended to replace a direct care nurse, but rather, being an extra team member. Although the virtual sitter program is in its early stages, it is expected to reduce patient falls and reduce fall-related costs.

XI. Managing Expectations

Facilities can work to protect themselves from litigation by managing the expectations of families and residents, educating residents and families on the facility’s policies and protocols and providing insight to the family on the aging process. Managing expectations starts with the image that a facility presents of itself to the community, through advertising and other means. Facilities should be careful when advertising not to present a willingness or promise to house a resident through the end of life. Otherwise, the residents and their families will assume that the staff at the facility can and will provide everything required by this individual until death. Facilities should avoid letting a resident ‘age in place’ indefinitely. It is important to be clear to the resident and their family that a facility is only able to provide care and supervision up to a certain point before a resident must be transferred to the next level of care afforded by a facility more suited to their needs.

Although these conversations may be difficult, the facility must educate the residents and their families on the aging process, the changes in the residents needs and the appropriate time to transition the resident to a facility with a higher level of care. This education should be ongoing and continual— as the aging process continues. The goal is to avoid surprise. This goal can often be accomplished through “video” tutorials or “resident meetings” that involve the individual at issue, the resident care manager, the responsible party, the social worker and the administrator, as needed. The staff and administrators should make sure residents and family members understand the particular level of care offered at independent or assisted living facility by explaining, in detail, what the facility can provide and what it cannot in terms of services. For example, if it is the policy of the facility to not perform emergency life-saving procedures, then the staff must inform residents and family members of this policy in a manner that ensures they understand completely.

The staff at the facilities should make it a priority to perform regular assessments of a resident’s health and capabilities, and should keep the residents and families informed of the findings. The staff should remain diligent about monitoring residents for any decline in ability and should explain the discharge protocol to residents, such as how a facility determines that a resident is no longer fit to stay at a facility and what a family’s options are once that determination is made. By staff keeping the family informed about the process, the resident and the family will be less confused, angry or overwhelmed by the sudden need to transfer the resident to a higher level of care and, in turn, the facility could avoid litigation down the line.
The facility should include all of this information in the admission agreement and the facility should at least review the admissions agreement with residents and their families on an annual basis. By making the process transparent to residents and their families, independent and assisted living facilities can help protect themselves when the inevitable aging process occurs.

XII. Defense Counsel Do’s and Don’ts

Residents will fall, they will wander and they will develop pressure ulcers. When a new case lands on your desk here are some practice tips from in-house counsel:

1. **DO get to know your client.** When defending on a traditionally insured policy, the lawyers typically get to know the carrier very well. Sometimes the relationship with the insured client – particularly one with its own legal department or management team, can feel odd. At the end of the day, our duty lies with the insured. Take the opportunity to get to know the people there – what reporting they need and the timelines that they are on. What is the ultimate goal – quick settlements? Trial? When you form the bond and trust with the client, additional work will come. Besides, you never know when an insurance carrier may change.

2. **DO keep the client informed.** Reporting is so vital. Don’t make your client or carrier have to remind you to report. Take the time, update the reports according to client guidelines.

3. **DO mind your guidelines.** If you client requires approval for experts, note that. If they won’t pay for copies, don’t bill them. When you client has to review and cut your hours for things you should already know, those little minutes add up to a lot of extra work.

4. **DON’T treat your client as if they have no expertise.** Consult with the client, ask for recommendations on experts that they may like. Give them options and work on them with strategy. They can often be the best resource.

5. **DON’T be afraid to admit you don’t know.** If you are unsure of things, tell the client you need time to research or work through some issues. Don’t bill them twice for “what you think” and then “what it really is.”

6. **DON’T pass the file without consulting the client.** If you are the rainmaker for the firm, before you pass off that file, introduce the team that will be handling the file.

7. **DO keep up with technology.** Know how to use file share programs and to manage large email productions. Educate yourself on various systems and options for large scale document reviews. Don’t assume that because your client is large or has a high net worth that it is sophisticated when it comes to technology.

XIII. References

42 C.F.R. §483.12(a).


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