Avoiding Litigation

Acuity Level Creep in Assisted Living

By Caroline J. Berdzik

The demand placed upon the assisted living community to balance the desire to age in place with the acute medical needs among the population will only continue to grow.

As the average age and debility of residents in assisted living increases, operators and their attorneys are faced with the dilemma of how to care for these residents in assisted living settings while mitigating potential legal exposure.

According to a recent survey conducted by PointClickCare and McKnight's Long Term Care News, 87 percent of respondents acknowledged a surge in rising acuity levels—meaning the care level required by an individual based on his or her cognitive and medical conditions—in assisted living, while 45 percent stated that they did not know how to respond to the trend. As an individual's acuity level rises, he or she requires more care. It is important for providers and their counsel to first understand what drives this rising acuity level trend among residents before attempting to analyze the potential legal risks and how to proactively mitigate them. For starters, many residents want to age in place in less restrictive and home-like environments, but they have more complex health care needs. Additionally, some families and residents may avoid higher levels of care due to more significant costs. Further, some facilities do not have systems in place to recognize when higher levels of care may be necessary in a timely way. In some instances, residents employ private duty aides, which can mask their actual acuity levels. Rising acuity levels in the less-defined regulatory environment in which assisted living facilities operate has resulted in higher stakes litigation for providers.

Services Provided by Assisted Living Providers

Assisted living is the fastest-growing segment in long term care with approximately 31,000 communities serving over 735,000 residents. Assisted living facilities provide all of the services and programs that might be offered by an independent living facility, in addition to some services to help residents with their activities of daily living (ADL), as well as some basic health care needs. Most residents in assisted living settings pay for their residencies with private funds, as opposed to relying on Medicare or Medicaid. Many providers have tiered levels of service that allow residents to pay for additional assistance for ADLs, depending on their needs. This tiered system may be very helpful in risk mitigation because it serves as an educational tool for families, residents, and facilities about the decline

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of a resident in a fairly easy-to-understand and measurable way.

Today's Assisted Living Resident

The assisted living resident profile in 2015 is different than what many may assume. It can be said that the residents in assisted living today are the residents that used to be in skilled nursing facilities several years ago. Data from the 2010 National Survey of Residential Care Facilities seems to back up this assessment. The survey reveals that the majority of residents in assisted living settings are non-Hispanic, white females, and over half of the residents are aged 85 and over. The survey found that the median length of stay was 671 days or 22 months. The typical resident generally will have several chronic health conditions and require assistance with at least one activity of daily living. In fact, according to the 2010 survey, almost 4 in 10 residents received assistance with three or more ADLs. Typically, these residents do not require continuous care and supervision that would be offered by a nursing home or skilled nursing facility.

According to the 2010 survey, 50 percent of the country's assisted living residents have three or more chronic conditions. The most common condition of assisted living residents is Alzheimer's or some form of dementia (42 percent), which poses risks and challenges for providers. Hypertension (56.7 percent), depression (27.4 percent), arthritis (25.1 percent) and osteoporosis (20.4 percent) are also common chronic medical conditions experienced by residents. In response to the increase in the extent to which assisted living residents experience these medical conditions, facilities have started to bolster the complement of nursing staff. In fact, the 2012 Performance Measures report by the National Center for Assisted Living (NCAL) noted that 94 percent of assisted living facility residents had access to a registered nurse.

Increasing Push for Regulation in Assisted Living

As acuity levels rise among assisted living facility residents, states are increasing regulation of assisted living facilities or introducing enhanced licenses that permit residents to age in place, but with more significant medical needs. It is estimated that 30 percent of the states made changes to assisted living regulations in 2012–2013. Major changes were enacted in New Jersey, New York, Colorado, Georgia, Michigan, Ohio, Oregon, Missouri, and Washington. The regulatory changes encompassed a variety of areas from enhanced survey approaches to additional levels of licensure for assisted living facilities.

While enhanced licensure has its benefits, if not done properly it can result in additional legal exposures for clients. With assisted living facilities traditionally relying on predominantly non-nurse staffing models, enhanced licensure calls for more skilled professional staff such as registered nurses (RNs) to deliver the enhanced level of care. If facilities undertake enhanced licensure without the appropriate policies and procedures for handling higher acuity levels of residents and the appropriate complement of trained staff, they risk scrutiny and litigation when adverse outcomes occur.

Identifying and Managing Risks in the Assisted Living

At the time of admission, it is critical to assess a resident's physical and mental condition and manage resident and family expectations. This initial assessment is critical to determine whether a facility can realistically meet the needs of a resident. Typically, 70 percent of residents come directly from home into an assisted living setting, so facilities may need to rely heavily on health care provider records with little context and incomplete anecdotal information from families and the resident. If a facility is uncertain whether a placement is appropriate, a respite stay for a determined length of time (*i.e.*, 30 days) may be considered.

Since a residency agreement sets the framework at the outset, it should be clear and unambiguous and explain services that are offered and not offered, as well as any tiered system and costs associated with enhanced levels of care. If these documents are vague and ambiguous, particularly when it comes to indicating which services are included in the basic rates and which additional services are available and at what rates, experience has shown that families are more apt to take legal action. Facilities may also want to consider having arbitration agreements as part of their residency documentation.

Additionally, education needs to take place with residents and families during the admission stage. Some providers give DVDs to residents and their families during the admission process to educate them on the particular attributes of a facility or describing chronic medical conditions that residents may have. It is of extreme importance that social media and any advertising materials be scrutinized closely so that they are accurate in their description of the services offered at a particular assisted living facility.

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This includes educating residents and families about the services that an assisted living facility does and does not offer. Families need to be educated on how an assisted living facility would respond in an emergency. This point was illustrated in 2013 when a California assisted living facility was in the news due to a resident who died at the facility after it was alleged that a staff member did not perform CPR after the resident's collapse. The facility had a policy not to perform CPR on residents that was provided to residents and family members. In this instance, the family declined to bring legal action stating that their mother wanted no medical intervention if such an emergency were to occur. Unfortunately, this incident resulted in negative publicity for the provider, as well as some discussion

regarding regulatory changes regarding CPR in assisting living facilities.

Admissions and marketing staff must be part of the training process; they have to be educated on the services offered at each facility. This is particularly true for services related to memory care and specialized memory care units. Vagueness in this area led some states to specify certain parameters and requirements for memory care and dementia and Alzheimer's programs. Some alleged misrepresentations also have caused families to bring legal actions sounding in fraud when negative outcomes have occurred.

NRAs can be used as a tool for educating and informing families and honoring residents' wishes.

Very importantly, families and residents need to understand that the condition of a resident is fluid and dynamic. There should never be promises made about how long a resident may stay in a facility or that a resident can remain at the facility until the time of his or her death. Declines in medical or cognitive status can be rapid or gradual, but they almost always do occur. It is unusual for residents to remain unchanged in this setting. As a result, assisted living facilities that have tiered levels of care seem to be better equipped to demonstrate to residents and families the various levels of care and the progression or regression of a resident from one level of care or another.

Dealing with Changes to Residents' Conditions

Many times a resident's medical or cognitive status may change, which may necessitate providing additional services to the resident. In some cases, medical or cognitive status change can make it necessary to have discussions with a resident and his or her family about transferring the resident from an assisted living setting to another setting where he or she can receive higher level of care. These are never easy discussions to be had, but if a facility has maintained regular and accurate communication between the facility and a resident and the family, these transitions can be smoother.

Service plan conferences should be held on a fairly regular basis to provide the opportunity to educate and to measure where a resident falls on the acuity level scale. As previously stated, assisted living regulations are less stringent than skilled nursing regulations. Consequently, it may be difficult to know when it may be appropriate to transfer someone to a higher level of care. However, there are certain states such as New York that do regulate retention standards and specify when a resident must be transferred to a higher level of care. We must keep in mind that 59 percent of residents eventually move to a skilled nursing setting, while 33 percent die while living in an assisted living setting.

Despite the apparent need of a resident for a higher level of care elsewhere, we have seen cases in which that transition does not occur. There are several reasons why residents remain in assisted living settings longer in these situations. A resident or his or her family may pressure a facility and staff to maintain the resident at a facility because the resident wants to age in place or the family wants their loved one to age in place or with as much independence as possible. Other times the push to remain in assisted living is financial. Skilled nursing is considerably more expensive. On the other side, some plaintiffs' attorneys have alleged that residents may stay longer their conditions would generally dictate due to providers' desire to keep occupancy at ideal levels so that the assisted living providers will remain profitable.

In fact, lawsuits that are filed against assisted living facilities frequently allege that residents have been kept in a setting where the facility allegedly could not meet the care required by a residents called for by increased acuity levels. These lawsuits raise issues such as falls and decubitus ulcer development, which also are common place claims in skilled nursing facility litigation. For example, in 2011, a St. Louis family sued an assisted living facility for negligence after their father fell in his apartment and was allegedly not noticed for two or three days. The family maintained that the facility was negligent and should have noticed that he did not sign up for meals and had not put out a "good morning" sign on his door. In a 2007 Arizona case, a family filed a wrongful death suit against an assisted living facility. Since the facility did not provide any medical care, the resident and family had contracted with an outside home health agency to provide regular nursing care. The resident unfortunately developed pressure ulcers, which worsened to the point of infection and subsequent death. The family sued and the facility was found partially liable for negligence.

With many residents suffering from dementia or other cognitive impairments in an assisted living setting, some of the more unfortunate and risky negative outcomes in assisted living are elopements. Assisted living residences typically do not have the physical safeguards of a skilled nursing facility. If a facility is not cautious and does not put certain precautions in place or transfer a resident with wandering behaviors who cannot be appropriately managed, the facility will expose itself to litigation.

Medication management is also an area that must be monitored closely to avoid risk to residents and a facility. Many residents take multiple medications on a daily basis. Some states allow residents to manage their medications, but this can be a complex and difficult endeavor. Facilities may want to monitor whether residents can safely manage their medications, although that can impose further duties on them from a liability perspective. Due to the increasing complexity of medication management for residents, many facilities have started to employ more nurses to assist in medication management. Assisted living facilities may be well served contracting with pharmacy consultants to evaluate the medication usage of residents on a periodic basis. Since many times a facility is not coordinating the medical care of the residents, it may not be apprised of the various medications that residents take that could have contraindications or other unintended consequences that could present potential for liability to the facility.

Conversely, lawsuits have also been brought by families and residents when a resident is not allowed to remain in an assisted living setting and age in place.

These families have used the Fair Housing Act and Americans with Disabilities Act to attempt to block transfers elsewhere to facilities that offer higher levels of care. Consequently, facilities need to review the medical records and physician determinations for residents carefully to be able to demonstrate if and when a higher level of care may be necessary.

Managing Staffing in Assisted Living to Reduce Liability

Traditionally, assisted living facilities have been primarily staffed with non-nursing staff. However, as acuity levels rise and residents present with more complex medical situations, facilities need to evaluate their staff and whether staff can appropriately handle the needs of the resident population. Facilities should also evaluate the training being provided to staff on a routine basis to ensure that employees can handle individuals with more complex needs.

Assisted living providers also need to be aware of residents and their families hiring private duty staff. In certain geographic areas, this is more commonplace than in others. If a family requests a 24/7 aide for a resident, whether the resident belongs in assisted living in the first place becomes questionable. The use of a private duty aide may mask the true acuity level of the resident or the resident's decline because the aide is doing for the resident that which the facility believes the resident capable of doing. Further, because the facility does not employ the private duty aide, the facility needs to determine how to hold the aide accountable for procedures and policies without creating additional liability. Since a private duty aide does work on the premises, a facility may have difficulty limiting liability if a negative outcome occurs. Best practices would point to having policies and procedures that include evidence of post-offer robust criminal background screening being performed by the employing entity and drug testing (if permitted by state law) for all private duty aides and reporting of any significant changes in a resident's condition. Some facilities have developed their own separate home health agencies and offered those services to family to avoid some of these concerns, but nevertheless, assisted living facilities need to pay close attention to this area.

Strategies for Reducing Litigation Risk

Assisted living providers may want to consider the use of arbitration agreements, dispute resolution procedures, and negotiated risk agreements or even waivers, when states permit them. Some states put restrictions on the use of negotiated risk agreements (NRAs), such as New Jersey. Not all states require that NRAs be in writing, and some refer to discussing risk as part of service planning only. NRAs can be used as a tool for educating and informing families and honoring residents' wishes. They may also be helpful in discussing issues and behaviors that can create risk and attempting to find solutions. A way potentially to overcome a negative perception of an NRA is not to insert a liability waiver.

Technology is another tool that assisted living providers use today to understand acuity creep in their population better. More robust software programs are being developed to manage residents with increasingly complex medical conditions in assisted living that interplay with staffing data and medication management. Technology can be used effectively not only to manage care better, but also to ensure that a facility will bill appropriately for the levels of care that it does provide.

Conclusion

As the population continues to desire to age in place and to experience more acute medical needs, the demands placed upon the assisted living community to balance these desires and avoid increased risk will continue to grow. It is imperative for providers to be aware of the changing demographics and acuity levels in their facilities and adapt or develop appropriate policies, procedures, and staffing models to address this evolution. FTD