Special Challenges in Assisted Living Facility Cases

Assisted living facilities and nursing homes are similar in many ways, but they present different challenges when an injured resident pursues litigation. Here's what you need to know to handle a case against an assisted living facility.

By || **Martin S. Kardon**

Residents of assisted living retirement communities have fewer infirmities and lower care needs than traditional nursing home residents, but these facilities present many of the same risks—as well as several additional ones.

A major part of the assisted living industry's approach to seniors and their families is the quality of life. For example, Sunrise Senior Living touts six "principles of service": preserving dignity, nurturing the spirit, celebrating individuality, enabling freedom of choice, encouraging independence, and involving family and friends.[1] These are laudable goals, but the reality for a resident of an assisted living facility (ALF) often is far different. Disabling fractures, medication errors, resident assaults, avoidable pressure ulcers, and elopements occur in assisted living facilities, as well as in more highly regulated skilled nursing facilities.

Despite defense arguments to the contrary, assisted living facilities are not supervised hotels for the healthy elderly. The hard truth is that residents of assisted living facilities require and contract for supervised care to address identifiable, chronic, and problematic impairments—and they are vulnerable to harm when supervised care is lacking. Pure and simple, an assisted living facility is a place where people with diminished physical, mental, and self-care capacities are cared for.

In ALF cases, several factors that are absent from traditional nursing home cases may contribute to liability. They include inappropriate admission or retention of a resident; lack of regulatory oversight and compliance; minimal training, education, and skill in the staff; diminished availability of medical and licensed nursing care; and contract claims.

When an ALF resident is injured, what happened may be obvious. The reason it happened can be elusive, but it is central to pursuing the case.

Inappropriate admission or retention. To be admitted to an ALF, a potential resident must be examined by a physician and certified as appropriate for the level of care the facility provides. People who cannot or will not ambulate (either by walking or in a wheelchair), who have advanced pressure ulcers, or who require nursing services such as tube feeding

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and respirators may not have their needs met in an assisted living facility. Even if such residents are appropriately admitted, many will gradually lose their ability to safely live in the ALF's less intensive setting.

Medicare and Medicaid pay for assisted living only in some instances.[2] Because ALFs lack government funding, they have economic incentives to retain private pay or long-term care insurance residents in the facility. While supplemental health services can sometimes be provided at the facility, given the degenerative process of aging, the care needs of certain residents inevitably will outpace the facility's abilities to meet them, as they are simply not intended to serve people with advanced illnesses.

Residents who should have been moved to a higher level of care may suffer avoidable, calamitous harm. A review of the facility records will often show either an inadequate, boilerplate completion of the annual certification or a failure to reevaluate a resident following an adverse change in condition that makes continued residency inappropriate.

Lack of regulatory oversight and compliance. While federal and state regulations are universal for skilled nursing facilities that accept Medicare or Medicaid reimbursement (which is all of them), no federal regulations or uniform state regulations pertain to the operation of ALFs.

All states have their own regulations and laws governing the operation of ALFs, but the lack of consistency throughout the country makes it important to research, identify, and become familiar with the laws and regulations for the state involved in any potential claim.[3] These regulations are diverse, but certain common threads run through them:

- admission procedures and standards
- physical building requirements
- assessment and planning processes
- licensing, inspection, and enforcement procedures
- heightened supervision of Alzheimer's units or units housing people with other moderately staged mental incapacities

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All states have regulators that issue licenses and inspect ALFs for compliance with state mandates. If not publicly available, a facility's regulatory history should be requested via subpoena or FOIA request.

In the vast majority of instances, ALF regulations are less extensive and less demanding than those for skilled nursing facilities. But with the expansion of ALF populations to people who have greater needs for supervision and care management, there is a growing recognition in some states that there must be greater regulatory control of these facilities. The result is that over the past 5 to 10 years, new sets of regulations have been passed.[4]

While skilled nursing facilities in every state are regularly visited, scrutinized, and penalized for violations of regulations and substandard care, the regulatory infrastructure covering assisted living facilities is less extensive. Substandard practices and regulatory violations frequently escape the notice of state regulators or fall outside the scope of their scrutiny and powers.

Inadequate staffing. While the underpinning of a skilled nursing facility is the mandated presence of professional nursing staff and the regular availability of medical care and rehabilitative services—such as physical, occupational, and speech therapy—the bar for professional services in an ALF is much lower. Often, staff need no more than to have attained the age of 18 and a high school education.

Generally, regulators do not mandate staffing levels, although they may scrutinize whether staffing levels are adequate, particularly for memory impairment units. Still, because government oversight of ALFs is less extensive, inadequate staffing levels and training are easy to miss.

Lessened availability of medical and licensed nursing care. Many facilities operate without a permanent licensed nurse on staff. Frequently, the person who serves as "director of wellness" (or a similarly named department) and supervises and scrutinizes residents' health does not have any formal medical training. Physicians, physician assistants, and registered nurses may occasionally be in the building but, consistent with the regulatory schemes in place throughout the country, these professionals are not required to be in place consistently. The people who attend to residents' medical care needs are frequently untrained or undertrained.

This approach to care does not reflect the realities of an elderly population living longer with more "managed" chronic illnesses. Residents are entitled to and need care and services commensurate with their functional capacities and health care conditions.

Breach of contract and unfair trade practices. While most states' laws hold that deviations from medical care standards are tort claims and not breaches

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of contract, the defense may attempt to characterize the parties' relationships as commercial arrangements far removed from medical relationships. If such a construct is accepted, plaintiffs may be entitled to both breach of contract claims and claims for unfair trade or business practices (which may entitle the claimants to added treble damages). Including such claims in the initial pleadings may be useful to undercut the defenses' "commercial transaction" postures.

Defense Tactics

Defendants have their own responses to plaintiffs' claims that may be unique to litigation against ALFs. They include the following.

"Shared risk" agreements. Facilities have these agreements signed by both residents and their families. The gist of these is usually a recitation of a resident's identified issues that present a risk of harm, a statement that the ALF provides limited supervisions and interventions regarding such risks, and gratuitous statements that the "homelike" environment and freedom afforded by the facility are known and willing tradeoffs for the increased risks inherent in such an arrangement.[5]

These documents buttress the defense's recurring argument that the duties owed to ALF residents are lower than those owed to skilled nursing facility residents. While this notion is accurate on its face, it misses the point that no "assumption of risk" can vitiate a defendant's acts of negligence and that ALF residents still are owed duties of care by a facility based on an accurate and timely assessment of their needs. Since a shared risk agreement will purport to immunize a facility for harming a resident, plaintiff lawyers should vigorously explore these agreements to eliminate any exculpatory effects.

Arbitration agreements. As in skilled nursing facility admissions, residents and families often are asked to agree to arbitrate claims for harm so that a claim for avoidable harm can be limited in its discovery, damages, and venue. The injustices inherent in arbitration agreements are well known. (See related article at p. 22.)

In ALF cases, procedural unconscionability—of duress, limited capacity, and unequal bargaining positions—may be harder to establish. Admissions are often planned in advance and phased in by the families; they usually do not follow an acute episode of hospitalization. Presumably, this affords families greater time to weigh their options and consider whether to sign an arbitration agreement. While this disregards the unequal bargaining power between the parties and the family's lack of experience in these matters, defendants still will argue that the essence of the parties' arrangements is commercial rather than medical or professional, as in a nursing facility admission.

Consent to lowered expectations of care in exchange for greater dignity and quality of life. The shared risk agreement embodies an essential theme in the defense of these cases: that the plaintiff or family was aware that they were bargaining for less intensive services and that they acknowledged that the plaintiff required less intensive services. Further, the benefits to the resident of such limited care were greater autonomy and dignity and a more homelike environment.

This characterization belies the reality that residents enter assisted living facilities only when they have already begun to suffer from impairments. The resident bargained for adequate, consistent care to address his or her needs as determined by a knowledgeable and skilled caregiver. The laudable goals of dignity, a homelike environment, and individual autonomy must be secondary to resident health and safety.

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As for damages, the results of substandard care for ALF residents may be less drastic medically than those of skilled nursing facility residents. Nonetheless, the losses ALF residents suffer can be every bit as substantial.

While a resident may survive an injury that heals, it could require an otherwise unnecessary move to a skilled nursing environment. This results in a loss of privacy (single rooms are uncommon in nursing homes), disruption of marital relationships (spouses frequently live together with their own furniture in ALFs), and an overall lifetime sentence to a more restrictive, institutional setting.

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Also, damages due to increased private payments or the accrual of governmental liens for Medicare/Medicaid payments can create "boardable" special damages that can be presented to the jury for repayment at the end of trial. Under the right set of facts, plaintiff lawyers should consider pressing for punitive damages against companies that focus on profits to residents' detriment.

The same corporate players often provide both skilled nursing and ALF levels of care, although they may do so under a different name or corporate guise. Since many of the major ALF players remain publicly traded,

A LONG-TERM CARE INSURANCE PRIMER

By Corinne Chandler and Glenn Kantor

Long-term care insurance policies theoretically provide valuable benefits. The product naturally appeals to senior citizens who want coverage for care they may need later in life. Consumers purchase these policies so that they will not be a burden on their families. But often, after paying premiums for 15 or 20 years, consumers discover that the policy does not provide the type of benefits they expected. At that point, they cannot switch coverage due to age or ill health, or the insurer's bureaucracy makes it difficult for elderly and infirm individuals to pursue their claims.

In contested claims, two themes often emerge: The insurer has changed the manner in which it interprets policies so as to deny benefits, or the policy the insured purchased is inadequate in today's market. The disputes rarely involve whether the insured is entitled to the care.

Most litigation centers around contract interpretation issues in ambiguous policies which must be resolved in favor of the insured. Frequent contract interpretation disputes may include the following.

Ineligible care provider. One of the most common grounds for claims denial is when the insurer determines that either the facility or the home health care provider is an "ineligible provider." This frequently occurs when the insured resides in an assisted living facility and receives caregiver services there. If a claim is presented under a home health care policy, the insurer may deny benefits because the insured is not receiving care in his or her "residence." However, "home" may not be defined in the policy or may be defined in such a manner that the facility should be considered the insured's home.

Alternatively, if the claim is presented under a nursing home or facility policy and the insured resides in an assisted living facility, the insurer may deny it because the facility is not "appropriately licensed." Older policies may require that a facility be specifically licensed as a "nursing home" to qualify as eligible. Benefits may be denied for the most common type of care being provided today—care in an assisted living facility. Many states now prohibit exclusion of assisted living facilities from policies that provide facility care.

There are several possible responses to an ineligible caregiver denial. For example, a nursing home policy may require only that the facility be "appropriately licensed." Under a literal interpretation, an appropriate license may include one for an assisted living facility, which may expand nursing home coverage to include an assisted living facility.

The same rationale may be used to rebut a denial under a home health care policy. The policy may contain language requiring that the caregiver be appropriately licensed in the applicable state. Some states, such as California, do not require caregivers to be licensed to provide unskilled services, such as companion or homemaker services.[1]

Unintentional policy lapse. Most insurers have protections in place to guard against an unintentional lapse of the policy. For example, the insured may designate third parties for the insurer to notify if the policy is about to lapse. The third party then can take steps to preserve the policy by ensuring a timely premium payment. If timely notification was not given to the third-party designee, the insured may contest the lapse.

Unfulfilled "gatekeeper" requirements. Older home health care policies usually contain gatekeeper requirements,

financial data can be obtained independent of discovery.

Senior citizens often must leave their homes for supervised care because of increasing physical or mental infirmities. If they receive careful attention and reasonable scrutiny by well-informed caregivers, an assisted living placement can raise the quality of life for the entire family. But assisted living residents' inevitably increasing fragility and vulnerability require constant vigilance by facility staff. When this vigilance is lacking and a resident is injured, plaintiff lawyers need to know how to hold the facility accountable.

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Notes

1. Sunrise Senior Living, Mission, Principles of Service, and Core Values, www.sunriseseniorliving.com/the-sunrise-difference/principles-and-values.aspx.
2. *See* AssistedLivingInfo, Paying for Care, www.assistedlivinginfo.com/Paying-for-Care/Overview.
3. For a complete list and description of the assisted living regulations in all states, see National Center for Assisted Living, Assisted Living Regulations, 2012 Assisted Living State Regulatory Review, www.ahcancal.org/ncal/resources/Pages/AssistedLivingRegulations.aspx.
4. For example, in Pennsylvania the regulations now separate "personal care homes" from "assisted living facilities," with the latter having greater service, documentation, and care requirements. *See* Pa. Code tit. 55, §§2600, 2800 (2010).
5. For example, Manor Care, Inc.'s policy of "negotiated risk agreements" (obtained in one client's case) states: "A negotiated risk agreement is completed by the executive director during move-in or during a resident's stay when a family's/resident's behavior or preferences puts the facility and/or the resident at risk. The form acknowledges that discussion of a particular risk(s) has taken place with the family/responsible party and that mutual understanding and agreement on the approach was reached."

which are now prohibited in many states. One of the most common requires the insured to be hospitalized for three days for the same condition that requires home health care. Many disabling conditions—such as Alzheimer's disease—do not require hospitalization, thus preventing the insured from using the policy as intended.

Litigation Tips

In many cases, the dispute involves a pure contract interpretation issue. If the policy language is not clear, other evidence may be helpful in ascertaining the parties' intent.

State departments of insurance may require insurers to submit advertising materials or outlines of coverage for approval before making them available to insureds.

Also, you may be able to gauge the insurer's intent by obtaining its communications with the department of insurance when it sought approval to sell the policy form or requested a premium increase. The insurer may have made representations regarding the scope of coverage that may be useful in your case.

Claims manuals, guidelines, and training materials are also relevant. Because many insurers have changed their approach to policy interpretation, it is helpful to obtain historical manuals and guidelines as well.

Discovery of other disputes involving the same issue may yield valuable evidence. For example, there has been extensive litigation involving premium increases imposed by long-term care insurers. There has also been litigation regarding the insurer's "alternate plan of care" provisions.[2]

Finally, you may be able to use a "conformity with state statutes" provision to bring the policy in line with current state statutes. Under this emerging theory, some courts have treated the annual insurance policy renewal as a new policy, which must conform to current state statutes that provide greater protection to insureds under long-term care contracts.[3]

Depending on the state, available remedies may include contract benefits and extracontractual remedies that are typically available in claims disputes. It may also be helpful to consult state statutes for enhanced remedies that may be available for the elderly.

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Notes

1. Cal. Health & Safety Code, §1727(d) (1989).
2. *See Roland v. Transamerica Life Ins. Co.,* 570 F. Supp. 2d 871 (N.D. Tex. 2008) (court upheld an insurer's denial of benefits under an "alternate plan of care" provision on grounds that the alternate plan of care had not been mutually agreed on between the insurer and the insured).
3. *See Bushnell v. Medico Ins. Co.*, 246 P.3d 856 (Wash. App. Div. 1 2001) (policy that was renewed annually must conform with current state statute that prohibited three-day hospitalization "gatekeeper" provisions); *Bell Care Nurses Registry, Inc. v. Contl. Cas. Co.,* 25 So. 3d 13 (Fla. 3d Dist. App. 2009). *But see Haley v. AIG Life Ins. Co.,* 2002 WL 417419 (D.N.D. Jan. 24, 2002) (refused to apply current law to "guaranteed renewable" policy on grounds that the policy was a continuation of the original policy and was not required to conform with current state law); *Yoder v. Am. Travellers Life Ins. Co.,* 814 A.2d 229 (Pa. Super. 2002).