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Proving a claim of low staffing against long-term care facilities

Elders are being neglected at an alarming rate in long-term care facilities in California. Staff is often cut to "make it work"

Elders are being neglected at an alarming rate in long-term care facilities in California. At the crux of the neglect is the cost of labor and expected profits by investors. Staffing, which is by far the most costly expense, is cut, as they say, to "make it work" and make it pay. The outcome is pretty simple – bad things happen to residents when no one is around to help.

It is undisputed that adequate staffing is critical to the provision of basic care to residents in long-term care facilities. Innumerable studies have shown that a lack of adequate staffing has a direct relationship to the quality of care provided. (See authors, e.g., *Aaronson, Zinn, & Rosko*, 1994; *Bliesmer, Smayling, Kane, & Shannon*, 1998; *Castle & Fogel*, 1998; *Cohen & Spector*, 1996; *Harrington, Zimmerman, Karon, Robinson, & Beutel*, 2000; *Porell, Caro, Silva, & Monane*, 1998; *Schnelle, Simmons, Harrington, Garcia, & Bates-Jensen*, 2004; *Unruh & Wan*, 2004.)

Understaffing will result in an increased likelihood of:

- Residents being sexually assaulted;
- Residents developing severe, gangrenous pressure ulcers;
- Residents suffering falls and severe fractures;
- Residents being made to lie in linens soiled with feces and/or urine for hours or days;
- Residents not being bathed or showered for days;
- Residents having call lights go unanswered for long periods of time, if answered at all;
- Staff performing duties outside the scope of their job description and training; and
- Residents suffering premature death.

Unfortunately, understaffing in long-term care facilities is widespread and accepted. Owners and operators of long-term care facilities deliberately choose to understaff their facilities to increase profits despite having full knowledge that understaffing is a severe detriment to the care of their residents. (See, e.g., Duhigg, *At Many Nursing Homes More Profit and Less Nursing*, N.Y. Times (Sept. 23, 2007); Jewett & Armendariz, *Nursing Homes Received Millions while Cutting Staff, Wages*, California Watch (April 17, 2010).)

Understaffing is a significant cause of injuries and deaths in both skilled nursing facilities (SNF) and residential care facilities for the elderly (RCFE). The type of evidence available to the practitioner differs in part due to the fact that RCFEs in California do not accept government funds and are not as highly regulated. We will discuss both below.

Skilled nursing facilities

The ongoing trend in skilled nursing facilities in California, particularly those belonging to large chains, is to focus on admitting short-term Medicare residents who have higher needs (i.e., high acuity). High acuity residents have the highest reimbursement rates of any payor type. The motivation is simply to increase revenues, which lead to greater profits. Tragically, these same facilities that target more vulnerable, medically-needy residents often fail to provide the necessary nursing staff required – or the nursing staff they are being paid to provide – to care for this fragile population, in direct violation of state and federal law.

The relevant laws are as follows:

- The basic licensure requirement for all skilled nursing facilities is to provide adequate, qualified staffing. (See Cal. Code Regs., tit. 22, § 72501, subd. (e), which lists as one of the "General Duties" that "[t]he licensee shall employ an adequate number of qualified personnel to carry out all the functions of the facility . . . .")
- Courts have emphasized that residents have "the right to reside in a facility with an adequate number of qualified personnel to carry out all of the functions of the facility." (See, e.g., *Shuts v. Covenant Holdco LLC* (2012) 208 Cal.App.4th 609, review den. Nov. 14, 2012, 2012 Cal. LEXIS 10444 (citing Health & Saf. Code, § 1599.1, subd. (a) (hereafter *Shuts*); *Wehlage v. EmpRes Healthcare, Inc.* (N.D. Cal. 2011) 791 F.Supp.2d 774, 788 [which involved a matter in which the plaintiff suffered numerous injuries and indignities as a result of understaffing] (hereafter *Wehlage*).)
- Under Health & Safety Code section 1276.5, subdivision (a), California skilled nursing facilities are legally mandated to provide a minimum ratio of 3.2 direct care nursing hours per patient per day ("NHPPD"). However, 3.2 NHPPD is simply the floor below which no facility may fall. (Pursuant to Health & Saf. Code, § 1276.5, subd. (b), "nursing hours" means the number of hours of work performed per patient day by nursing assistants, licensed vocational nurses, and registered nurses (excluding Directors of Nurses in facilities of 60 beds or larger capacity) while performing direct-care nursing services. The process of determining which staff hours "count" toward the direct-care nurse staffing requirement is set forth by the Department of Public Health and is well recognized by the industry. (See Cal. Dept. of Public Health, all facilities letter (Jan. 31, 2011) pp. 11-19.))
- The California Legislature and the California Department of Public Health

Low Staffing *continues*

("DPH") have emphasized that the 3.2 NHPPD is a *bare minimum,* and that additional staff may be necessary to provide adequate care to residents and to ensure the safety of residents. (See Health & Saf. Code, §§ 1276.5 & 1599.1, subd. (a); Cal. Code Regs., tit. 22, §§ 72329.1, subd. (a) & 72501, subds. (e) & (g); and 42 C.F.R. § 483.30 (October 1, 2011).)

• Under Health and Safety Code section 1599.1, subdivision (a), a Skilled Nursing Facility "shall employ an adequate number of qualified personnel to carry out all of the functions of the facility." Indeed, courts have held that this is a resident's right. (*Shuts*, *supra*, 208 Cal.App.4th at p. 62, citing *Wehlage*, *supra*, 791 F.Supp.2d at p. 788.)

• Health and Safety Code section 1276.65, subdivision (d) states, in relevant part:

> The staffing ratios to be developed pursuant to this section shall be minimum standards only. *Skilled nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents* and to ensure compliance with all relevant state and federal staffing requirements.

(Health & Saf. Code, section 1276.65, subd. (d), italics added.)

• Title 22 of the California Code of Regulations states, in relevant part:

> Skilled nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

(Cal. Code Regs., tit. 22, § 72329.1, subd. (a).)

> The Department may require the licensee to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional personnel is needed to provide for the health and safety of patients.

(Cal. Code Regs., tit. 22, § 72501, subd. (g).)

The daily direct care nursing staff level required to meet the needs of any skilled nursing facility's resident population is directly dependent on the aggregate acuity of the resident population. Thus, for facilities that have high patient acuity (i.e., need levels), staffing over and above the bare minimum 3.2 NHPPD is a necessity. In other words, these facilities should provide the care they are getting paid to provide.

The acuity of each resident is assessed upon admission, quarterly, annually, and upon any material change of condition. This process, which is mandated for all residents in Medicare- or Medicaid-certified nursing homes, is known as the Minimum Data Set (MDS) assessment protocol. The MDS

assessments, performed by licensed health-care professionals – usually Registered Nurses employed by the nursing home – analyze the entire health status of the resident, including cognitive patterns, communication and hearing patterns, vision patterns, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems for certain activities, including bed mobility, transfers, locomotion in room, corridors and unit, dressing, eating, toilet use, personal hygiene, bathing, balance range of motion, continence, diseases, health conditions, oral, dental and nutritional status, activity pursuit patterns, medications, special treatments, discharge potential, and therapies. The MDS assessment results in a comprehensive assessment of each resident's functional capabilities. The assessment process helps skilled nursing facility staff to identify health problems and care needs. Upon completion of the MDS assessment, an overall Resource Utilization Group (RUG) score is assigned to the resident. The RUG score provides the overall foundation upon which a resident's individual care plan is formulated. An aggregation of acuity assessments provides the basis for determining the number of qualified personnel needed to carry out all the functions of the facility and meet the needs of the residents.

Relevant documents in skilled nursing facility cases

A facility's failure to meet adequate staffing requirements can be evidenced by the following documents:

Documents from the defendant

- All documents regarding budgeted and actual daily nurse staffing levels, including reports, emails, letters, operating budgets, memoranda, and CMS 671 forms.
- Daily electronic payroll data and time detail reports (segregated by job category), daily assignment sheets, and daily sign-in sheets for all nursing staff (including registry).
- Documents sufficient to identify job and account codes, job titles, and job descriptions.
- Electronic data showing the resident census by day.
- All documents regarding residents' needs, acuity, and/or RUG scores, including residents' assessments, MDS Forms, and CMS 672 forms (resident names redacted).

• Policy and procedures or operational manuals, including those used to assess, calculate, or monitor NHPPD and for determining whether the facility had sufficient nurse staffing.
• Any documents regarding occupancy and occupancy goals.
• Any documents regarding nurse staff training and in-services.
• Any complaints regarding staffing or resident care.
• All documents regarding any bonus structures and incentives.
• All advertisements and marketing scripts with claims about the quality, characteristic, type, and standard of care provided to the residents of the facility.

Documents from other sources

• Office of Statewide Health Planning & Development (OSHPD) Long Term Care Summary Individual Disclosure Report (http://siera.oshpd.ca.gov/FinancialDisclosure.aspx) These reports contain tremendous amounts of helpful information, including number of licensed beds, patient census and occupancy rates, and gross and ancillary services revenue and payor mix (see, esp., p. 1 and sections 4.1 to 4.3 of the Report); hours worked by nursing staff and management (see p. 3 of the Report, "Productive Hours and Salaries and Wages"); and ownership and management information and related party transactions (see sections 3.1 to 3.3 of the Report).
• Center for Medicare & Medicaid Services, Expected Staff Time Values Data (http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html)
• The DPH licensing and certification file for the facility, including all citations, statements of deficiencies, and plans of correction.
• Center for Medicare & Medicaid Services, Nursing Home Profile (including inspection reports and penalties) (http://www.medicare.gov/nursinghomecompare/search.html)
• California Advocates for Nursing Home Reform, Nursing Home Guide (http://www.nursinghomeguide.org)

Residential care facilities for the elderly

Residential care facilities for the elderly offer room, board, and daily assistance for seniors in certain activities of daily living (ADLs), such as preparing meals, shopping, transportation, preparing and taking medication, using the telephone, paying bills, housekeeping, and others.

Pursuant to section 1569.2, subdivision (k) of the California Health and Safety Code, a "'[r]esidential care facility for the elderly' means a housing arrangement chosen voluntarily by persons 60 years of age or over, or their authorized representative, where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided, based upon their varying needs, as determined in order to be admitted and to remain in the facility." The law governing residential care facilities for the elderly is in large part set forth in sections 1569 through 1569.87 of the California Health and Safety Code and sections 87100 through 87730 of Title 22 of the California Code of Regulations.

Residential care facilities for the elderly are intended to provide a level of care appropriate for those who are unable to live by themselves, but who do not have medical conditions requiring more extensive nursing care and significant assistance with most of their ADLs.

However, similar to the profit-seeking trend in skilled nursing facility admissions, there has been an increasing trend for residential care facilities for the elderly to accept and retain more residents with conditions and care needs that were once handled almost exclusively in skilled nursing facilities. Residential care facilities for the elderly typically charge residents a base rate plus additional fees based on their assessed personal care level and the services and assistance associated with that level. Thus, the higher the personal care level determined for a resident, the more money the residential care facility for the elderly charges the resident. Admitting residents with greater needs has allowed residential care facilities for the elderly to increase not only the potential resident pool but also the total fees charged to residents and/or their family members.

Unfortunately, residents of residential care facilities for the elderly are falling through the widening gap between a defendant RCFE's profit-seeking mode of operation and the laws put in place to regulate them. In particular, administrators of residential care facilities for the elderly are admitting and retaining residents in violation of law, including Title 22 of the California Code of Regulations section 87615, which sets forth some health-prohibited conditions:

> § 87615. Prohibited Health Conditions
> (a) In addition to Section 87455(c), the following persons who require health services for or have a health condition including, but not limited to, those specified below shall not be admitted or retained in a residential care facility for the elderly:
> (1) Stage 3 and 4 pressure sores (dermal ulcers).
> (2) Gastrostomy care.
> (3) Naso-gastric tubes.
> (4) Staph infection or other serious infection.
> (5) Residents who depend on others to perform all activities of daily living for them as set forth in Section 87459, Functional Capabilities.
> (6) Tracheostomies.

(Cal. Code Regs., tit. 22, § 87615.)

Residential care facilities for the elderly often violate staffing and training requirements, including Title 22 of the Code of Regulations section 87411, which mandates that "[f]acility personnel shall at all times be sufficient in numbers, and competent to provide the services necessary to meet resident needs." Thus, staff of residential care facilities for the elderly struggle to provide adequate care to residents. (Cal. Code Regs., tit. 22, § 87705, subdivision (c)(4) further requires RCFEs that retain residents with dementia to maintain "an adequate number of direct care staff to support each resident's physical, social, emotional, safety and health care needs as identified in his/her current appraisal.")

Additionally, residential care facilities for the elderly create a perfect storm for residents and their families through aggressive and false advertising claims that misstate the services provided by the facility in violation of the laws. (See, e.g., Cal. Code Regs., tit. 22, §§ 87207; Civ. Code, § 1750 et seq. (Consumer Legal Remedies Act); and Bus. & Prof. Code, § 17200 et seq. (Unlawful, Unfair and Fraudulent Business Practices).) A common example is a residential care facility for the elderly marketing itself as providing "expert dementia care," when discovery later reveals the staff had no such specialization or training.)

As a result, residential care facilities for the elderly are failing to provide residents with basic care, in violation of regulations, including Title 22 of the Code of Regulations, section 87464, and causing severe injury to our loved ones.

Relevant documents in RCFE cases

Many of the relevant documents obtained from a defendant residential care facility for the elderly are similar to those obtained from a defendant skilled nursing facility. However, there is significantly less information available publically regarding California's some 7,500 residential care facilities for the

elderly. Residential care facilities for the elderly do not receive reimbursement from the government. As such, government agencies collect significantly less data on the operations of residential care facilities for the elderly.

Documents from the defendant

- All documents regarding budgeted and actual daily staffing levels, including reports, emails, letters, operating budgets, and memoranda.
- Daily electronic payroll data and time detail reports (segregated by job category), daily assignment sheets, shift schedules, and daily sign-in sheets for all staff.
- Documents sufficient to identify job and account codes, job titles, and job descriptions.
- Electronic data showing the resident census by day.
- All documents regarding residents' needs at the facility including resident's assessments and reassessments (resident names redacted).
- Policy and procedures or operational manuals, including those used to assess, calculate, or monitor staffing levels and for determining whether the facility had sufficient staffing.
- Any documents regarding occupancy and occupancy goals.
- Any documents regarding staff training and in-services.
- Any complaints regarding staffing or resident care.
- All documents regarding any bonus structures and incentives.
- All advertisements and marketing scripts with claims about the quality, characteristic, type, and standard of care provided to the residents of the facility.

Documents from other sources

- The Department of Social Services, Community Care Licensing Division (DSS/CCL) licensing and certification file for the facility, including all citations, statements of deficiencies, and plans of correction.
- California Advocates for Nursing Home Reform, Residential Care Guide (www.residentialcareguide.org).

We need better regulations for residential care facilities for the elderly

This year the California Legislature was presented with over a dozen bills regarding RCFE reform. As of the writing of this article, many have been gutted or declared dead. Some are on life support and some are lucky enough to have made it into law. (See, e.g., CANHR RCFE Reform Act of 2014, *available at* http://canhr.org/legislation/rcfe_reform_act.html (last visited September 15, 2014).)

More needs to be done. Cash-strapped Community Care Licensing simply cannot keep up, and people are dying. In the last year, a wave of scathing investigative reports has revealed the shocking extent to which residential care facilities for the elderly are violating regulations and injuring their elderly residents. (See, e.g., "*Life and Death in Assisted Living*," Frontline, available at http://www.pbs.org/wgbh/pages/frontline/life-and-death-in-assisted-living (last visited September 15, 2014).)

Because the only thing that the industry fears is a threat to the pocket book, it is the plaintiff's lawyer who must take up the cause. Consider this a call to action.

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