

Understaffing in Nursing Homes and Assisted Living Facilities

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No business runs efficiently if it is understaffed. The employer's work does not get done timely or correctly. Customers are not satisfied when their needs are not met and employee morale suffers. Cutting the cost of payroll can, however, boost profits for the employer. Conversely, no employer wants to pay the expense of staff if they are not needed. Nursing homes and assisted living facilities are no different than any other business. If they are understaffed they are unable to meet the needs of their residents and poor care may occur.

Simple case investigation in any case involves the consideration of "who, what, where, when, and why." Understaffing can often be the answer for the "why". Severe injuries and death occur often to the elderly and disabled in facilities. Without understanding why such events occurred, the defense will often try to shift the blame to the nursing home resident's health conditions or co-morbidities. While proper resident assessment, care planning, interventions, and treatments all play a key role in proper care and safety, understaffing usually applies to the implementation of assigned tasks. The majority of care given in nursing homes and assisted living facilities are rendered by the lower level nursing staff, generally aides. They are assigned tasks to do for each resident on each shift. If there is not enough staff, often tasks aren't completed properly or at all. There is simply not enough time to do all the assigned tasks properly. Improper delegation of nursing tasks may also cause injuries or death to those not properly supervised or trained to render certain care. So the questions to investigate are "why"

did the resident get a pressure ulcer (aka decubitus ulcer or bedsore) or “why” did they fall. Was it failure to do a proper assessment and care plan? Was it the failure to ensure implementation of the care plan by the aides? Or was it a corporate decision to understaff the facility to increase profits? Themes such as “profits over people” have yielded many large verdicts throughout the country including punitive awards for the deliberate understaffing of nursing homes and assisted living facilities.

Litigation of a nursing home or assisted living case should not have the same trial strategy or case plan as a medical malpractice case. Sure, you always have to prove breach of a standard of care, causation, and damages, but that should not be the emphasis of the case. Jurors must feel empowered to react to “why” the event happened, based on the actions of the defendant. Jurors don’t want to punish caregivers who are over-worked and have little assets. It is the company’s management that needs to be held accountable. A story needs to be told why there was a corporate decision to not provide enough staff. Corporate negligence actions can may be maintained on a respondeat superior basis, and or as well as, by direct participant liability based on the corporate actions.¹ Although it is difficult to obtain punitive damages in Maryland, jurors don’t like defendants who falsify charts, cover-up facts or cut staff levels to increase profits rather than render good care. Similarly, jurors are not impressed with owners and their connected companies taking large salaries or fees when paying for an additional certified nurse aide would only cost them \$10-12 an hour to provide better care. If these facts can be shown, better settlements and verdicts can be secured.

¹ See the U.S. Supreme Court case of U.S. v. Bestfoods, 524 U.S. 51, 118 S. Ct.1876 (1998)

So what are the documents and tools available to the litigator? There are many documents available in skilled nursing cases which are not available in assisted living cases. This is because the Center for Medicare and Medicaid Services (CMS) requires various forms to be completed by facilities to participate in their payment process. Nursing facilities must report acuity, census information, costs and expenses (cost reports), as well as staffing levels. Some information is available online to the general public, from the CMS website, the Maryland Department of Health and Mental Hygiene's, Office of Health Care Quality (OHCQ) website. Other information can be obtained by discovery requests under the Maryland Rules. The starting point is to look at what the government requires.

Nursing homes and assisted living facilities are both regulated industries. Nursing homes are regulated by both federal law and state law.² Assisted living facilities are only regulated by state law.³ Anyone litigating one of these cases for negligence needs to have a thorough working knowledge of these regulations and statutes.⁴

Under the Federal Nursing Home Reform Act, which is part of the Omnibus Budget Reconciliation Act of 1987(OBRA), regulations were established for nursing homes which accept Medicare and Medicaid reimbursement or payment. "Medicare and Medicaid Requirements of Long Term Care Facilities",⁵ addresses mandated regulation on a variety of topics, such as resident rights, quality of life, quality of care, resident assessments, care plans, nursing services,

² 42 C.F.R. 483, Subpart B, if a skilled nursing facility accepting Medicare or Medicaid , Annotated Code of Maryland, Health-General Article, §§19-308, 19-308.1, 19-323, and 19-1401 et seq.; Public Safety Article, §14-110.1; Annotated Code of Maryland, & COMAR 10.07.02).

³ Annotated Code of Maryland, Health General Article, Title 19, Subtitle 18 and COMAR 10.07.14.

⁴ The author suggests obtaining a copy of "The Long Term Care Survey" from AHCA, as it contains interpretive guidelines, Ftags and other helpful information regarding nursing homes. This is also guidance to state surveyors who conduct the surveys of compliance.

⁵ 42 C.F.R. 483, Subpart B.

physician services, other health care provider services, infection and administration. Failure to abide by these regulations can result in a survey deficiency requiring the facility to submit a plan of correction, submit to a fine or even possible decertification. Low staffing levels can lead to a variety of severe and fatal conditions such as malnutrition, dehydration, infection, poor skin care, and falls. There is a direct connection between staffing levels and regulatory deficiencies.⁶ These regulations may also set a standard of care or violation of statute, indicating evidence of negligence. There are currently efforts being made in Congress to amend the Affordable Care Act to adopt language that violation of these regulations do not set the standard of care. Some specific sections of the Medicare and Medicaid Regulations are:

42 C.F.R. 483.25 Quality of Care “Each resident must receive and the facility must provide the necessary services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.”

42 C.F.R. 483.30 Nursing Services “The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by resident assessment and individual plan of care.” Additionally, the facility must post daily and make available to the public, the resident census and the total number of registered nurses, licensed practical nurses, and certified nurse aides that are working.⁷

⁶ Kim, et al, (2009) A Panel data Analysis of the relationships of Nursing Home Staffing Levels and Standards to Regulatory Deficiencies, *Journal of Gerontology: Social Sciences* 64B(2),269-278

⁷ 42 C.F.R. 483.30(e)

Assisted living programs must comply with the Code of Maryland Regulations

(C.O.M.A.R) 10.07.14.14 Staffing Plan. Among other provisions states:

- A. "Following an analysis of the number of residents that the assisted living program intends to serve and the individual needs of each resident, the licensee shall develop a staffing plan that identifies the type and number of staff needed to provide the services required by this chapter."
- B. "The staffing plan shall include on-site staff sufficient in number and qualifications to meet the 24 hour scheduled and unscheduled needs of the residents. When a resident is in the facility, a staff member must be present."

The above regulations can be broken down into specific Request for Admissions, deposition questions, or for cross examination at trial. The defendant or their expert will have to agree that they must comply with these regulations.

There are several methods and documents to obtain during investigation and discovery to prove understaffing.

Probably the best sources of information are the facility employees who provide the direct care of the resident. Counsel should review the Rules of Professional Conduct to determine the permissibility of interviewing employee witnesses. It is best to try to interview them prior to litigation, if you can find them, but a discovery request later asking for the names and contact information of all current and former employees that were involved in the care of your client, for a specified period, should be made. Counsel should not be adversarial with these employees. These employees are usually certified nurse aides (CNA) in the nursing homes and resident aides in assisted living. They will often tell you that they intended to do all care

required, but simply can't complete all the tasks for all residents during the course of a shift. Additionally, they may tell you that they are tired, overworked and underpaid. They may be your best witnesses. Jurors will listen to them. They are the ones in the trenches. They are not hired guns and are not getting paid to render opinions as expert witnesses. Common tasks they may perform include: showering or bath, personal hygiene, catheter care, tracheostomy care, dressing, toileting, incontinent care, wound care, skin care, bed making, turning and repositioning, serving food, feeding, vital signs, hand washing between residents, assisting residents ambulating, charting, etc.

There are several key questions to ask the CNA or resident aide:

1. How many hours does the CNA work in a shift?
2. What is the number of residents the CNA usually has in a shift?
3. How many residents are total care, need toileting, feeding, assistance with ambulation, catheter or tracheostomy care, and other care needs?
4. What are the CNA's duties and tasks?
5. How long does it take to do each task?
6. How much time does the CNA take for meals and breaks?
7. Are there any tasks that can't be done each shift?
8. What documentation is done regarding tasks done or not done?
9. What happens when a CNA calls in sick or does not show for work?
10. Is the CNA aware of the facility's Policies and Procedures with regard to the issues of the case, for example wound care or fall prevention policies?

11. Does the resident have dementia, Alzheimer's, or other physical or mental disability that requires additional time for care due to difficulty understanding the CNA?
12. Did employees make complaints to management and what was the response?
13. Was there staff turnover and why?

The level of each nursing home resident's medical complexity of their illness or condition is called "acuity". Higher acuity levels mean more money in Medicare or Medicaid reimbursement. "Census" means the total number of residents residing in the facility. Medicare reimbursement classifications are established according to Resource Utilization Guidelines (RUGS). Classification is based on a standardized assessment tool for each resident known as the Minimum Data Set (MDS). The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological and psychosocial functioning. The items in the MDS give a multidimensional view of each resident's functional capacities and helps staff to identify health problems. Information in the MDS is not only used for RUG or payment classification. It also identifies the areas required to be care planned for each resident. CMS's Resident Assessment Instrument (RAI) is instructive on filling out the MDS form.

The MDS is completed at various timed intervals during the residence in the facility and when there is a significant change in condition. Submission of the MDS is mandatory of skilled

nursing facilities seeking payment or reimbursement from Medicare or Medicaid.⁸ After the MDS is completed each resident is assigned a RUG classification. The Facility Case Mix Score is determined by assigning an index of all the resident RUGS and dividing that index by the census.

When a resident's acuity level increases, his or her RUG rating and reimbursement rate also increase. The premise is that a patient with a higher RUG rating requires more skilled care. More skilled care means more time allotted to the resident by staff. Thus, there is a need to increase staffing levels, to provide additional time to provide proper care. By increasing acuity levels the facility can increase its revenues. Often the number of skilled staff does not increase. This is a corporate decision. "Per Patient Days" (PPD) is the total number of nursing hours for all nurses on duty in a given day divided by the patient census for the same time period. Staffing analysis requires an understanding of resident population acuity and the PPD ratio. Expert testimony, usually by a former or current nursing home administrator would be needed to show an understaffing based on PPD and acuity.

Many of the documents can be obtained in discovery or prior to filing suit. Documents to request either by:

- a. An initial Public Information Request
- b. A Request for Production of Documents or
- c. By a corporate designee deposition include the following, subject to appropriate redaction of other residents names or identifiable information only:

⁸ 42 CFR §483.20(f)(1), (f)(2), and (f)(3),

1. All of your client's MDS report submissions. These are usually requested with the initial chart request by the attorney. If not, it can be requested in a discovery document request.
2. Medicare and Medicaid cost reports. In addition to requiring the facility to send detailed information about each resident on the MDS, the nursing homes must send detailed information about its own income and operating expenses to Medicare by cost reports. Additionally, these reports show related organizations and corporate affiliates, ownership, annual RUG data, beds, annual census, cost allocation, payroll, wage index information, line items of amounts paid to owners and administrators. These cost reports can be used to show PPD trends and funds allocated to direct care staff. These cost reports can be obtained from State intermediaries. In Maryland they can be obtained The Department of Health and Mental Hygiene (DHMH), Division of Cost Accounting. Additionally they can be requested from the defendant in discovery.
3. Roster/Sample Matrix of residents. CMS Form 672 shows resident census and conditions of residents. Names of the resident are not shown. Form 802 is the Roster/Matrix with resident names and health conditions. The names would need to be redacted.
4. Posted nurse staffing information. The numbers of nursing staff information required by 42 C.F.R 483.30(e) is required to be posted in each facility.

5. Punch detail reports. Actual time clocked based data should be maintained by facilities to see when each employee is actually working, what shift and how many are working in the facility during a shift.
6. Turnover reports. Usually something the administrator or management keeps. These provide statistical data every month, quarter or yearly. Turnover rates often indicate poor employee morale due to being overworked.
7. Employee Roster. A list of all staff. Useful in locating employees.
8. Schedules of employees. This is when they were supposed to work, not actual work.
9. Daily Room assignment sheets. Show what rooms and how many residents were assigned to each CNA.
10. Floor plans. Useful in seeing how far away the resident was to the nursing station.
11. Depositions of key staff. In addition to the direct care employees, Depositions of the Administrator, Director of Nursing, corporate designees and others can provide useful information.
12. Office of Health Care Quality (OHCQ) Deficiencies and Plans of Correction. Some of the deficiencies by searching "Nursing Home Compare" via CMS website. Or they can be obtained by links on the OHCQ website or the defendant. Plans of Correction are rarely on the website, but can be requested from OHCQ or the defendant. Defendant will object to the use of plans of correction and contend that they are "subsequent remedial repairs" and thus inadmissible.
13. CMS "Nursing Home Compare" Website. You can search and obtain staffing information, quality of care ratings and other valuable information on specific

nursing homes. The OHCQ website also contains some information on assisted living facilities, however that information is not always complete.

14. ADL or 24 hour care sheets. Many facilities require the staff to chart the activities of daily living (ADL) and tasks performed for each resident..
15. Medication Activity Reports (MARS) and Treatment Activity Reports (TARS) Usually a matrix style chart of physician ordered medication and treatment. Usually initialed by staff when done or claimed to have been done. For example an order to turn and re-position every two hours for wound care.
16. Policies and Procedures may often be used in setting a standard of care of what should be done in a facility. But many lower level care staff, such as CNAs, are not instructed in the practices or procedures or even know there are any.

The same principles apply to assisted living facilities even though there is little documentation to be filed with the State other than what is found in C.O.M.A.R. The information would be used to show that “the staffing plan was not sufficient in number and qualifications to meet the 24 hour scheduled and unscheduled needs of the residents.”

By an analysis of the various documents and individual interviews with key aides and staff, low staffing levels can often be shown to be the source of “how and why” an event occurred. Some situations may include, by example:

- a. A resident requiring a two staff transfer assist, and only one staff actually assisted, resulting in a fatal fall.
- b. A person developed pressure ulcers (bedsores), because an aide didn’t have enough time to turn and reposition the resident every two hours as ordered.

- c. Catheter care did not get done, resulting in a urinary tract infection leading to sepsis and death.
- d. Tracheostomy monitoring and suctioning care did not get done, resulting in asphyxiation and death.

By using the testimony of key employee witnesses, the documents required by the facility to be kept or filed with the government agencies, along with the resident's chart, understaffing can be shown. If the corporate desire to maximize profits while minimizing direct care to residents can be proven, the plaintiffs' attorney can show a deliberate decision on management's part to put residents at risk of severe injury or death. Most jurors would rather hold an owner of a facility accountable rather than the lower level staff rendering care. These deliberate corporate decisions give the plaintiffs' attorney ammunition to obtain successful settlements and anger and empower jurors to render higher verdicts. So, when investigating "what" happened, it is also important to determine "how and why" it occurred.

ADDITIONAL RESOURCES

<http://www.weinberglaw.com>, <http://www.weinberglaw.com/nursing-homes/>,
<http://www.weinberglaw.com/assisted-living-facilities/>