LIABILITY
landscape

BY LINDA WILLIAMS, RN

Be careful what your assisted living facility offers

More and more assisted living facilities (ALFs) are providing an increased scope of services as their average tenant acuity level has risen dramatically over recent years. These ALF providers have compensated for higher acuity levels by offering more activities of daily living (ADL) assistance, blurring the categories of care that traditionally have separated ALFs from nursing homes. These hybrid services have spurred a regulatory climate change as many states are now considering, or have already enacted, legislation to regulate this growing industry in order to make it more accountable for the care that is provided.

Today, the scope of services available in an ALF community may vary tremendously depending on state law and regulations and the assisted living community's philosophy about the level of services provided. While many states uphold the philosophy of a tenant's right to "age in place," other state statutes impose limitations by prohibiting tenants with failing health to reside within an ALF. Failing health can be defined as an inability to manage one's own incontinence, feed oneself, or transfer independently from a bed to a chair.

It is the responsibility of all ALFs to operate within the state's regulations and their own policies, otherwise problems can ensue. Please review the following situation and make changes as appropriate in your facility.

The Situation

An 80-year-old woman was diagnosed with a terminal illness. As her health began to fail, she moved from her independent living apartment to an ALF so she could receive help with her ADLs. One month later, the woman suffered a fall, but fortunately was not injured. As a result, the staff at the ALF began assisting her more frequently as she became weaker. Within days, she could no longer walk the distance to the dining area on her own. The staff told her physician about her rapid decline and subsequent greater dependence on others to meet her needs. They questioned whether she should be moved to a facility with a higher level of care, such as a nursing home. The physician responded to the inquiry by visiting and examining the woman. He concluded that the ALF level of care was still appropriate for her. Throughout this time, the staff attempted unsuccessfully to notify the woman's niece about the situation.

By the following month, the woman could no longer ambulate independently and she became incontinent, developing a rash on her skin. The staff once again reported these declines to her physician, who responded with a fax asking if they were still able to care for the woman. A nurse responded by saying that they "just wanted to keep him updated" and did not answer his question. The staff attempted to call the woman's niece three more times with updates about her condition, but continued to be unsuccessful. They later discovered that the niece was traveling out of the country and had left no forwarding contact information. Unfortunately, the woman's health continued to rapidly decline and she was taken to the hospital a week later, where she died from congestive heart failure the following month.

The Lawsuit

A year after the woman's death, the facility received a notice that her niece had filed a lawsuit claiming gross negligence, wrongful death, and pain and suffering. Allegations were made that the woman had developed bedsores while at the facility and the staff did not transfer her to a higher level of care when she became incontinent and could no longer ambulate on her own. In fact, the state health department had investigated the situation shortly after the woman's death and issued a violation, stating that the facility allowed her to remain when she no longer met the level of ALF care for which the facility was licensed.

The lawsuit further alleged that a friend

of the woman had visited the ALF and observed her lying on a plastic trash bag, which constituted neglect. The friend was a former nursing home administrator and the incident allegedly happened a week before the woman was sent to the hospital. To settle the matter, the woman's niece demanded $750,000.

An investigation by the facility's defense counsel determined that neither of the woman's records at the ALF or hospital supported the allegation that she had developed bedsores. While she had a mild rash as a result of her incontinence, the records indicated that it was only prevalent the last 39 days of her life, which were primarily spent at the hospital. Although the woman became incontinent while at the ALF, the staff reported that she could clean and care for herself, which they argued would have allowed her to stay at that level of care until other arrangements could be made.

In addition, the staff denied the allegation that the woman had ever been placed on a plastic trash bag and asserted that the condition of her skin would have been much worse than a mild rash had she been allowed to lay directly in urine for very long. They finally reasoned that the woman's decline happened so rapidly that the whole dispute of whether she should have been moved centered on a short three-week time frame, during which the staff could not contact the niece nor obtain the physician's approval for transfer.

In summary, the defense argued that the cause of the woman's death was congestive heart failure and the only physical damage to her system while at the ALF was a mild rash. She was dying from a terminal illness, and any actions or inactions by the ALF staff, whether technical violations or not, did not contribute to this. The lawsuit was eventually mediated and settled for a fraction of the amount of money demanded by the niece.

Protective Measures

Unfortunately, the expanded categories of care and services that are now offered by the ALF industry have not only caught the attention of government authorities, but also that of litigators. Certainly, more services mean higher liability risk exposures, as the ALF in this situation discovered. To protect your facility from a similar crisis, please review the following precautions:

1. Establish a clear, person-centered philosophy for the type of care that your facility is licensed for and able to provide, and focus all interventions, interactions, and programming around it.
2. Identify the resident acuity level for which your facility can safely provide care and services. Resident contracts should contain all the facility's commitments and actual practices, including the criteria and procedures for admission, monitoring, on-site transfers, and discharge. Consider including an arbitration of disputes clause into your admission agreement, as your state allows.
3. Screen all potential residents in their existing home environments, looking for odors, safety concerns, etc. A qualified person should review any history and physical information before admission.
4. Require a new physical examination before admission to assess the resident's health, psychosocial, and cognitive status. At that time, the physician should declare the appropriate level of care for the resident. If the resident is on the border between two levels, first offer admission to the higher level of care. Then if the resident makes the adjustment/transition, reevaluate him or her for a lesser level of care. Be consistent and only accept those individuals whose needs can be met by your staff.
5. Obtain at the time of admission all of the information from the resident's physician, as well as documents pertaining to guardianship papers, powers of attorney, living wills, and do-not-resuscitate orders. Record all emergency and contact information and request the resident and responsible party report any changes immediately, even if only temporary.
6. Provide educational opportunities for the resident and responsible party about diagnosed disease processes and what to expect when transitioning into a new environment.
7. Assess each resident's ability and develop a service plan that will meet his or her needs. The plan should include the scope, frequency, and duration of services and monitoring, and must be responsive to the resident's needs and preferences. Communicate this plan to the resident, responsible parties, and staff.
8. Review the plan of care routinely, according to facility policy and state guidelines. Record any changes in behavior or condition. Acute changes in behaviors may indicate that a medical problem exists. Report the change immediately to the resident's physician and arrange for the resident to be seen as soon as possible. Likewise, keep responsible parties informed of all resident changes or occurrences and document your efforts. Provide ongoing treatments, assessments, and monitoring, as indicated.
9. If a resident refuses to comply with the previously agreed-upon service plan or engages in potentially risky behavior, negotiate a shared-risk agreement through discussions with management and family members. The shared risk agreement form should be developed with the assistance of legal counsel. This agreement should never be used as a means of retaining residents who are beyond the scope of care that can be provided in the setting.
10. Assign enough staff on each shift to meet the needs of the residents and ensure that they have knowledge of the individual resident's care needs. The facility should have ongoing training for staff on how to monitor changes in residents' physical, cognitive, and psychosocial conditions.

By heeding these precautionary measures, you can protect your facility now and into the future. ■

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The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk management issues. For more information, phone (877) 448-4331, ext. 5175; e-mail slc@guideone.com; or visit www.guideone.com. *To send your comments to the author and editors, e-mail williams0807@nursinghomesmagazine.com.*