

Best Practices for Managing Acuity Creep in Assisted Living
American Health Lawyers Association-*Long Term Care and the Law*
New Orleans, Louisiana
February 23-25, 2015

By:
Caroline J. Berdzik, Esq.
Goldberg Segalla LLP
cberdzik@goldbergsegalla.com
and
Julia McMillen, General Counsel
Post Acute Partners
jmcmillen@postacute.com

Introduction

The trend of increasing acuity in assisted living (“AL”) facilities has reached a heightened level. According to a survey conducted by PointClickCare and *McKnight’s Long Term Care News*, 87% of respondents acknowledged a surge in acuity levels in AL while 45% stated they did not know how to respond to the trend. There are many reasons for increasing acuity levels including: residents wanting to age in place in less restrictive environments, but with more acute health care needs; families and residents avoiding higher levels of care due to more significant costs; and facilities not timely recognizing when higher levels of care may be necessary. Furthermore, some residents who live in assisted living settings employ private duty aides which sometimes can mask the actual acuity level of the residents and can bring additional liability risks for providers. Rising acuity levels in a less defined regulatory environment has resulted in an untenable situation which has driven the push from lobbying groups for increased regulatory scrutiny of assisted living facilities and which has also unfortunately resulted in higher stakes litigation for providers. This session will discuss the current state of assisted

living and its residents, recent trends in senior housing, assisted living regulatory developments and risk strategies for post acute providers navigating higher levels of acuity in assisted living settings.

Assisted Living Basics: What It Is and What It Isn't

The definitions in senior housing (independent living, continuing care retirement community, assisted living facility, skilled nursing facility) is largely defined by state law. However, generally speaking, an assisted living facility provides 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 level (“ADL”), as well as some basic health care needs. Assisted living is the fastest growing segment in long term care with approximately 31,000 AL communities serving over 735,000 residents.

Unlike skilled nursing facilities, most residents in AL settings pay privately for their care, as opposed to being Medicare or Medicaid recipients. The costs associated with assisted living vary by state, but according to the Genworth’s *2013 Cost of Care Survey*, the national median was \$3450 per month, representing a 4.55% increase from 2012. Many AL providers provide for tiered levels of service that allow residents to pay for additional assistance for ADLs on an à la carte basis depending on their needs. As explained in further detail below, this tiered system may be very helpful in risk mitigation as it educates both families and residents about any decline of the resident in a fairly easy-to-understand and measurable basis. In the 2009 *Overview of Assisted Living Report*, it was noted that 25% of AL communities offered an all-inclusive rate and that 45% of AL communities offered a tiered model.

Recent Trends in Assisted Living

The profile of an assisted living resident in 2015 is markedly different than what it was 10 or even 5 years ago. As some have stated, the residents in AL are the residents that used to be in skilled nursing facilities several years ago. Data from the *2010 National Survey of Residential Care Facilities*¹ seems to back up this assessment in terms of the profile of AL residents. The survey reveals that the majority of residents in AL settings are non-Hispanic white females and over half of the residents are aged 85 and over. Residents in the age bracket of 75-84 make up 27% of residents. Typical residents have experienced a general decline in health and require assistance with at least one activity of daily living. Interestingly, according to the 2010 Survey, almost 4 in 10 residents receive assistance with three or more ADLs with bathing and dressing being the most common. The survey found that the median length of stay was 671 days or 22 months.

Typically, these residents do not require continuous care and supervision that would be offered by a nursing home or skilled nursing facility. Nevertheless, many residents in assisted living do suffer from some form of cognitive impairment or chronic medical condition. According to the 2010 survey, 50% of the country's AL residents have three or more chronic conditions and 42% have Alzheimer's or some other form of dementia. The most common health conditions of AL residents are hypertension (56.7%), Alzheimer's/dementia (41.8%), depression (27.4%), arthritis (25.1%) and osteoporosis (20.4%). In the 2012 Performance Measures report by NCAL it was

¹ Christine Caffrey, Ph.D.; Manisha Sengupta, Ph.D.; Eunice Park-Lee, Ph.D.; Abigail Moss; Emily Rosenoff, M.P.A.; and Lauren Harris-Kojetin, Ph.D. *Residents Living in Residential Care Facilities: United States, 2010*, NCHS Data Brief No. 91 April 2012.

determined that 94% of AL residents had access to a registered nurse which appears to demonstrate the increasing acuity in AL facilities.

Regulatory Developments in Assisted Living

It is estimated that 30% 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. While assisted living is the most common name afforded this type of senior housing, states also call this type of housing “residential care”, “basic care” and “personal care home”, among other terms. The regulatory changes encompassed a variety of areas from enhanced survey approaches to additional levels of licensure for AL facilities.

As acuity levels rise, states are increasing regulation of AL facilities or introducing enhanced licenses that try to fill the gaps for residents that still want to age in place in an AL setting, but with more substantial medical needs. New York, like several other states, provides for enhanced licensing of AL residences. An enhanced license can be obtained for an entire residence or portions of a residence.

This NY AL enhanced certification allows residents to “age in place” who have some of these characteristics:

- (1) are chronically chairfast and unable to transfer, or chronically require the physical assistance of another person to transfer;
- (2) chronically require the physical assistance of another person in order to walk;
- (3) chronically require the physical assistance of another person to climb or descend stairs;
- (4) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or

- (5) have chronic unmanaged urinary or bowel incontinence.

In New York, there is also a special needs licensure for which an AL residence can apply that allows the facility to care for residents with cognitive impairments.

The NY regulations also permit the retention of a resident in a certified enhanced assisted living residence who may need 24 hour skilled nursing care under the following circumstances:

- (1) the resident in need of 24 hour skilled care hires appropriate nursing, medical or hospice staff to meet his or her needs.
- (2) the resident's physician and home care services agency determine and document that the resident can be safely cared for in the residence.
- (3) the assisted living facility provider agrees to retain the resident and coordinate all medical care.
- (4) the resident is otherwise eligible to reside at the facility.

To add to the complexity of the regulatory structure, New York also has a Medicaid Assisted Living Program, which allows certain types AL facilities to apply to have a certain number of beds in the facility designated as Medicaid Assisted Living Program, which means that they can place Medicaid-eligible residents in those beds. This is an attractive option for individuals who may come into an AL facility private pay, but who spend down their assets while in the AL due to the average length of stay associated with AL. The Medicaid Assisted Living Program, of course, has its own regulatory complexities to layer onto the already complex licensure structure. For example, the facility must also be licensed to provide home care services.

AL operators in states like New York, need to approach enhanced licensure with careful, thoughtful planning. Critical to the success of enhanced licensure is appropriate staffing and training. With AL facilities traditionally relying on certified medication

aides (“CMAs”) and predominantly non-nurse staffing models, enhanced licensure calls for more skilled professional staff like LPNs and RNs to deliver the enhanced level of care. Facilities that have enhanced licensure but do not have appropriate policies and procedures for dealing with higher acuity residents and the appropriate complement of trained staff are risking regulatory scrutiny and litigation from residents and families when adverse outcomes occur.

Identifying and Managing Risks in the AL Setting

Admissions

At the time of admission, the condition of residents is generally assessed by the facility and service plans are drafted to monitor the resident’s condition throughout the stay. This initial assessment is critical to determine whether an AL facility can realistically meet the needs of the resident. AL facilities need to closely assess all of the needs of the resident (medical, social, cognitive). Typically, 70% of residents come directly from home into a AL setting, so facilities may need to rely heavily on health care provider records with little context and anecdotal information from families and the resident. It is estimated that 9% of residents come from nursing homes and about 9% come from retirement communities or independent living facilities where there may be more information available to assess the resident’s suitability for AL. If the facility is unsure whether the placement is appropriate the AL facility may want to evaluate the pros and cons of a respite stay for a determined length of time (i.e. 30 days) to see how the resident functions in the AL setting.

The admission process is also a critical time for education to take place with residents and families and to set the table and manage expectations. Some AL chains and providers have DVDs provided to residents and their families during the admission process to educate them on the particular attributes of an AL facility. Websites, advertisement materials and social media regarding the assisted living should closely scrutinized and must be accurate in their description of services offered.

Residents and families need to clearly understand what services are and are not offered in assisted living. This holds true in particular for emergency situations. In 2013, a California assisted living facility was in the news due to a resident who died at the facility after a staff member did not perform CPR after the resident's collapse citing the facility's policy not to perform CPR on residents. In this instance, the family declined to sue stating that their mother wanted no medical intervention if such an emergency were to occur. However, this incident resulted in negative publicity for the provider, as well as some regulatory changes regarding CPR in assisting living.²

Admissions and marketing staff need to be trained on not over-selling or over-promising on services that are offered. In particular in the past, many AL operators were advertising programs dealing with cognitive impairments and establishing memory loss units or similar programs when in reality these programs were not what some families and residents expected. This led some states to specify certain parameters and requirements for memory care and dementia/Alzheimer's programs. This also led families to bring legal actions sounding in fraud and misrepresentation when negative outcomes occurred.

² <http://usnews.nbcnews.com/news/2013/03/05/17199790>.

Since the admissions 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 AL facilities are vague and ambiguous, particularly when it comes to indicating what basic services are included in the basic rates and what additional services are available and at what rates, experience has shown that families are more apt to take legal action. In sum, facilities should try to avoid surprises and admission is the time to be specific so the resident and facility can make an informed decision if this is an appropriate placement.

Very importantly, families and residents need to understand that the condition of a resident is a fluid and dynamic situation. Families and residents should be educated on the chronic medical conditions that exist and progression of these conditions. There should never be promises made as to how long a resident may stay in the facility or that the resident can remain at the facility until the time of his or her death. Declines in medical and/or cognitive status can be rapid or gradual, but they almost always do occur. It is unusual for residents to remain static in the AL setting. As a result, AL 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 the resident from one level of care or another. AL facilities may want to consider this tiered approach to help demonstrate changes in acuity levels and manage the expectations of residents and their families.

Technology is another tool that is being used by AL providers to deal with the acuity creep conundrum. More robust software programs are being developed to manage residents with increasingly complex medical conditions in AL that interplay with staffing

data and medication management. Technology can be used effectively to not only better manage care, but also to ensure that the facility is billing appropriately for the levels of care that it is providing. Facilities may want to evaluate the software that is available to utilize for managing acuity creep.

Changes to Higher Levels of Care

As previously stated, many times there are changes to the resident's medical or cognitive status which may necessitate additional services for the resident or, in some cases, discussions with the resident and his or her family about an increased level of care in a setting outside of AL. These are never easy discussions to be had, but if regular and accurate communication has been maintained with the facility, the resident and the family, these are more informed discussions and do not come out of the blue.

Service plan conferences should be done on a consistent basis and provide the opportunity to educate and measure where a resident falls on the acuity scale. It is crucial during any of these service plan conferences that expectations continue to be managed with residents and families and that an active dialogue is maintained. As previously stated, assisted living regulations are less stringent than skilled nursing regulations. Since these standards are somewhat nebulous, it may be difficult for the facility, residents and families to know when transferring to a higher level of care may be appropriate. However, there are certain states such as New York which regulate retention standards for when a resident must be transferred to a higher level of care. However, enhanced licensure is allowing the change to a higher level of care outside of the AL setting to be delayed further or to never occur at all. Keeping in mind that 59% of residents eventually move to a skilled nursing setting, while 33% die while living in an AL setting.

The pressure to maintain residents longer than a facility actually should is two-pronged. Typically, the resident or family may pressure the facility and staff to maintain the resident at the facility because they want to age in place or have their loved one age in place or with as much independence as possible. Other times the push to remain in AL is due to financial considerations as skilled nursing is considerably more expensive and more restrictive. On the flip side, it has been alleged by many in the plaintiffs' bar that residents may stay longer than they should in order to keep occupancy at ideal levels for AL providers to remain profitable.

Lawsuits that are filed against assisted living facilities seem to echo a similar theme—residents being kept in a setting where the facility could allegedly not meet the increasing acuity. These lawsuits concern issues such as falls and development of decubitus ulcers—claims very common to skilled nursing facilities. By way of example, in 2011, a St. Louis family sued an assisted living facility for negligence after their father fell in his apartment and was not noticed for two or three days. The family maintained that the facility was negligent and should have noticed that the man did not sign up for meals and had not put out a “good morning” sign on his door.³ 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 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 40% liable for negligence.⁴

³ <http://www.stltoday.com/news/local/crime-andcourts/article9e947684-7cdc-11e0-b0b1001a4bcf6878.html>.

⁴ *Blackowski v. Golden Years Inc.*, 2007 Ariz. App. Unpub. LEXIS 76 (2007).

Perhaps, some of the more unfortunate and risky negative outcomes in assisted living are elopements. With many residents suffering from dementia or other cognitive impairments in an AL setting, elopements are not out of the question and, in fact, are a substantial risk due to the freedom generally afforded AL residents. Further, AL residences typically do not have the physical safeguards of a skilled nursing facility. If an AL 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 is opening the door to litigation and adverse regulatory action. For example, in Ohio, an 89 year old resident wandered away from a facility in cold weather and wound up dying in the assisted living facility's parking lot purportedly due to hypothermia. The family later sued.⁵

Medication management is also an area that must be closely monitored to avoid risk to residents and the facility. Many residents take multiple medications on a daily basis. Some states allow residents to manage their medications, but as one can imagine, this can be a complex and difficult endeavor for individuals with evolving cognitive impairments. Facilities may want to monitor whether residents can safely manage their medications, although that can impose further duties on them from a liability perspective. Some facilities use certified medication aides to administer medications. These CMAs have some training, but do not have the training or knowledge of licensed professionals such as LPNs or RNs. Due to the increasing complexity of medication management for residents, many facilities have started to employ more nurses to assist in medication management. Additionally, assisted living facilities are well served contracting with

⁵ <http://businessjournaldaily.com/company-news/grace-woods-senior-living-sued-wrongful-death-2013-4-12>.

pharmacy consultants to evaluate the medication usage of residents on a periodic basis. Since many times the AL facility is not coordinating the medical care of the residents, they may not be apprised of the various medications that residents are taking which could have contraindications or other unintended consequences that could present while the resident is at the AL facility and thus creating the 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 the AL building and age in place. These families have used the Fair Housing Act and Americans with Disabilities Act to attempt to block transfers to higher levels of care. Consequently, facilities need to carefully review the medical records and physician determinations to be able to demonstrate if and when a higher level of care may be needed.

To manage the threat of litigation and the defense strategy if claims are filed, AL providers may want to consider the use of arbitration agreements, dispute resolution procedures and, in some states, negotiated risk agreements or even waivers. For example, if a resident does not want to wear an emergency call pendant, this wish can be honored, but the risks should be fully disclosed in writing to the resident and/or the resident's family and there should be a signed waiver of the risk for not having an emergency pendant. While this may not avoid litigation, it can certainly be used to demonstrate that the resident or the family was aware of the risk and assumed the risk.

There are some states which put restrictions on the use of Negotiated Risk Agreements ("NRA") 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 education 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. Some believe that these agreements are solely designed to attempt to limit the legal risk of a facility for any adverse outcome. A way to potentially overcome a negative perception of an NRA is to not insert any liability waiver. Additionally, there may be times when these NRAs need to be modified based on a resident's cognitive decline.

Staffing Risks in AL

Traditionally, AL facilities have been primarily staffed with non-nursing staff. However, as acuities rise and residents present with more complex medical situations, facilities need to evaluate their staff and whether the staff can appropriately handle the needs of the resident population. This is particularly true for AL facilities with enhanced licenses or that are permitted to have residents age in place that need lifting and transfer assistance. Facilities should evaluate the training being provided to staff on a routine basis to ensure that employees can handle individuals with more needs. Even though it may not be a regulatory requirement to have licensed staff, it may be necessitated by the acuity levels in the building.

Another significant staffing concern that AL providers need to be attuned to is residents and their families hiring private duty staff. In certain geographic areas, this is a more common phenomenon. Unfortunately, this can lead to risks if not managed appropriately. If a family is requesting a 24/7 aide for the resident it begs the question whether the individual is appropriate for the AL setting in the first place. Secondly, the use of a private duty aide may mask the acuity of the resident or the resident's decline because the aide is doing for the resident that which the facility believes the resident is

doing for herself. Further, as the individual is not employed with the facility, the facility needs to determine how to hold the aide accountable for facility procedures and policies without creating additional liability. As these aides are working on the premises, it is going to be difficult for a facility to limit liability if a negative outcome occurs.

Consequently, best practices would point to having policies and procedures that include robust criminal background screening and drug testing for private duty aides and reporting of any significant changes in the resident's condition. Some facilities have developed their own separate home health agencies and offered those services to family to avoid the private duty aide dilemma, even if those services are not required to be provided by the facility as a condition of licensure or certification.

Conclusion

As the population continues to age and get sicker, the demands being placed upon senior housing, particular the AL community is going to increase. Facilities should become conversant with the changes taking place with the acuity levels in their facilities and make sure they have policies in place to handle these issues, as well as the appropriate compliment of staff.