The Nuances of Litigating Assisted Living Facility Cases

By Elisha Hawk

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For most medical malpractice attorneys, if I brought you a case of an 87-year-old with a dozen comorbidities and on as many prescription medications and asked if you'd consider a medical malpractice action on her behalf, you'd probably show me to the door – thanks, but no thanks. No one wants to litigate a case where the focus is on their elderly patient – the odds are stacked against you.

Enter the nursing home world. Almost every client is old. If not, they are most certainly vulnerable. They all bring with them a host of comorbidities. I say, bring it. I don't care about the comorbidities. I don't care how many medications my client is on. That's because when we talk about nursing homes, we are not talking about a patient-centered framework. We are talking about a system failure. The focus is not on my client. The focus is on the system in place at the facility and where that system failed and caused the injuries we are claiming. And the system is handed to us on a silver platter by the Nursing Home Reform Act of 1987 (also known as the Omnibus Budget Reconciliation Act of 1987, or OBRA).

This Act set out a regulatory framework for keeping patients safe. Any nursing home receiving government funding from the Center for Medicare Services is required to adhere to the regulations. So, when you are litigating a case of medical negligence in the long-term care setting, by focusing on the regulatory system in place (along with the facility's own policies and procedures), the liability framework writes itself.

But what happens when the injuries did not occur in a skilled nursing facility (SNF)? What happens when the injury happens in an assisted living facility (ALF)?

Most cases against ALFs turn on whether the resident was appropriately admitted to the facility in the first place and whether the facility should have discharged or transferred the resident once their condition worsened. So, how do you figure that out? The regulations provide the framework. While ALFs do not fall under the federal regulatory scheme, there is still a regulatory framework from which to build your system.

In Maryland, ALFs must adhere to a comprehensive set of state regulations that govern resident care found in the Code of Maryland Regulations (COMAR), specifically under COMAR Title 10, Subtitle 07, Chapter 14. These regulations create a different set of obligations for ALFs than skilled nursing facilities. These obligations include:

1. **Resident Assessment and Admission Protocols:** Every Maryland ALF must conduct a thorough assessment using the Resident Assessment Tool (RAT) prior to admitting a resident. This assessment allows the facility to determine whether it can meet the resident's needs. Unlike SNFs, which often accept residents requiring skilled care, ALFs in Maryland are designed for residents who need assistance with ADLs but do not require daily nursing care.

2. **Service Plans:** Similar to the comprehensive care plans required in nursing homes, Maryland law mandates that ALFs develop an individualized service plan for each resident. However, unlike the detailed care plans in skilled nursing facilities, ALF service plans are generally less stringent and focus primarily on support for activities of daily living (ADLs). ALF service plans take into consideration that residents often live behind closed doors, as compared to care plans in skilled nursing facilities, which anticipate 24/7 care not just supervision. Assisted living service plans must be reassessed at least every 45 days by the Delegating Nurse, a licensed nurse assigned to monitor resident care.

3. **Staffing Requirements**: COMAR does not impose the same rigorous staffing requirements as federal regulations do for SNFs. There is no requirement for round-the-clock RN staffing. Instead, ALFs must employ a Delegating Nurse to oversee care, but often from a distance with 45-day reassessments, as noted above. Caregivers in ALFs typically assist with ADLs such as bathing, dressing, and medication management, but they are not charting by shift, or even daily, and they are not providing wound care or management.

4. **Training Requirements:** COMAR requires specific training for ALF staff, including orientation on resident rights, abuse prevention, and emergency protocols. Depending on the care being offered, caregivers must also be trained to meet the particular needs of the residents, such as assisting those with dementia or mobility issues. However, the training requirements are

less individual care centered, and less intensive than those mandated for staff at SNFs, where nursing and clinical expertise are essential due to patient acuity.

5. **Monitoring and Oversight:** Maryland ALFs are subject to inspections by the **Office of Health Care Quality (OHCQ)**, but these inspections are less frequent and often less detailed than the surveys conducted in nursing homes. This difference in regulatory oversight can be a key point of contention in litigation, especially when system failures go unchecked for extended periods.

6. **Quality of Care Standards:** While COMAR regulations emphasize the importance of maintaining residents' dignity, autonomy, and safety, they do not impose the same comprehensive quality-of-care standards as federal law does for SNFs. For example, ALFs are not required to implement detailed preventive measures for conditions like pressure ulcers or falls unless the resident's individual assessment deems such interventions necessary—Medicare waivers are often required to care for assisted living residents under these circumstances.

While there are distinctions, the state regulations provide a framework that you can use to explain to a jury the standard of care the ALF was required to follow.

Tip: Familiarize yourself with the COMAR regulations applicable to Maryland assisted living facilities, including the health care and social services identified in COMAR 10.07.14.28 (F). These rules often outline staffing requirements, admission protocols, and reassessment timelines, which can be pivotal in establishing system failures.

Assisted Living Facilities: The First Step

Your first inquiry is to identify the type of ALF you are dealing with:

1. **Is it a mom-and-pop facility?** If so, does it have insurance? In Maryland, ALFs are not required to carry malpractice insurance. So, you need to figure out at the outset whether and how you are going to recover any judgment. Is all the negligence stemming from the ALF itself? Perhaps there was an outside agency providing the nursing care – were there failures by that outside agency? Was there a physician serving the function of the "delegating nurse" or otherwise managing the medical and nursing care happening in the facility? What is the system that was in place? How did the system fail? Are you going to be able to litigate this case absent a source of recovery? Is this case one you take simply for the social justice of holding the owner operator accountable?

2. **Is it part of a national chain or a larger corporate community?**

Once you've sorted out the coverage issue, the next inquiry is figuring out the corporate structure. ALFs come in a variety of shapes and sizes, ranging from small, family-owned operations to large national chains. Sometimes, ALFs are part of a continuing care community wherein there is an ALF, a skilled nursing facility, and/or independent living arrangements, all existing under one corporate umbrella. Why does it matter? The key here is that the level of care and supervision offered in ALFs is different from the 24/7 skilled care we find in SNFs. So, in addition to the Maryland regulations, you want to look at the corporate structure and oversight of the nursing care, and the company's own policies and procedures. National or regional chains – think Genesis, ManorCare/ProMedica, Autumn Lake, Communicare – often have a wealth of administrative and nursing policies. They often have corporate and regional directors who oversee clinical care in the facilities and who ensure that corporate policies and procedures are in place and followed. This is true for their skilled facilities and for their assisted living facilities, to the extent they have them. For example, ManorCare/ProMedica operates a string of memory care ALFs.

Tip: Get the policies and procedures early in written discovery and depose the Administrator and Director of Nursing on them. Be sure to ferret out who the regional folks were, how often they were in the facility, and of course get the admission that the company policies were in place to keep patients safe and that every member of the nursing staff was trained on them and was required to follow them.

Sometimes, national or regional chains or even local corporations have both skilled care and assisted living facilities operating under the same umbrella. In that circumstance, a resident's care can sometimes be downgraded from skilled nursing to assisted living. If so, how do these facilities under the same corporate umbrella interact? For example, is the skilled facility collaborating with the admissions office of the assisted living facility? Who is deciding what's best for the resident? What information is being passed along? Does the assisted living facility have the same ability to implement appropriate care as the skilled nursing facility? What interventions did the skilled nursing facility have in place in the care plan? Are those interventions no longer needed? Who made that determination? These are important questions to answer as you look to develop your system failure case – that is because cases against ALFs most often turn on whether the resident was an appropriate candidate for assisted living in the first place and whether the facility inappropriately failed to transfer them to a higher level of care in response to their changing condition during their residency. So where do you find the answers?

The Admission and Retention Dilemma

This is where Maryland's regulatory framework proves invaluable. Every assisted living facility is required to use a **Resident Assessment Tool (RAT)** to assess whether the resident is suitable for admission. This document, often found in the resident's records, provides a wealth of information and is critical to your case.

Tip: Defense counsel often asserts that a physician cleared the resident for admission, but that doesn't absolve the facility of responsibility. Ultimately, the ALF bears the duty to ensure that the admission is appropriate based on the RAT.

Service Plans and Delegating Nurse Responsibilities

Once admitted, each resident must have a **service plan** tailored to their individual needs, and the facility's **Delegating Nurse** must reassess the resident at least every 45 days. If the resident's condition changes, the service plan should be modified to reflect their new needs. The critical documents in an assisted living case include:

- The Resident Assessment Tool (RAT)
- The service plan
- The Delegating Nurse's notes from reassessments
- Weekly caregiver notes
- Medication administration records (if relevant)

These documents collectively reveal whether the facility was actively managing the resident's care as required by the standard of care or allowing system failures to occur by neglecting to update the service plan or missing crucial reassessments required by COMAR.

Tip: Pay close attention to whether the facility made timely adjustments to the service plan in response to changing needs. This is where you'll often find evidence of neglect, particularly in cases involving falls, dehydration, or pressure wounds.

The Importance of Admission Appropriateness

A hallmark of assisted living litigation is the focus on whether the resident was ever appropriately placed in the facility from the outset. Unlike skilled nursing homes, ALFs do not offer daily skilled nursing care, which is why so many cases turn on whether the resident should have been admitted or kept in the facility as their health declined.

For example, consider a resident who is a known fall risk. Is the facility capable of providing the interventions necessary to minimize fall-related injuries? If not, why was the resident admitted, and why was the family not notified when the resident's needs exceeded the facility's capacity?

Tip: Defense will often argue that the resident or family played a role in their injury—"We can't force her to sleep in a bed when she chooses to sleep on the couch." This argument doesn't hold weight if the facility failed to document its inability to safely care for the resident in light of her choices.

Practical Tips for Building Your Case

The strength of your ALF case is in the facility's records, combined with the depositions of key staff members. Here are some practical steps to follow when building an assisted living case:

1. **Gather Key Documents:**

   COMAR is your friend – use it when requesting documents – these regulations not only define the document you are requesting but ensure that these documents ought to exist at the ALF. The following documents ought to exist at any ALF, and are defined in COMAR:

   - Resident Service Agreement
   - Resident Assessment Tool
   - Policies and procedures
   - Training materials
   - Service plans
   - Staffing plans
   - Communication logs between caregivers and the Delegating Nurse
   - Delegating Nurse's 45-day assessments
   - Recommendations for additional care (e.g., physical therapy) and documentation regarding implementation of those recommendations

2. **Depose Key Staff Members:**

   - **The Delegating Nurse:** Focus on how often they assessed the resident and whether they recommended changes to the care plan.
   - **The Caregiver:** Choose the one with the most contact with the resident. Inquire about the day-to-day challenges in caring for the resident.
   - **The Assisted Living Manager:** They will be familiar with the regulations, training requirements, and the facility's responsibility to meet the resident's needs.
   - **The Person Who Completed the Resident Assessment Tool:** How thoroughly did they complete the assessment? What was the basis for their determination that the resident was appropriate for the facility?

3. **Identify the System and How the Facility and its Employees Failed to Implement it.**

Understanding the facility's Pre-Admission Requirements is critical, including how the facility determines whether a resident's needs can be met by the program. How does the facility use The Resident Assessment Tool to determine the required level of care? How does the facility create, review, and implement Resident Service Plans?

You also need to understand how the resident was assessed, keeping an eye toward the type of harm your client or their family member suffered: fall, wound, malnutrition, choking. For example, in a fall case, were there functional assessments of the resident? What level of support and intervention was documented? Was there a need for any special equipment to compensate for any deficits in activities of daily living? Were there physical or psychological symptoms requiring monitoring, support, or other intervention of the assisted living program? Did the resident exhibit behaviors that presented a risk to their health and safety? Did the resident require Awake Overnight Staff? This information will be on the RAT, but was it completed accurately? In a fall case, make sure you have a clear understanding of the resident's room and furnishings in light of the RAT.

Wounds in an assisted living case are a big red flag, because only licensed nurses can provide wound care, change dressings, etc. If you have a wound in an assisted living case, you must determine if there were any Level of Care Waivers. In other words, was the facility seeking to provide a higher level of care to the resident than they were licensed to provide? Were there any Denial of Level of Care Waiver Requests specific to the resident?

No matter what kind of assisted living case you have, carefully review the Resident Agreement, all Delegating Nurse documentation, all Resident Care Notes, all medication administration records, all labs, all orders, and all communication logs.

If dementia or cognitive function are an issue and the facility has a memory care unit, then you must obtain all documentation from The Memory Care Unit, including a description of the unit, the form of care and treatment provided on the unit, and the services provided on the unit as compared to other units. Was the resident's level of care properly assessed?

Finally, no matter what kind of ALF case you have, you need to understand the organization and staffing. Are there different units? What is the staffing like on each unit? How are meals handled? Be sure to obtain a copy of the Staffing Plan, that must be maintained by the ALF as required by COMAR 10.07.14.14.

Assisted living cases are not quite the same as nursing home cases: the level of care is different and the regulations are not as stringent. But there is still a system that must be followed to ensure resident safety. COMAR provides a great framework for building your case and establishes the system that the ALF ought to have followed to comply with the standard of care. The facility's own website and policies will also be helpful in defining the system. As with all nursing home cases, the proof is in the documentation (or lack thereof). By focusing on whether the facility appropriately assessed and cared for the resident, you can build a compelling case.

Biography

Elisha N. Hawk joined Jenner Law, P.C. as a partner in 2023, bringing 15 years of experience representing people and families who have been injured by the abuse and neglect of others. Her practice focuses on cases involving personal injury, nursing home abuse and neglect, therapy abuse and clergy abuse.

Elisha started her career as an associate working under Jenner Law, P.C.'s founding partner, Rob Jenner, where she represented people who had been harmed by dangerous drugs and devices. Over the course of practice, she has proven to be a zealous advocate for her clients, both inside and out of the courtroom.

Prior to earning her law degree, Elisha completed a Master of Liberal Arts program at Johns Hopkins University. She also taught middle school English for 11 years in the Baltimore area. Elisha graduated from the University of Maryland Francis King Carey School of Law, with a certificate in Health Law.

Along with her law practice, Ms. Hawk is an active member of Maryland Association for Justice (MAJ). She served as President of MAJ from 2017 – 2018, and she remains active in the organization.

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