Understanding the Nursing Home Environment

2:1 Key Definitions

Elderly residents seeking supportive care have multiple options today. No single view could capture all the aspects of all the residential facilities in the United States. In this text we refer generically to the category of long-term residential skilled-care facilities for the elderly as the “nursing home,” but we recognize that there are subcategories that are relevant to the litigator’s evaluation of a potential case. Many plaintiffs’ malpractice counsel are familiar with lawsuits alleging that the high duty of care owed by hospitals to their patients was not met; but these facilities are not treated as hospitals under regulatory systems or under state negligence jurisprudence. In many states, effective lobbying by hospitals has placed limitations on the malpractice actions that can be brought, and in some states long-term care facilities also enjoy
the advantages of this statutory protection. The category of facilities addressed in this text is much broader than hospitals, and receives a different, lighter “duty of care” analysis in the courts.

We address in this book the tens of thousands of long-term care facilities that are certified to receive Medicaid and Medicare reimbursement funding for occupants of some or all of their beds. These include skilled nursing facilities that use licensed nurses; subacute or “intermediate care” units; and special care units. Facilities that do not perform or maintain higher-skilled patient care measures, such as gastric tube feeding of impaired patients, reside in the broader category of “nursing facilities.” All of these are subject to state license requirements and must comply with state rules, local health rules, and local fire codes. Some of these are certified facilities, meaning that they have passed inspection (“survey”) by a team of state long-term care inspectors and can have the costs of their care of individual Medicaid or Medicare patients reimbursed by federal and state funds. The blood that pumps through the system of nursing homes is federally directed and state-shared Medicaid money, and if the government funding for a facility stops, the facility will (almost inevitably) close down.

Sometimes the same building or complex of buildings contains several types of facilities, from assisted living up to skilled nursing, and the licensure and funding arrangements vary within that overall facility in order to classify and receive reimbursements for those who are deemed to be Medicaid eligible. To study a particular entity, one would consider the detail in a nursing home’s Medicare annual cost reports as a useful differentiating marker of the subcategories. The federal database Nursing Home Compare2 has a useful set of baseline information. Counsel who consider using that federal and state data in trial would be well advised to read the website commentaries on the data, its origins, and limitations.

“Long-term care” as a category includes services to elderly persons, disabled persons, mentally challenged persons, and persons

---
undergoing extensive rehabilitation after injury or illness. A separate category is “assisted living facilities,” which cost far less than a nursing home and provide fewer services.³

The evolving nature of state and federal control of private in-home health care services⁴ makes them interesting for study, but these situations vary so greatly that we cannot cover all of them in this text. Other texts are available on these issues.

2:2 Background

This section very briefly explains the regulatory background of the nursing home and skilled nursing home. Decisions about patient safety issues were not a part of the original 1962 Medicare system. Medicaid for low income persons with few assets evolved later and has had a very large impact on the nursing home field. Medicaid’s regulatory controls on nursing home patient safety were included in 1987 legislation, the Nursing Home Reform Act, known by the acronym of its larger packet of legislation, OBRA-87.

The federal Center for Medicare and Medicaid Services (CMS) controls the standards for funding with which nursing homes are reimbursed for their services to indigent persons covered by Medicaid.⁵ It also manages the reimbursement of the limited services, about 100 days of inpatient care, for elders covered by Medicare. The reimbursement for services and for resident care is governed by a complex federal statute⁶ and a complex set of rules.⁷

Lawyers who have not seen such detailed regulatory controls in prior cases may be surprised by the study of the CMS control on nursing homes.⁸ Metrics of health and safety performance for the nursing

⁴. Id. at 411.
⁸. For example, the CMS Surveyor Guidance is a 400-page loose-leaf binder, available from the states, from CMS, or from the American Health Care Association website. Ctrs.
home are fixed in CMS rules. Patient rights may have been violated in a particular injury case. These federal rules are comprehensive standards for health, safety, and protection of the rights of the nursing home patients.

The federal standards for nursing home operations are implemented by state long-term care agencies, and states operate with requirements in their programs that are in addition to the CMS rules and guidance documents. The Medicaid norms are dominant as the primary standards of care, but they are not exclusive; the state may require more actions by nursing home operators to satisfy state legislation, such as a statutory “patient’s bill of rights.”

The private nursing home may choose to advertise and market its additional level of performance. Referencing third-party accreditation in its brochure may create an obligation to show a higher standard of behavior.

Funding sources for skilled nursing care have largely been government sources such as state/federal Medicaid, veterans benefits, or a limited amount of days under Medicare after hospitalization ends. A nursing home could survive without federal funds if it had donors or private-pay patrons who could make up for the loss of public funding. Such a home could opt not to “certify” certain bed spaces for Medicare or Medicaid patients. It could become totally “self-pay,” or could be a fully not-for-profit charity institution, and thereby would be outside CMS controls, subject only to state licensure controls. It has been relatively infrequent that a nursing home has not sought and accepted Medicaid/Medicare patients.

---

2:3 Federal Funding Brings Control

The federal government funds Medicare and a large portion of the federal-state Medicaid program.\(^{13}\) (Medicare is for the elderly; Medicaid is for indigent or disabled persons.) States provide a significant share of Medicaid funding. Reimbursement of costs through these federal-state funding mechanisms is the power that fuels the regulatory authority of the government over the nursing home. Conformity to “Conditions of Participation” in Medicare and Medicaid is essential to the income stream of the skilled nursing facility.

Beyond that general description, this text will not attempt to describe the financial aspects of the nursing home industry. Historians of the ancient empire that centered around today’s Turkey, the Byzantine Empire, gave that name to complex and multilayered “byzantine” designs that are virtually impossible for the lay person to understand. Legions of American lawyers have become vested in the lucrative arts of interpreting this byzantine fiscal arrangement for skilled nursing facilities and their supportive networks of companies. When we call the funding aspects of modern nursing home regulation “byzantine,” we mean that its bureaucracy has grown into a jungle of rules, guidelines, exceptions, and subexceptions that defy the reader’s ability to comprehend how it actually works. For that reason, if the reader wishes to delve into funding and finance issues, we recommend other resources.\(^{14}\)

Our focus is on the patient injury compensation disputes that arise out of actions or omissions by the staff of a nursing home. To the extent that a plaintiff could show that an injury was due to a deliberate reduction in key medical or personal care staffing by a for-profit care facility, the jury’s decision on liability may be affected by the view that the circumstances of patient harm came from a pattern of willful neglect that was intended to maximize profitability of the nursing home.


\(^{14}\) See, e.g., Douglas Singh, Effective Management of Long-Term Care Facilities (2005).
States have the primary role in oversight of virtually everything about long-term skilled nursing care facilities, except the financing of the nursing home, and even there, loan and aid programs may have funded the bricks and mortar of the facility. State long-term care agencies or health departments issue nursing home licenses, inspect and certify the compliance of a new facility, conduct surveys, test and give credentials to administrators and medical personnel, receive complaints, and take enforcement actions.

The federal role of funding Medicaid and Medicare comes with strings attached, and these conditions include complying with the federal norms or “Conditions of Participation” that have been set by CMS. A 2008 federal report showed that 91 percent of the 15,000 covered facilities that are subject to periodic survey visits had an average of seven deficiencies noted in the postsurvey reports.\(^\text{15}\)

Legislating about elder care is done carefully by all prudent elected officials. State statutes about nursing homes reflect the reality that elders vote and their collective anger against a state legislator could doom reelection prospects. Opposing protections for vulnerable elders in nursing homes makes the legislator very vulnerable to criticism. As a result, societal decisions about nursing homes are taken by legislators in response to public revulsion about abusive conditions in nursing homes. The federal 1987 Nursing Home Reform Act, known by the acronym OBRA-87, is the foundation for today’s federal regulation of nursing homes. Some states before OBRA-87, and many states since, have adopted state-specific norms of quality performance that are to be followed by the nursing home owners and operators.

About 23,000 nursing homes receive federal funding.\(^\text{16}\) These are subject to insessional “surveys” done by states under contract with the federal CMS. Chapter 23 discusses the survey process. The


\(^{16}\) U.S. Gov’t Accountability Office, GAO-06-326, LONG TERM CARE FACILITIES (Mar. 31, 2006).
enforcement burden falls on the states, though it is arguably without sufficient federal funding to comprehensively audit all of the state’s licensed facilities.\(^{17}\) State budgets are tight. Investigators have been critical of the weakness of this enforcement process: “Low [penalty] imposition rates and slow and/or difficult collection efforts may minimize the effect that [CMS penalties] ultimately have on noncompliant facilities.”\(^{18}\) The OBRA-87 amendments empowered the federal CMS to impose penalties and, in extreme cases, to suspend new admissions or to impose receivership over the management of the nursing home.\(^{19}\) More than 1,000 appeal case precedents can be reviewed in the “nursing home” category of decisions within the U.S. Department of Health and Human Services’ Departmental Appeals Board.\(^{20}\) In addition, state health agencies may impose their own sanctions with their own set of appeal procedures.\(^{21}\)

2:5 Regulatory Interaction with Tort Liability

The feds have the money to build and equip and fuel the growth of skilled nursing facilities; but the states have the license authority and the tort liability system to discipline the system.

From the standpoint of patient safety, the four protectors against patterns of nursing home misconduct are

- state surveys;
- federal “Conditions of Participation” standards;
- plaintiffs’ attorney advocacy; and


\(^{18}\) *Id.*


• insurance carrier “loss control” inquiries.

The size of potential tort jury verdicts deters some insurance companies from writing liability policies for operators of nursing homes. This experience induces the insurers to audit their already-insured facilities to help the owners forestall avoidable patterns of misconduct. The state tort precedents about nursing home liability are therefore quite significant as a force for self-regulatory action.

The death or serious injury cases are likely to be expensive for the site operator and for its insurer. The utilization of state tort standards of due care during highly publicized trials featuring victimized, helpless elders will “send a message” encouraging quality care. This message will augment weaknesses in state and federal supervision, as many observers including the U.S. Government Accountability Office have observed shortcomings in the public regulatory apparatus.22

The state tort precedents and state or federal rules are not a perfect fit; much of the state common law of duties of care will be applied to actions or omissions, while state regulatory duties apply, since the defendant in the negligence trial is also a highly regulated facility. Publicly held data will aid the plaintiff’s assembly of its case; in some tort cases, information comes out of discovery that triggers intense scrutiny by regulatory officials. One can picture the on-camera television reporter asking the state nursing home regulator why this terrible situation had been “tolerated” or “ignored” by the state. Winning a no-pay jury verdict might be a short-lived triumph if the “for cause survey” team arrives one week later, armed with the exhibits used at the trial.

For experienced tort lawyers who are novices in this nursing home field, appearances may be deceptive: trouble with nursing homes cannot always be detected from the public agency survey records. Whistleblowers are invaluable guides. Ombudsman records and

---

22. Among the many Government Accountability Office reports on nursing home conditions are GAO-06-117 (Dec. 28, 2006) (serious gaps exist between state survey and federal survey results; states missed key care concerns in numerous nursing home visits); GAO-05-65 (Nov. 10, 2004) (VA spent 27 percent on community, private and state nursing homes), and GAO-04-684 (Apr. 30, 2004) (assisted living facilities).
testimony may demonstrate a pattern of ignored abuse. Experienced advocates know that the combination of rules and lawsuits should deter further cases of abuse and neglect, where either remedy alone—a tort trial or a wider regulation—would do less.

Nursing home rights legislation has been passed in California, New York, and other states that empowers the resident or his or her personal representative to sue for violations and to obtain punitive damages and attorney’s fees in certain cases. Negligence per se can be used in tort cases by establishing that violations of the law or relevant rules were proximately causative of the patient’s harm. State contractual and tort law standards of care can be applied, in appropriate cases.

The legislative picture is not one-sided in favor of the elderly residents. Nursing home industry lobbying efforts have succeeded in some states with the adoption of owner protections through state law, authorizing exclusive arbitration, caps on remedies, and so on. But a pragmatic politician knows that angry picketing by elders is newsworthy and a reputation for protecting elders is more valuable than a pre-election contribution from a lobbying firm for the state’s long-term care association.

**2:6 Purposes of the Nursing Home Stay**

Experts in the nursing home field categorize the residents of nursing homes in several subcategories:

1. Short-term rehab patients who leave in a matter of weeks;
2. Physically normal persons with Alzheimer’s or brain disease who need protective care for activities of daily life;
3. Mentally competent persons with physical impairments who need help with daily activities of life;
4. Very sick patients, such as ventilator-dependent persons discharged from hospitals for the nursing care available at a competent nursing facility; and
5. Patients with chronic end-stage ailments.  

---

The third and fourth categories are most susceptible to negligent care and will be most susceptible to injuries as patients in the nursing home. The second category contains persons who will “wander” and may be injured outside the home if they can escape its security.

Concerns have been expressed that the government policy for use of long-term care should be better defined in Medicaid legislation. Traditionally, policy has been based upon a step-down or devolution from hospital care, which has been called “the culture of illness and disease.”²⁴ The only legally enforceable duty of nursing homes that provide “intermediate care” is to monitor and then to move more-diffuse patients to a skilled nursing facility where the degree of medical care will meet their needs.²⁵

### 2:7 Significance of the Federal Categories

The availability of long-term care usually depends on individual payments (self-pay or insurance) or on poverty (Medicaid). The inability to pay costs of long-term care may qualify a person for Medicaid.

There is not a similar poverty requirement for Medicare, eligibility for which is age related, limited in time, and controlled by specific restrictions. Where the funding source is Medicaid, the indigent person demonstrates eligibility for one of the designated beds in the desired nursing home; these can be available for years, but the person could lose eligibility by receiving substantial additional funds, such as from a lawsuit verdict or an inheritance. When the funding source is Medicare, the elderly patient’s short-term needs after hospital discharge are met by a stay that cannot exceed 100 days in a year. When the funding source is the resident’s private long-term care insurance or the family’s private-pay assets, no federal or state conditions apply.

Federal nursing home benefits legislation has been a complex part of the Medicaid/Medicare program for years. In addition, the Department of Veterans Affairs uses privately run or state-run nursing homes

---

²⁴. *Id.* at 44.
for about 27 percent of its veterans’ nursing home needs. Other sources provide detailed background on these complicated regulatory and financial issues.

2:8 Tort Liability

Several factors correlate with a higher likelihood of a nursing home being sued: nursing home deficiencies found in the survey done by state survey inspectors; large, for-profit chain ownership of the nursing home; and location of the home in a state that has “nursing home resident rights” legislation in place. There are useful websites for regulatory information about nursing home quality, but the vulnerability of a specific nursing home or chain is almost impossible to discern from outside. The great majority of these cases are settled, and leave no precedential effects on the record. The Westlaw newsletter Verdicts, Settlements & Tactics provides many of the settled cases and defense verdicts that do not appear in conventional reporters.

Liability is well recognized among caregivers and institutions. The risk of being sued does have a negative effect on nursing home operations. A nursing home staff member said it best: “The threat of malpractice is by far more central to our operation than the residents’ control over their own lives and property. ‘Safety first’ means safety from lawsuits; caring for oneself, independence, and self-esteem matter less.”

The plaintiff’s counsel in a nursing home case may be encountering his or her first conflict with the well-organized health care industry. This is a mismatch; the very effective targeting of the lobbyists has been very well organized in the state legislatures. What is “business as usual” for the industry is novel and challenging for the attorney first entering a tort case on these issues. So the attorney should not be naïve; if your state elder care agency seems to be tilted toward the interests of the defendant operator, and if it seems that the enforcement director never quite bites the vulnerable nursing homes, then look at the campaign money that is reported for the legislators whose committees oversee the state elder care agency. Shielded by potent but barely visible political forces, the respondent in a state proceeding may get the benefit of the doubt. Plaintiffs’ counsel will never have the pervasive, constant presence that defendant nursing home operators will maintain in political circles.}