

Legal Issues



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Light Staffing Can Mean Heavy Liability

Most states have mandatory staffing ratios or other regulations intended to ensure that an adequate number of skilled personnel are on hand to provide quality nursing home care. Federal regulations are less specific, providing only that Medicare-certified nursing facilities “must provide services by sufficient numbers of ... personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.”

Thus a nursing facility must have personnel in excess of applicable state requirements if the facility’s residents require more care or supervision than can be met by the state standard.

This past summer, a California jury found Skilled Healthcare Group guilty of understaffing its 22 nursing homes. The nursing home operator claimed that its facilities were unavoidably understaffed

because of area workforce shortages. But the jury awarded statutory damages in the amount of \$613 million, which was \$500 per patient per day that the company was not in compliance with the state minimum staffing level of 3.2 nursing hours per patient per day.

Although the plaintiffs did not show that any resident injury had resulted, California law permits plaintiffs to claim damages solely for violations of state regulations. The jury also awarded \$58 million in restitution damages.

In September, the company settled the matter for \$50 million, with an additional \$12.8 million to cover an earlier injunction that each of the company’s facilities comply with state staffing levels.

Despite the relative vagueness of the federal regulation on staffing, California is not atypical among states in specifying a minimum number of nursing or direct-

care hours that a facility must provide per resident, per day. Because of the typical state-federal difference, the staffing level required of a particular nursing home (located at Tag F353) will vary according to multiple factors, including the acuity level of the facility’s residents and even its physical layout.

In a 2006 decision, the Centers for Medicare & Medicaid Services’ Departmental Appeals Board upheld the CMS’s citation of a facility at the immediate jeopardy level and the imposition of civil money penalties after state surveyors determined that the facility was too spread out physically to allow a few staff members to care for many residents. Nurses in one unit were not able to see residents in another unit, the surveyors found.

The facility had eight wings but only three nurses’ stations. They were situated such that nurses sitting at the stations could not see down all the halls to which they were assigned. In fact, one nurses’ station faced away from the halls to which the nurses were assigned.

In addition to the difficult layout, nurses and nurses’ aides were assigned to a large number of residents, many of whom required frequent, specialized care. The surveyors found that one aide was responsible for 34 residents located throughout three wings of the facility. Of those 34 residents, 27 were cognitively impaired, 26 were at risk of falling, 21 were incontinent, 12 were totally dependent, and 6 required assistance.

The aide was required to perform 15-minute visual checks of all of the residents, but the surveyor testified that there was no way that the aide would have been able to do so. This aide and others, as well as nurses assigned throughout the facility, told the surveyors that it was difficult to complete their required tasks but that they did the best they could.

At the time of the survey, several of the facility’s residents had recently experienced serious falls and other accidents. The surveyors and the Departmental Appeals Board determined that the facility’s staffing deficiencies were tied to its failure to prevent these incidents to the extent practicable. Even though the facility’s staffing level exceeded the minimum required by state law, the board held that the level was insufficient to comply with Medicare’s condition of participation: enough “to provide nursing care to all residents in accordance with resident care plans.”

In 2005, the federal government settled a False Claims Act case with Life Care of Lawrenceville, Ga., for \$2.5 million. The complaint was originally filed by five whistleblowers who alleged that the fa-

cility failed to provide appropriate nursing care such that premature deaths of several residents occurred.

Among other things, the whistleblowers said that the facility was severely understaffed and did not provide what staff there was with adequate training. Examples of poor care at the facility included the death of a resident receiving warfarin because staff failed to check the resident’s blood-clotting times. Another resident was alleged to have died of maggot infestation in her mouth because the facility’s staff failed to provide basic oral hygiene. In addition to the monetary settlement (\$400,000 of which the whistleblowers received), the facility entered into a quality of care corporate integrity agreement with the U.S. Health and Human Services’ Office of the Inspector General.

Because of the subjective nature of the federal staffing regulation, determining the level required of a facility to stay within the Medicare conditions of participation is not cut and dried. Facility administration should review staffing levels regularly to determine whether residents’ needs can be met appropriately at all times.

Although many state regulations are based on ratios, a facility’s management should review staffing according to the acuity of the residents, the number and specific skills of the staff, and the licensure levels of its members. All staffing, not just nursing, should be reviewed regularly and modified based upon the current resident mix.

When reviewing accident hazard and prevention requirements, the CMS Departmental Appeals Board has held that “CMS can accept as sufficient staffing levels that might not prevent every incident, as long as the facility has staff that can reasonably be expected to fulfill resident needs by, for example, reducing the number and severity of such incidents to the extent practicable.” Failure to maintain adequate staffing levels can result in regulatory deficiencies and civil money penalties, and can open the facility up to the possibility of civil lawsuits and False Claims Act allegations. 

This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.

Medical Expert Perspective

In the interest of full disclosure, I need to mention that I served as a defense expert witness at trial on behalf of Skilled Healthcare in the Eureka class action lawsuit. My testimony largely dealt with the notion that there is no simple numerical formula to fulfill the requirement of “meeting the needs of the residents,” since those needs are so dependent on case mix and the fact that there is a lot of care provided in facilities that is not taken into account in arriving at the nurse-hours-per-patient-day (PPD) calculation.

While it’s clear that the jury did not find my testimony compelling, the defense mounted an excellent case that was hampered by significant bias on the part of the judge, as well as some juror misconduct too lurid to detail here. The judge did not allow the jurors to hear that other states have significantly lower PPD minimums or that the 3.2 California minimum was passed into law contingent on funding, which had never materialized (so that the minimum is arguably 3.0).

In spite of the fact that no damage or injury to any person was alleged in this case, the judge allowed the jurors to see an array of deficiencies and citations that some of the defendant facilities had received. In fact, a great majority of these had no relationship to staffing levels. This case would have stood an excellent chance for a successful appeal, but

the company did not have the \$1 billion or so necessary to post a bond for the appeal.

In any event, these cases serve as a cautionary tale for facilities. There is some evidence, hardly surprising, that the higher the ratio of nursing staff (especially RNs) to patients, the better the care. Some advocates and time-and-motion researchers believe (and testified in the Skilled Healthcare case) that a more reasonable minimum for PPD in a nursing home would be 4.1, although it is not required anywhere.

While these kinds of studies do not consider direct or indirect assistance provided by other staff, family members, hospice personnel, volunteers, etc., they shed some light on how much care an individual nurse or nursing assistant can provide. But they do not acknowledge that when several patients need significant care simultaneously, it hardly matters how well staffed a nursing home is.

The continuing trend toward sicker and more dependent residents in our buildings should encourage all of us to be mindful of the differing needs of people under our care. Otherwise, we can become targets of the classic plaintiff accusation that we place “profits above patient care.” Juries, understandably, do not like that idea, and these cases make that crystal clear.

—Karl Steinberg, MD, CMD
Editor in Chief