Healthcare

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Independent Living: Major Risk Factors, Effective Interventions

Currently, independent living communities (ILCs) find themselves in a proverbial "good news/bad news" situation. On the one hand, the emergence of "smart" technologies – such as home sensors and automated medication dispensers – permits higher-acuity residents to live more autonomously, which has helped increase occupancy levels for ILCs.[1] On the other hand, lawsuits against senior living settings are on the rise, reflecting the risks inherent in accepting residents with chronic, debilitating medical conditions, including early-stage dementia.[2]

In light of this changing resident profile, ILCs that fail to perform adequate screening, clearly define their service capabilities, implement effective safety programs, and regularly re-evaluate residents for increasing acuity levels and care needs expose themselves to a range of potential allegations, including false advertising, neglect, and wrongful resident placement and retention.

This *AlertBulletin*® features two hypothetical case histories that highlight some of the critical risk issues confronting ILCs. These liability scenarios are complemented by risk control questionnaires that can help owners, administrators and staff evaluate their ability to make accurate service representations, gauge resident suitability, maintain a safe environment, foster reasonable expectations, actively solicit family input and achieve optimal resident satisfaction levels.

Scenario One:

Misrepresentation of Available Safety Measures and Failure to Monitor or Transfer At-Risk Resident

A 72-year-old female resident with Parkinson's disease suffered from several secondary medical conditions, including hypertension, for which she received medication that induced occasional dizziness. Her admissions assessment noted her balance problems, and her healthcare information record indicated that she had sustained no fewer than 12 known falls during her two-year stay.

The ILC's advertising and admissions materials contained descriptions of services expressly designed to prevent and mitigate falls. Safety measures included emergency pull cords in apartments to help residents quickly summon staff, as well as twice-a-day wellness checks, staff assistance for bathroom transfers and 24/7 monitoring of emergency calls by an on-site vendor.

These safeguards failed to protect the resident when she slipped in her bathroom. While falling, she pulled the emergency response cord, but the alert went unheeded by ILC and vendor staff. It was not until 12 hours later, when the resident failed to show up for breakfast, that caregivers finally performed a safety check. She was found prostrate, dehydrated, confused and complaining of severe pain. Emergency medical services transported the resident to the hospital, where she was admitted for surgical repair of a fractured hip. Her hospitalization was followed by a lengthy stay at a rehabilitation center.

1 Independent living settings have an average occupancy rate of more than 90 percent, compared with approximately 86 percent for assisted living facilities. Noted in Regan, T. "Independent Living Innovation a Must as Competition Heats Up." *Senior Housing News*, May 2, 2018.

2 In 2019, senior living-related general and professional liability claims rose between 8 and 12 percent in terms of both frequency and severity. See Sudo, C. "Senior Living Faces Aggressive Litigation, Rising Insurance Costs in 2020." *Senior Housing News*, January 21, 2020.

Allegations:

The resident and family members sued multiple parties for compensatory and punitive damages, including the ILC, certified nursing assistants and the staff of the contracted vendor service. The lawsuit alleged misrepresentation of services, failure to properly monitor an at-risk resident, delayed response to an emergency, lack of timely assessment and failure to transfer the resident to a higher level of care when necessary.

Assessment of Risk Exposures:

The resident's care plan acknowledged a history of falls and instructed staff to utilize available environmental safeguards to protect against falls, which together suggested that the resident required a higher level of staff supervision and care than the ILC was equipped to provide. The medical expert for the resident cited the organization's failure to recommend transfer to an assisted living facility (ALF), despite the resident's documented vulnerability to falls. The expert further opined that the resident's injury was compounded by the ILC staff's failure to respond to the emergency call for help and to urgently attend to the hip fracture. Finally, the facility was criticized for maintaining staffing levels too low to ensure a timely and effective response to a resident fall.

Defense medical experts agreed that the delay in responding to and treating the resident contributed to the severity of her injuries and length of rehabilitative care. The defense experts further noted that the ILC failed to …

- **Provide all services and safety measures referred to in promotional materials,** leaving the organization open to claims of misrepresentation.
- **Outline the scope, frequency and limitations of available services and safeguards during the admissions process,** potentially misleading the resident and her family.
- **Continually evaluate residents for evolving care requirements** and appropriateness of ILC placement.
- **Employ sufficient staff,** resulting in inadequate observation of the resident and delayed response to an emergency situation.
- **Exercise proper oversight of service vendors,** including periodic safety inspections and documentation audits, leading to performance lapses by contractors and noncompliance with established operating procedures and safety measures.

In view of these serious risk management deficiencies, the insured was advised to settle the case.

Risk Control Self-assessment:

As the above scenario demonstrates, ILCs need to clearly and accurately describe their capabilities and institute sound risk-mitigation measures designed to preclude allegations involving marketing materials, monitoring procedures and outside vendor practices. The following questions can serve as a starting point for this process:

Evaluative questions	Comments
1. **Do online and printed marketing materials correctly describe currently available services,** as well as limits on supervision of residents?	
2. **Are all marketing materials reviewed** by senior management and legal counsel?	
3. **Does the admissions process focus on providing honest information about the setting's nature and capabilities,** rather than "hard-selling" prospective residents regardless of their level of independence and suitability for the environment?	
4. **Are admissions and marketing staff regularly reminded to avoid overpromising,** especially in regard to "round-the-clock" observation and care?	
5. **Do marketing and admissions materials address the realities of "aging in place,"** clearly describing available levels of care and underscoring the impossibility of safeguarding residents from all risks?	
6. **Do marketing staff emphasize to prospective residents and families that resident falls and changes in health status cannot always be prevented** and are not necessarily the result of substandard care?	
7. **Are objective criteria in place to guide assessment of current and prospective residents' overall functional level** and to judge the suitability of ILC placement?	

Evaluative questions	Comments
8. **Do admissions contracts state that residents whose condition and needs are changing may be asked to relocate,** thus protecting vulnerable residents and ensuring that families are not taken by surprise by such a request?	
9. **Do staff and administrators exercise due caution when discussing duration of stay within an ILC,** carefully avoiding the implication that all residents can age in place even as their healthcare needs change?	
10. **Are family members and/or other responsible parties included in the admissions process,** when permitted by the resident?	
11. **Is the ILC leadership team aware of the need to manage resident and family expectations and clarify shared responsibilities** during the admissions process and throughout the resident's stay?	
12. **Is pertinent communication with the family documented in the admissions agreement,** including discussions about resident and family concerns and expectations, as well as available services and safety measures?	
13. **Is family members' understanding of ILC capabilities documented during the admissions process,** in order to counter possible later allegations that they were unaware that ILC residents are not under continual supervision?	
14. **Are staff members trained to observe residents** for physical, cognitive and behavioral changes?	
15. **Are regular meetings scheduled with families to keep them informed of changes in the resident's daily routines, physical condition and/or cognitive status** that could require an immediate or eventual shift in level of care (e.g., to full-time personal care, private duty aides or assisted living)?	
16. **Are changes in resident condition and needs conveyed to family members in writing,** as well as verbally?	
17. **Are policies in place governing use of private duty aides,** such as criminal record screening and sex offender registry checks, as well as reporting protocols and basic rules and expectations?	
18. **Is the appropriateness of the ILC setting reviewed whenever the resident's condition changes** and at least on a quarterly basis (or more frequently if required by state laws and regulations)?	
19. **Are residents and families told during the admissions process of the services provided by outside vendors,** and are they periodically reminded of the role of contractors in assisting and safeguarding residents?	
20. **Are written, signed contracts maintained with outside vendors,** detailing the responsibilities and expectations of both parties?	
21. **Is legal counsel consulted when vendor contracts are developed and reviewed,** in order to ensure that service terms are fully delineated and that valid indemnification and hold harmless provisions are incorporated?	
22. **Are contractors required to show proof of insurance** from a recognized insurer with an AM Best rating of A- or above, and to carry limits of liability equal to the ILC's insurance coverage?	
23. **If any positions of authority are held by contracted professionals, are these contracts regularly reviewed,** with due attention paid to indemnification and hold harmless provisions, as well as insurance coverage requirements?	

Scenario Two:

Failure to Properly Assess an Elopement-prone Resident

A 65-year-old male resident with early-onset dementia resided in an ILC facility located within a larger continuing care retirement community (CCRC) campus. During the admissions process, the CCRC neglected to conduct a thorough needs assessment. As a result, the resident's cognitive decline and associated symptoms, including a tendency to wander at night, were not noted. During his first week, the resident was found several times roaming around the campus, both indoors and out, in a disoriented state. Notwithstanding this pattern of behavior, the resident was not reassessed, nor was his family informed of the situation and the need to consider transfer to a more secure, supervised residential setting.

On a cold winter night less than a month after admission, the resident eloped from the grounds. Staff failed to notice he was gone until a friend reported him missing the next afternoon, at which time the police were urgently summoned and a search conducted. Tragically, the resident was found too late, having succumbed to exposure in a park located several blocks from the facility.

Allegations:

The resident's family filed a lawsuit against the parent company of the CCRC, administrators of the ILC, the CCRC medical director, certified nursing assistants and the facility's security personnel. The suit alleged inadequate assessment, failure to move the resident to a higher level of care within the CCRC, and wrongful death as a result of negligence and willful misconduct.

Assessment of Risk Exposures:

Plaintiff counsel and medical experts focused their efforts on demonstrating that the resident was not an appropriate candidate for an ILC. The litigation strategy spotlighted several perceived deficiencies in the areas of admissions policy, assessment, communication practices and documentation, including the following:

- **The organization did not screen prospective residents for signs of cognitive impairment or establish related admissions criteria,** suggesting that some residents placed in the ILC instead should have been assigned to an ALF.
- **Admissions materials included a brief, generic statement of available services,** including existing safeguards, but failed to delineate the types of care *not* provided by the ILC, such as close monitoring and other anti-elopement measures.
- **The ILC's records did not indicate any re-evaluation of the resident's cognitive functioning** subsequent to admission, nor was there any sign that family members had been notified of behavioral concerns or changes in mental condition.
- **Although the resident's initial wandering episodes were documented, there was no record of any team meetings convened to address the issue** or of the family being informed of the need to transfer him to a safer, more appropriate setting.

Due to these and other procedural lapses, legal counsel was not able to mount an effective defense on behalf of the organization.

ILCs offer active older adults **the appealing prospect** of extensive autonomy within **a homelike environment**. However, the **minimal supervision** in independent living communities **presents** a degree of **risk to vulnerable residents**, especially those experiencing cognitive deficits.

Risk Control Self-assessment:

ILCs offer active older adults the appealing prospect of extensive autonomy within a homelike environment. However, the minimal supervision in these settings presents a degree of risk to vulnerable residents, especially those experiencing cognitive deficits. The following self-assessment questionnaire, which should be adapted to suit the unique features and resident population of each facility, is intended to help ILC operators, administrators and staff evaluate the organization's ability to manage higher-acuity residents, especially those with wandering tendencies.

Evaluative questions	Comments
1. **Are there written admissions criteria,** which clearly distinguish between acceptable and unacceptable levels of functioning for prospective ILC residents?	
2. **Are thorough, appropriately documented pre-admission assessments performed** to evaluate residents' acuity level and range of needs?	
3. **Do admissions staff exercise prudence when considering prospective residents,** recommending more suitable levels of care to individuals whose needs are at the upper range of manageability?	
4. **Is an elopement assessment completed prior to admission,** and are residents determined to be at risk for wandering steered away from the ILC and toward a memory care unit?	
5. **Are written criteria in place for determining when resident needs can no longer be met,** and for initiating transfer to a higher level of care?	
6. **Are admitted residents continuously re-evaluated for wandering tendencies,** and are changes in behavior documented in writing?	
7. **If new-onset wandering behaviors are observed, are family members promptly notified** so that residents can be transferred to a higher level of care?	
8. **Does the facility have a daily resident check-in program,** as well as consistent follow-up procedures if a resident fails to report?	
9. **Is the effectiveness of check-in and follow-up procedures periodically assessed,** in order to maximize resident compliance and enhance staff response?	
10. **Is a "buddy system" in place,** in order to heighten resident safety and reduce potential isolation?	
11. **Is there a missing resident protocol,** and are periodic, documented search drills performed to ensure that staff members are prepared to respond quickly and effectively in such situations?	
12. **Are residents informed about fire safety and evacuation procedures upon admission** and periodically thereafter?	
13. **Are outdoor areas well-maintained,** with frequent documented checks of lighting, sidewalks, driveways, lawns and parking lots?	
14. **Does the organization communicate regularly with residents and family members about available services, limits of care and similar topics,** utilizing email, family council meetings, the ombudsman program and other methods?	
15. **Are resident/family satisfaction levels and complaints tracked,** in order to ensure that relatively minor concerns are addressed before they can develop into serious problems and potential lawsuits?	

While today's ILCs are capable of serving residents with a wide range of needs and abilities, not everyone is a candidate for independent living. Individuals who are admitted to an ILC must be carefully assessed for suitability, fully apprised of the facility's service limitations, provided with needed safeguards, monitored for changing functional level and referred to a higher level of care when they can no longer be securely accommodated. The hypothetical case histories and suggested interventions within this newsletter are intended to help administrators and staff view organizational policies and practices objectively, and to encourage discussion of ways to enhance resident safety and reduce liability exposure.

Quick Links

- Adler, J. "The Acuity Creep Challenge." *Seniors Housing Business*, March 23, 2015.
- Arko, V. "How to Build to Last in an Era of Rising Acuity." A white paper available for download from *Senior Housing News*, November 27, 2019.
- Gordon, P. "The Importance of Managing Rising Acuity Levels: Legal Risks Warrant an Inventory of Responsive Strategies." *Seniors Housing Business*, October-November 2012, pages 22-23.
- Holland, R. "Top Three Risks of Acuity Creep." *McKnight's Long-Term Care News*, May 9, 2016.

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