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Brother's Keeper or Big Brother? Resident Safety vs. Resident Rights

Emily M. Park

Nursing facilities have long been operating between that proverbial rock and a hard place when it comes to resident safety and resident rights. On the one hand, facilities are required to ensure the resident environ-

ment remains free from accident hazards and each resident receives adequate supervision to prevent accidents.[1] On the other hand, the Nursing Home Reform Act in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) requires facilities to provide care and services so that residents "attain or maintain the highest practicable physical, mental and psychosocial well-being . . . ."[2] In addition, facilities are responsible for maintaining and enhancing each resident's dignity and respect[3] and each resident has a right to refuse treatment, be autonomous, and make choices about his or her everyday life.[4] Resident smoking is a leading example of the catch-22 faced by facilities with respect to choosing between promoting resident safety or autonomy.[5]

The bad outcomes associated with failures involving resident rights are not as obvious or life-threatening as the bad outcomes associated with failures to comply with safety requirements. The harsh consequences imposed on facilities for failures to prevent accidents has understandably caused facilities to approach residents with a "safety above all else" attitude, a concept commonly known in the industry as "surplus safety."[6]

In recent years, there has been some recognition that surplus safety has its own negative consequences,[7] such as emotional harm and, quite possibly, "excess disability."[8] In addition, the aging baby boomer popula-

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1 42 C.F.R. § 483.25(h).
2 42 U.S.C. § 1396r(b)(2); 42 C.F.R. § 483.25.
3 42 U.S.C. §§ 1395i-3(c)(1)(A)(v)(I), 1396r(c)(1)(A)(v)(I); 42 C.F.R. §§ 483.15(a), 483.15(e)(1).
4 42 C.F.R. §§ 483.10(b)(4).
5 Resident smoking involves risks to other residents as well. Facilities face an even bigger conundrum when residents engage in risky behavior that does not take into consideration the safety of other residents.
6 Ruta Kadonoff & Ken Burgess, *The Emerging Concept of Surplus Safety and its Potential Implications for Skilled Nursing Facilities* 1 (AHLA Long Term Care and the Law Conference, Feb. 2013) [hereinafter *The Emerging Concept of Surplus Safety and its Potential Implications for Skilled Nursing Facilities*], *available at* www.healthlawyers.org/Events/Programs/Materials/Documents/LTC13/papers/ff_burgess_kadonoff.pdf.
7 *Id.* at 2–3.
8 *Id.* Excess disability is described as a decrease in functional ability as a result of safety precautions that limit the resident's ability to exercise his or her remaining functions. The authors give the following example: a resident able to ambulate is encouraged to use a wheelchair due to an increase risk of falls, then loses the ability to walk because of loss of conditioning and muscle strength.

tion values individual rights more so than generations past,[9] which has resulted in a strong push against surplus safety. In response to this push against surplus safety, "negotiated" or "shared" risk agreements[10] were created, but proved controversial; rather than remedying surplus safety, the agreements only created new issues and muddied the waters.[11]

At the September 2012 Surplus Safety Symposium,[12] other solutions to address surplus safety were considered, including revision of the Centers for Medicare and Medicaid Services' (CMS) scope and severity grid by changing the criterion for immediate jeopardy from "potential for serious harm" to "probability of serious harm."[13] Although many feel this proposed change is warranted, it is unlikely to be made. There has been no effort by CMS to revise or clarify the scope and severity grid in that respect.

Symposium participants did recognize, however, that existing laws and regulations create a framework in which facilities can balance safety against resident rights.[14] The problem is that both CMS and its surveyors' (collectively referred to in this article as CMS) focus on safety

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9 Steve Gillon, Boomer Nation: The Largest and Richest Generation Ever, and How It Changed America 11-12 (Free Press 2004).

10 In a nutshell, a negotiated (or shared) risk agreement is an agreement between a facility and a resident, under which a resident agrees to waive a facility's liability for injuries resulting from activities or behaviors the facility finds "risky" to the resident's safety. *The Emerging Concept of Surplus Safety and its Potential Implications for Skilled Nursing Facilities*, at 8–9.

11 *Id.* at 8–13. As an example, facilities were accused of using negotiated risk agreements in an attempt to avoid liability for poor care. *Id.* at 9–10.

12 The September 2012 Surplus Safety Symposium, organized by The Erickson School of Aging Studies, was a meeting of resident advocates, facilities, regulators, residents, attorneys, and researchers to comment on surplus safety and discuss potential solutions. *Id.* at 5–6.

13 *Id.* at 7. The scope and severity grid is used by CMS to determine which sanctions to impose on a nursing facility for deficiencies. The grid ranks nursing facility deficiencies in accordance with patient harm. *See* Office of Inspector General, Dept. of Health and Human Servs., Nursing Home Enforcement: The Use of Civil Money Penalties 4 (2005). "Scope" refers to the number of patients affected by the deficiency, while "severity" refers to the degree of harm. *Id.*

14 *Id.* at 8.

and fail to consider resident rights adequately,[15] mainly because (i) the negative harms resulting from rights failures are not as immediate and apparent as the harm from safety failures, and (ii) proof of the harms resulting from resident right deficiencies imposes a greater evidentiary burden on CMS.

So, although the industry is moving away from surplus safety, CMS continues to move in the opposite direction, pressuring facilities to eliminate all possible risk. In addition, CMS is requiring facilities to manage safety risks faced by residents *outside* the facility without regard for the expressed desires of the residents.[16]

In December 2009, the Departmental Appeals Board (DAB)[17] attempted to highlight these issues to CMS in the *Venetian Gardens* case. In *Venetian Gardens*, a facility successfully appealed an Administrative Law Judge's (ALJ) summary determination that the facility was not in substantial compliance with Section 483.25(h)(2)[18] when a mentally competent resident who repeatedly chose to leave the facility in his motorized wheelchair was killed when his wheelchair was hit by a car. The resident was a 56-year-old man with advanced Parkinson's disease who traveled on a rural highway with a speed limit of 45-miles per hour. The resident often left in the late evening to go to a local bar to socialize.[19] The evidence in the case indicated the resident was "resolutely determined to maintain all possible measures of adult independence . . . ."[20]

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15 *Id.* at 14–15*; see also, e.g., Venetian Gardens*, DAB No. 2286 (Dec. 7, 2009) [hereinafter *Venetian Gardens*], *available at* www.hhs.gov/dab/decisions/dabdecisions/dab2286.pdf.

16 *See, e.g., Venetian Gardens*.

17 The DAB, which is a part of the United States Department of Health & Human Services, "provides impartial, independent review of disputed decisions in a wide range of Department programs . . . ." *See* About DAB, www.hhs.gov/dab/about/index.html (last visited March 24, 2016).

18 42 C.F.R. § 483.25(h)(2) (supervision and devices to prevent accidents).

19 *Venetian Gardens*, at 3.

20 *Id.* at 11.

The DAB faulted CMS and the ALJ for: (i) failing to consider the resident's condition and rights; (ii) depicting the resident exclusively in terms of his impairments; and (iii) adopting, without any support, a view that facilities must provide supervision and assistance outside facility premises to a competent resident who chooses to leave temporarily and independently.[21] As the DAB pointed out, this "broad view" of Section 483.25(h) was not supported with any citation to or analysis of the section's wording, its history, CMS guidance, or professional standards of care.[22] A cursory review of the Interpretive Guidelines for Section 483.25(h) (F323) in the State Operations Manual, Appendix PP, shows that the regulation is oriented toward safety in the "resident environment."[23]

Despite the DAB decision in *Venetian Gardens*, CMS continues to impose strict safety obligations on facilities with respect to competent residents who leave the facility on their own accord. Until CMS and its surveyors level out the balance between safety obligations and resident rights, facilities will continue to operate between a rock and a hard place.[24]

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21 *Id.* at 7, 11, and 17–18.
22 *Id.* at 18.
23 CMS, State Operations Manual, Appendix PP, F323 (Aug. 17, 2007), *available at* www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
24 In the *Venetian Gardens* case, the facility attempted to address the conflict between resident safety and resident rights by counseling the resident with respect to the safety risks associated with his choices. The DAB questioned whether such counseling was consistent with the resident's right to dignity in light of the resident's documented frustration with the counseling. *Venetian Gardens*, at 15.