Assisted Living Facilities and Adult Homes

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I. Overview of the Assisted Living Industry

a. Current Trends

The nation's population of persons 65 years of age or older increased by 12% between 1990 and 2000.[1] As of the 2000 census, there were approximately 35 million people counted that were 65 years of age or older.[2] It must be noted that this only represents those who were actually *counted* in the census, not necessarily the *actual* number. Additionally, the percent increase was the highest in the age group of 85 years of age or older, increasing by 38%.[3]

Assisted living facilities are becoming increasingly more popular with the elderly as a comfortable middle ground for housing once they become unable to safely live at home alone. These facilities offer such services as meals, laundry, housekeeping, community activities and 24-hour staff. However, these facilities do not inhibit a resident's daily activities in the same way a nursing home does. For example, in a nursing home, typically a resident would not have the ability to leave unattended from the facility; in an assisted living facility, on the other hand the resident would be able to as long as the facility was not concerned with the resident's ability to do so.

Some factors contributing to the popularity and growth of the assisted living industry include the aging of the American population, the need of seniors for assistance with activities of daily living, and the continued increase in the number of seniors living alone. Societal factors, such as divorce and the role of women as work force members,

[1] US Census Bureau, The 65 Years and Over Population: 2000, http://www.census.org/gov/prod/2001/p-ubs/c2kbr01.pdf. Last visited August 4, 2004.
[2] Id.
[3] Id.

have also contributed to the trend of seniors living alone. Additionally, the increased net worth of seniors may prevent an individual from qualifying for public assistance for other alternative housing options. Furthermore, the nation is constantly looking for less costly methods to provide health care for seniors as well as other individuals. A resident in an assisted living facility is most likely a private pay resident, with no financial assistance for the cost of the facility. This is a savings to the Medicare and Medicaid systems.[4]

II. Statutory and Regulatory Protections of Residents

a. Assisted Living Reform Act – Public Health Law Article 46-B

Since there are no federal statutes or regulations applicable to assisted living facilities at this time, you must look to State law. To address the increase in popularity of assisted living facilities and the problems created by that increase, as well as in response to several investigative reports involving these facilities, Governor George Pataki proposed an Assisted Living Reform Act in 1999. On October 26, 2004, Governor Pataki signed into law the Assisted Living Reform Act[5] (hereinafter referred to as "ALRA"). This Act will become effective February 23, 2005 and will be codified as Public Health Law Article 46-B.[6] Below is a discussion of highlights of the legislation.

i. Definitions

[4] *Facts About Assisted Living*, Assisted Living Federation of America, 2004, http://www.alfa.org/public/articles/details.cfm?id=143, last visited November 17, 2004.
[5] Assembly Bill A11820 and amends the Public Health Law, Social Services Law and the State Finance Law.
[6] There are also amendments to Soc. Serv. Law § 2 and the State Fin. Law § 99-L; however, the bulk of the Act is codified in Pub. Health Law Art. 46-B.

One of the main components of ALRA centers on the definition of an "assisted living facility" and what requirements are triggered once a facility is defined as such.[7] An assisted living facility is defined as, "an entity which provides or arranges for housing, on-site monitoring, and personal care services and/or home care services (either directly or indirectly) in a home-like setting to five or more adult residents unrelated to the assisted living provider."[8] An "adult home" is defined as an adult care facility established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care (either directly or indirectly), and supervision to five or more adults unrelated to the operator.[9] An important distinction between an assisted living facility and an adult home is the ability of an assisted living facility to arrange for the services enumerated to be provided to the resident, while an adult home must provide those services themselves. It appears that this distinction was made for Medicaid funding purposes. Specifically exempted from the definition of assisted living facilities are:

- Licensed residential health care facilities;
- General hospitals;
- Continuing care retirement communities[10] that possess a certificate of authority unless the continuing care retirement community is operating an assisted living facility;
- Residential services that are currently provided for under different licenses;
- Assisted living programs approved under Social Services Law Section 461-l[11];
- Naturally occurring retirement communities;

[7] NY Pub. Health Law Article 46-B.
[8] NY Pub. Health Law § 4651(1).
[9] Soc. Serv. Law §2(25).
[10] A separate law was passed this year covering these types of facilities individually.
[11] These types of facilities currently have very similar regulations as are provided for under the Assisted Living Reform Act and are licensed separately.

- Public or publicly assisted multi-family housing projects under HUD provided they do not provide or arrange for home care or supervision or both;
- An operating demonstration
- A hospice
- An adult care facility not using the term "assisted living" nor required to obtain an enhanced assisted living certificate;
- And independent senior housing facilities.[12]

In addition to simply defining assisted living facilities, ALRA attempts to bring in many, if not all, of the facilities that have come to be known as "look-alike" facilities. These are facilities that are operating in a manner as to arguably keep them outside of the current definition of an assisted living program, yet who market themselves as providing "assisted living" or "assisted living services." Section 4656(1) addresses that ongoing problem by providing that no entity, "shall establish, operate, provide, conduct or offer assisted living, or *hold itself out* as an entity which otherwise meets the definition or *advertise itself as assisted living or by a similar term* without the approval of the Department of Health to operate as an adult care facility" (emphasis added) or obtaining approval under ALRA. If the intent of the Legislature, the Governor, and many of the supporters of ALRA is carried out, this section will require many, if not all, of the look-alike facilities to be licensed.

ii. Licensing

If a facility meets the definition of assisted living set forth in ALRA, it must obtain licensure through the New York State Department of Health.[13] In order to do so, the facility must have a valid adult home or enhanced housing program certificate and

[12] NY Public Health Law § 4651(1).
[13] NY Pub. Health Law § 4652.

that certificate must be in good standing with the Department of Health.[14] The facility must file an application with the Department of Health and show that the building, equipment, staff, standards of care and records all comply with all applicable statutes, regulations and local laws.[15] Furthermore, the facility must show that there are adequate financial resources to provide the assisted living as proposed.[16] Operating an assisted living facility without the proper licensure is deemed a Class A misdemeanor.[17]

iii. Regulations Applicable to Adult Homes

All regulations applicable to adult homes or enriched housing facilities will now be applicable to assisted living facilities that are also licensed as such. You should be thoroughly knowledgeable of 18 NYCRR Part 487 for adult homes and 18 NYCRR Part 488 for enriched housing facilities. While these regulations are similar to each other, there are subtle differences that are outside the scope of this paper.

iv. Residency Agreement

Pursuant to ALRA, each resident entering into an assisted living facility must enter into a written residency agreement.[18] ALRA sets forth specific provisions that must be included.[19] The minimum requirements for the residency agreement include such things as: name, address and telephone number of the facility, the owner of the facility, and the operator of the facility; the name of an individual that can accept legal service for the facility; a statement of the licensure status of the facility and any home health care or

[14] NY Pub. Health Law § 4656.
[15] Id.
[16] Id.
[17] Id.
[18] NY Pub. Health Law § 4658.
[19] Id.

personal care service agency that is under an agreement with the facility; the effective period of the residency agreement; and the name of the resident's representatives.[20] The agreement must also set forth what services will be provided to the resident and at what monetary rate, as well as any additional services that are available for an additional cost, either directly from the facility or through an arrangement with another agency.[21] The name of any agency that is under contract with the facility must also be disclosed.[22] Criteria used for admission and retention of a resident must be set forth as well as the procedures and standards for termination, discharge or transfer of a resident.[23] The facility must disclose to the resident:

- The state of licensure;
- Any ownership interest the facility has in excess of 10% in a company that is providing through the facility care, materials, equipment, or other services to the residents;
- Any ownership that those entities may have in the facility;
- The resident's ability to receive services from other entities and from their choice of physicians;
- Availability of public funds for payment;
- The Department of Health's toll free telephone number for complaints;
- And the availability of an ombudsman and his or her telephone number.[24]

A copy of the residency agreement must be given to the resident, the resident's personal representative, and legal representative, if any.[25] Furthermore, all residency agreements must be kept on file for at least three years after the termination of the residency.[26]

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[20] Id.
[21] Id.
[22] Id.
[23] Id.
[24] Id.
[25] Id.
[26] Id.

v. Individual Service Plan

Upon admission, pursuant to ALRA, an individualized service plan (hereinafter referred to as "ISP") must be developed for each resident of an assisted living facility.[27] The ISP must be developed "with the resident, the resident's representative, the resident's legal representative, if any, the assisted living operator, and [if appropriate] a home care services agency."[28] Furthermore, the ISP must be developed in consultation with the resident's physician.[29] The ISP must be developed in accordance with the medical, nutritional, rehabilitation, functional, cognitive and other needs of the residents, and must include the services to be provided to the resident, and how and by whom those services will be provided.[30] Additionally, the ISP must be reviewed and revised as frequently as necessary to reflect changes in the resident's needs but not less frequently than once every six months.[31]

vi. Resident's Rights

The rights of the residents will also be substantially enhanced after ALRA becomes effective. A resident must be a voluntary participant in assisted living and must be given the information necessary in order to make an informed decision as to participation.[32] As well as retaining the rights set forth in the existing law, residents are now also protected against coercion to work or a requirement of working in the facility,

[27] Pub. Health Law § 4659(1).
[28] Pub. Health Law § 4659(2).
[29] Id.
[30] Pub. Health Law § 4659(3), (4).
[31] Pub. Health Law § 4659(5).
[32] NY Pub. Health Law § 4660.

and given security of their personal possessions stored by the facility.[33] The residents are also guaranteed the right to be fully informed of their medical condition and proposed treatment and are given the right to refuse treatment or medications after being fully informed.[34] Additionally, the residents are given the right to advance notice of any fee increase.[35] This notice must be given at least 45 days prior to the effective date of the increase and the notice must be in writing.[36] Any waiver of the resident's rights is void as against public policy.[37] A written statement of the resident's statutory rights must be given to the resident as well as posted in a public area of the facility.[38]

Furthermore, every resident shall have the right to receive courteous, fair, and respectful care and treatment from the facility and shall have the right to receive adequate and appropriate assistance with activities of daily living.[39]

This discussion of the enhanced rights is just a sample and is not an exhaustive list of the rights enumerated. At this time, however, there are no penalty provisions for violation of any of these rights. It is also unclear whether or not Public Health Law §2801-d will apply to assisted living facilities. In my opinion, §2801-d should apply to those assisted living facilities that have an enhanced assisted living facility license as they are providing health related services. As a provider of such services, they arguably are health care facilities as defined in Public Health Law §2801. If this is so, then Public

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[33] Id.
[34] Id.
[35] Id.
[36] Id.
[37] Id.
[38] Id.
[39] Pub. Health Law § 4660(3)(H), (L).

Health Law §2801-d would provide residents a private cause of action for violations of their rights.

vii. Marketing

As mentioned above, it appears that ALRA is designed to address the problems of facilities that were not licensed in any way or in very limited ways through the state, yet advertised themselves as service providers for residents with special needs. In addition to other requirements for licensure, ALRA requires that any residence that advertises or markets itself as serving individuals with special needs including such things as dementia or cognitive impairments, must submit a "special needs plan" to the Department of Health setting forth how the special needs of the residents will be "safely and appropriately met."[40] No residence may market or advertise services to meet special needs without prior approval from the Department of Health.[41]

viii. Complaint Hotline

Every resident must also be given a consumer guide that will include the Department of Health's toll-free telephone number for the reporting of complaints regarding home care services and the services provided by the assisted living facility operator. The Department of Health was given the responsibility under ALRA to prepare that consumer guide.

ix. Task Force

[40] Public Health Law § 4655(5).
[41] Id.

A Task Force on adult care facilities and assisted living facilities was created as a result of ALRA.[42] The task force, which was to be convened no later than December 1, 2004, is to, among other things, update and revise the requirements and regulations applicable to adult care facilities and assisted living facilities. The task force must report its findings to the Governor no later than June 1, 2005, and each year thereafter.

x. Comparison of New and Existing Law

There are several differences between the existing Assisted Living Program and ALRA. One of the major differences is the penalty provided in the event an entity is not properly approved or licensed as an assisted living program or facility. Under the Assisted Living Program, a facility can be assessed a penalty of up to $1,000.00 per day for operating without the required approval from the Department of Health.[43] Under ALRA, however, the operator of that same facility would be committing a Class A misdemeanor.[44] This penalty is a substantial difference from existing law. Jail time can now be imposed rather than simply writing a check.

III. Case Selection

It is very important that you invest the time and sometimes money into screening your prospective cases very carefully. You will save as much money by declining marginal cases as you will in selecting quality ones. These cases are very expensive and time consuming. Assisted living cases present all of the obstacles of a nursing home case with few of the benefits. Unlike nursing home cases where the general public harbors ill

[42] State Fin. Law § 99-L(5).
[43] 18 NYCRR 486.5(b).
[44] NY Pub. Health Law § 4656.

feelings toward the facilities, assisted living facilities have not garnered the same feelings from the public. The general public for the most part has had little or no experience with assisted living facilities prior to placing a loved one there. Some of the obstacles include limited damages, little if any pecuniary loss, no financial dependents, possible Medicare/Medicaid liens, and an elderly client with little life expectancy. The benefits of nursing home cases, such as the statutory and regulatory scheme establishing the standard of care and the outrage factor from the jury, are lacking in an assisted living case. On the other hand nursing homes are frequently in the news for neglecting or abusing residents. For these reasons it is very important that you establish a set of case selection criteria that you strictly adhere to. Below are some of my suggestions.

a. Initial Intake

i. Injury

I would not accept cases that have marginal injuries. If you do not have significant damages then the case will not justify the time and expense. If the injury is serious but not egregious then I would not accept the case unless liability is without question.

ii. Family Dynamic

It is very important that in selecting these cases you have a real understanding of the family dynamic. First, question the relationship between the caller and the resident. Was the caller involved in the resident's life? Did they visit? Are they familiar with the resident's medical conditions? Do they have the health care proxy or power of attorney if

the resident is still alive? If they were not involved and the victim is deceased, ask if anyone else was involved and if so, speak with him or her.

TIP: If it turns out the family was not involved and did not visit then make certain that you want to handle the case. Would the jury care more about the victim than the family did? Maybe, if the injury was egregious enough.

Find out as much as you can about the family dynamics. Are all the siblings on speaking terms. Is the spouse alive? If there is no spouse, will the siblings understand that they will have to share the settlement with their siblings? You may hear, "but my brother was not involved, he never visited, why should he get anything?" Investigate these issues up front and tell the family that you cannot take the case unless the issues are resolved as this dynamic is present in most cases. It may be extremely helpful to meet all potential family members who can legally pursue the intestate's claim, if applicable. Select the most compelling, reliable and knowledgeable individual to act as the estate representative.

TIP: An efficient way of finding out the family dynamic is to ask the caller the names and addresses of all their siblings. If there is a family split, the caller will likely say something to the effect of, "I have no idea about my brother so and so, I haven't spoken to him in years" or "Well, the last I knew my sister was in prison somewhere."

iii. Liability

Unlike a motor vehicle accident where you might have questionable liability but egregious injuries and still take the case, in assisted living facility cases you must have clear liability as a threshold matter. You cannot expect nuisance value in cases like this.

In order to establish your theory of liability, you will necessarily expend significant sums of money. Don't take this as advice to reject any case where the liability is not immediately apparent; rather, you should attempt to identify a liability issue that is worth investigating. More often than not, questionable liability will become more apparent with further investigation. For example, clearly an elopement from a nursing home would violate the standard of care under OBRA. However, in an assisted living facility, if there is no statutory or regulatory scheme in your state, you may very well have to develop a standard of care. Remember, these cases will be aggressively defended.

Obviously, you should obtain as much information as possible about the assisted living facility involved. This information will guide you with respect to possible notice requirements or statutes of limitations issues.

iv. Who is the Defendant?

As a part of the intake process you should contact the Department of Health to determine the owner and operator of the facility. By doing this you can anticipate any pre-suit notice requirements that must be met. Currently, the Department of Health posts on their website information regarding nursing homes and adult care facilities. It is anticipated the Department will do the same for assisted living facilities.

I also recommend that a full title search be performed in order to determine the owner and operator of the facility as well as the owner of the property where the facility is located. We have found through our investigations that typically the land where the facility sits is owned by one entity while the building is leased to yet another. A typical problem arises when a title search is not immediately completed and reveals a

municipality or state owns the property. Notice issues could have been avoided by a timely title search.

After performing a title search and a record search of any regulatory agency with respect to assisted living facility licensure or approval, it is advisable to name all parties – owner of the facility, operator of the facility if different, and the owner of the property. In the event it becomes apparent that the owner of the property had no management authority over the facility's operation, that entity can be released from the suit.

v. Statute of Limitations Issues

A full investigation into the applicable statutes should be completed immediately. For example, if your case involves an intentional tort such as assault, and in some instances fraud, the time periods may be significantly shorter than a typical negligence case. Additionally, if the owner of the facility is a state or municipality, notice requirements may be applicable.

b. Pre-suit Discovery Considerations

i. Documents to Request

- Lease;
- Marketing materials;
- Any written agreement between the client and the Defendant;
- Any agreement between the Defendant and any service provider;
- Facility and property ownership documentation;
- Facility websites.

You should review the above-listed documents for such things as arbitration clauses and contractual limitations on liability. Furthermore, such things as marketing materials will indicate what, if any, representations the facility has made with respect to care and services provided. For example, the facility may advertise 24-hour supervision,

which, in a wandering case, will be fruitful in establishing the standard of care the facility held itself out to provide.

ii. Physical Evidence

1. Photographs

If the resident is alive at the time of the initial intake, have the family or a professional photographer take photographs of the resident's injuries. For example, if this is a bedsore case you should have professional photographs taken. I also attempt to obtain a photograph of the resident shortly before they entered the facility so a comparison can be made. Photograph and videotape the facility if this is a wandering case.

2. Private Investigation

If the case justifies the expense I will hire a private investigator prior to putting the case into suit in order to take statements from potential witnesses. Since the greatest employee turnover is among certified nurse assistants I typically have the investigator take statements from them. If they are not willing to talk, at a minimum, the investigator will ask for their personal information and the name of former employees that they think may talk. More often than not you will not be able to obtain the name and address of former employees. You will simply be told there is no forwarding address. Of course if your client is alive and competent you should secure your client's statement as soon as possible.

3. Records

To the extent that you can, you should have the family demand every record that the facility is willing to provide pre-suit.

IV. Typical Assisted Living Facility Case Scenarios

a. Elopement

Know the difference between wandering and elopement. A resident wanders by entering or leaving an area without permission, although typically they are not seeking an exit. On the other hand, a resident is seeking to exit the facility if he or she elopes. Wandering behavior will usually precede an attempt to elope. Elopement will probably be the most likely scenario in an assisted living facility, as the resident will be seeking to leave the facility.

b. Falls

Falls are becoming increasingly common in the assisted living facility context. Residents enter an assisted living facility primarily because they need some assistance with activities of daily living. As their residency time increases, their needs will likely increase as well. These needs may include assistance in ambulating. In the event a facility does not recognize this need or does not provide adequately for it, a resident's risk of falling increases. Additionally, items left unattended such as lunch carts or cleaning carts may pose a significant threat for a resident ambulating through hallways.

c. Bed Sores

While less frequent in assisted living facilities, as more people turn to assisted living facilities we are seeing more bed sore cases. The typical theory would be that the resident was not suitable for an assisted living facility and should have had a higher level

of care such as a nursing home. The typical assisted living resident upon admission is ambulatory and, as a result, does not develop bedsores. However, as time progresses, the resident's health declines and he or she may become unable to ambulate. This significantly increases the risk of developing bedsores. Often, assisted living facilities are not properly transferring these residents to nursing homes when a higher level of care is needed. There may be a violation if they retained a resident beyond the time that they could properly care for him or her. Also, you must investigate the resident's health at the time of the admission to the assisted living facility for such things as the risk for bedsores, skin breakdown or dehydration. In most cases, liability can be determined by the state's admissions criteria.

It is very important in a bed sore case to determine or locate each and every health care provider that had contact with your client from the date of admission. Typically, the assisted living facility will have a contract with a home health care agency to meet all of the residents' needs. This health care provider is both a potential defendant and another insurance policy. This is particularly helpful when you have an unlicensed assisted living facility that contracts with a licensed home health care agency.

For example, in Sander v. Mendosa, Fla., Dade County Cir. Ct., No. 01-30436 (CA13), June 8, 2004, T. Patrick Ford, Jr., Esq., sued both the unlicensed owner/operator of the assisted living facility and the licensed home health care agency for severely neglecting a resident resulting in horrific bedsores. While his client prevailed against both defendants, only the licensed home health care agency had insurance that has since paid on the judgment.

Because these cases will typically involve neglect over an extended period of time, which can be viewed as rising to the level of abuse, your local law enforcement agency may be interested in prosecuting this case. However, it has been my experience that for the most part, law enforcement is not interested in these types of cases.

d. Medication Errors

According to a recent study conducted by USA Today, more than 1 in 5 of the assisted living facilities inspected by several states[45] were cited for at least one significant violation with respect to medications. Several violations were repeatedly cited such as giving too much or too little medication, improperly labeling medications, failing to properly train staff dispensing medications, failing to have prescriptions refilled on time, and failing to ensure residents were taking the medication prescribed. The study also indicated that a 2002 survey by the National Academy for State Health Policy found that nearly half of the 34 states responding to the survey identified medication errors, one of the most often cited violations.

This is something to look for in every case. Medication errors can be a contributing factor to many other problems with an assisted living facility. For example, if a resident was given too much or too little of a prescribed medication, or is given a medication that has not been prescribed, this may be a factor in a fall by a resident. The medication may affect the resident's balance or focus, causing them to be uneasy on their feet. Also, if a resident is given too much of a medication, such as Coumadin, a blood

[45] USA TODAY reviewed inspection records for the period of 2000 through 2002 for the states of Alabama, Arizona, Colorado, Florida, Indiana, New York and Texas. This report can be found at http://www.usatoday.com/money/industries/health/2004-05-24-assisted-living-cover_x.htm, last visited November 24, 2004.

thinner, the resident may suffer from internal bleeding that either injures the resident or even causes the resident's death.

You should have an expert review all prescribed medications as well as all administered medications. These should be examined for the correct application of medications for the resident's mental capabilities. Often, a resident will be suffering from dementia in some form without being diagnosed as such; therefore, the medication prescribed is not treating the dementia or its symptoms. This can lead to poor quality of care.[46]

e. Sexual Assault

Sexual and physical assault in assisted living facilities is prevalent. Liability typically is established either by the admission and retention criteria if the assailant is another resident, or the employment practices if the assailant is an employee of the facility. Often, you will find that the facility had inadequate staffing as well. These cases will likely involve a failure of the facility to supervise not only the victim but also the assailant. For example, in an Illinois case, an assisted living facility resident was severely assaulted by another resident. Discovery revealed that the defendant's program director had assured the victim's family that the assailant would have one on one supervision, which did not occur. Kosac v. REM Indiana, Lake County (IN) Superior Court, Case No. 45D10-0201-PC-00006.

If your client was involved in a case of potential sexual or physical abuse, or there is a suspicious death, there may be an investigation performed by a law enforcement

[46] Agsalsa, Sharon, Study Shows Inadequate Psychiatric Care in Assisted Living Facilities, November 10, 2004, http://www/eurekalert.org/pub_releases/2004-11/bpl-ssi111004.php, last visited November 20, 2004.

agency. These reports provide immediate, frontline investigation of such incidents, which will serve as a valuable discovery tool in your case. Law enforcement agencies sometimes are eager to discuss an abuse case with you and advise you "off the record" as to what they have found.

f. Failure to Supervise

This will likely be found in all cases of liability of an assisted living facility. Most times, an investigation will uncover inadequate staffing. Staffing shortages and insufficient training place the elderly at risk in assisted living facilities. A USA TODAY investigation revealed that nearly one in five facilities were cited for at least one staffing violation. They ranged from too few employees to a lack of a certified facility manager. In some cases, residents were left to fend for themselves because there were no caregivers on site. More than one in four facilities were cited for training violations such as failing to ensure that employees had adequate instruction in first aid, emergency procedures, and resident rights. It is estimated that the actual violations are significantly higher because of weak regulatory oversight.[47]

Some facilities' employees lack even basic first aid and CPR training. For example, in Florida a resident was found by other residents choking on food. However, when the residents called for assistance from the employee on duty, that employee did not have the required training in first aid and CPR. A resident had to contact emergency personnel.[48]

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[47] USA TODAY study, *supra*.
[48] Problems with Staffing, Training Can Cost Lives, USA TODAY, May 26, 2004, http://www.usatoday.com/money/industries/health/2004-05-26-assisted-day2_x.htm, last visited November 20, 2004.

V. Theories of Liability

a. Common Law Negligence

In every assisted living facility case, you should assert a common law cause of action for negligence. However, be careful in pleading this cause of action. If you allege breaches in medical or nursing standards of care, you will likely face a motion to dismiss on the grounds that the case is truly medical malpractice and not negligence. Since assisted living facilities are not providing medical care, there is no reason to allege breaches of medical or nursing standards of care. Instead, you should cite your state statutes or regulations as the standard of care and the facility's failure to comply with the same as a breach of that standard of care.

One of the benefits of pleading common law negligence is that you will not be subject to medical malpractice damage caps and/or limitations on attorney fees. Typically a negligence cause of action has a longer statute of limitations and does not have the pre-suit requirements and during-suit discovery limitations of a medical malpractice case. Since assisted living facilities are not providing health care, quality assurance privileges should not apply.

b. Statutory Violations

As stated above, you should review ALRA, Social Services Law referenced above, the rules and regulations referenced above, as well as Article 28 of the Public Health Law. It is unclear to this author at this time whether Article 28 will be applicable to assisted living facilities.

c. Wrongful Death

The challenge in a wrongful death case can be causally relating the death to an injury. For example, if a resident falls and breaks her hip, then dies three months later, it may be difficult to causally relate the death to the fracture, although there was a steady decline in health. Discuss this in-depth with your expert. Be mindful of the statute of limitations, as it is two years from the date of death.

Damages in a wrongful death case are limited to economic loss such as lost wages, funeral expenses, medical bills, and loss of financial support. Therefore, your damages under this cause of action will often be very limited, as the resident will likely not have much economic damages.

d. Consumer Fraud

Depending on the facts of your case your client may have a cause of action in consumer fraud. It is likely that the assisted living facility made certain representations either in its marketing materials, in negotiations with your client or the client's family, or in the lease or contract that was eventually signed by your client. The new Assisted Living Reform Act may reduce the number of consumer fraud claims. In the event these representations were false in a material way with respect to the services provided to the resident, and those representations damaged the resident, plead this cause of action. New York Gen. Bus. Law § 350-e grants the courts discretion to award attorney's fees and treble damages to a plaintiff prevailing on a consumer fraud or false advertising claim. Additionally, New York Gen. Bus. Law § 349-c provides for civil penalties when consumer fraud or false advertising involves a person 65 years old or older.

Pleading this cause of action may broaden your availability of certain materials during discovery such as marketing research studies, internal memos regarding marketing practices and research, contractual relationships with marketing agencies, etc.

e. Breach of Contract

Upon admission, prospective residents will sign a contract and/or lease. As stated above, you should carefully review this contract for such clauses as arbitration agreements, waivers of liability, and limitations on damages. The theory of a breach of contract cause of action in an assisted living facility will hinge on the facility's failure to fulfill its duty to provide the contracted for services. The challenge to this cause of action is determining the damages caused by the breach. One claim for damages could be to claim all monies paid to the facility, particularly if your client is a private payer. In other cases, you may be able to recover for failure to provide services contracted for that did not cause physical injury. For example, if the facility agreed to perform all laundry services for the resident and failed to do so, the resident may have contracted with an outside agency for this service. Damages would then be easily determined by the cost of the outside service.

f. Premises Liability

When your case involves a fall or a wandering case, it is important to find out who owns and maintains the facility and the grounds. These entities should be named as defendants. For example, the facility may have a contract with a company for all maintenance required. In most instances these companies will be brought in as a third party defendant as they do not have a contractual relationship with your client directly.

Furthermore, as stated above, assisted living facilities are consistently arguing that they have no duty to the resident other than as landlord. In the event a facility is successful in arguing this defense to the court, a resident's complaint will not be entirely dismissed if a cause of action has been plead in premises liability. Even a landlord has liability for those common areas under his control.

VI. Discovery Considerations

a. Depositions

You should be prepared to conduct multiple depositions in these cases. You should also be prepared for some sort of motion from the defendant for a protective order. Defense counsel will argue that these individuals have no relevant information to provide. Be prepared to educate the judge about the complexity of these cases, the statutes and regulations that may apply, and why these witnesses have relevant information. Retaining an assisted living expert early in the case will assist you later in obtaining court approval to depose these individuals.

It is very important that you depose someone that is knowledgeable about the corporate structure of the assisted living facility. This will typically be the owner, administrator or someone from management. It is very important that you establish from this witness who the owners are and their relationship, if any, to the other defendants. I have found that more often than not the same officers or directors that own the facility also own the building and property the facility leases. I have also found that there are common owners for the assisted living facility and the home health care agency that exclusively provides care to assisted living facility residents. I would obtain a copy of all

contracts, agreements, etc., that may exist between these various corporations. Remember, unlike nursing homes that must maintain medical records, many assisted living facilities will have few, if any, records.

While it may be difficult to follow the money, it can be very effective. I have found that there are often layers upon layers of corporations that support one another. For example, I had one case where an owner was also the owner of a consulting company that was paid to provide a consulting service to the facility. If punitive damages are available in your state, it would be crucial to know the corporate structure and to follow the money in order to determine the actual income of the owners.

b. How to Respond to Defendant's Delay Tactics

i. Serve Demands with the Complaint

It is a part of my office routine to serve demands prior to receiving the answer. Included in these discovery demands should be, at a minimum, a demand for the facility's entire record with respect to your client as well as a demand for all of the facility's policies, procedures and protocols. Beyond giving your client the advantage of striking first in discovery, this may also give the defendant the correct impression that you will vehemently prosecute this case and that you have put time and preparation into the matter already.

ii. File R.J.I. upon receipt of the Defendant's Answer

As discussed above, the defendants in these cases are not particularly concerned with moving these matters forward. One way to avoid some of the stall tactics used is to file a request for judicial intervention immediately.

iii. Request Scheduling Order

Once a judge is assigned to your case, request a discovery scheduling order. This will also help to avoid the delay tactics of your adversary. However, it has been our experience that these orders are not necessarily set in stone. Most courts will allow some leeway and others can be downright unresponsive to missed deadlines. This order is still advisable for each case as continued disregard of the deadlines will eventually anger the court and garner an appropriate response such as sanctions or orders of preclusion.

iv. Make all Scheduled Deadlines

A plaintiff should always meet each and every deadline with respect to discovery demands and/or scheduling orders. If anyone is going to miss a deadline, let it be the defendant. This way, when the inevitable day comes that you must submit a motion to compel or preclude, you are able to claim that you have met every deadline set by the court. As they say, let those without sin cast the first stone.

v. Motion to Compel if Defendant has not Responded Timely

As intimated above, if the defendant is consistently missing deadlines or is refusing to answer discovery demands, a motion to compel is the plaintiff's first line of attack. You must be prepared and willing to move the court to compel the defendant to answer these demands. Keep in mind there may be some pre-motion practice that must occur prior to submitting these motions.

vi. Motion for Sanctions

In the event the defendant's attorney is severely abusing the discovery procedures or the deadlines, a motion can be brought for sanctions against the attorney. For example, if an attorney repeatedly interrupts a deposition, makes inappropriate objections, or directs the witness not to answer questions, a motion to compel reproduction of that witness combined with a motion for sanctions should be brought. This will make the defendant's attorney understand that you are serious in the prosecution of the case, even if the court denies your motion.

VII. Settlement Considerations

a. Medicare/Medicaid

Unlike nursing homes, in most assisted living cases you will find that there are no Medicare/Medicaid liens. Medicare will not pay for assisted living facilities and Medicaid will only pay for a small percentage of the cost. Accordingly you will likely have no Medicare/Medicaid liens in these cases. Nonetheless, you should contact the local Medicaid provider, which is typically the Department of Social Services for the county where your client resides and confirm that there are no Medicaid liens. If there are any liens, you should advise the client of the lien and how you intend to resolve it. While most insurance adjusters will tell you that the existence of a lien does not give the case more or less value, a client, however, will want to know the bottom line. After all the expenses, attorney fees, and liens are paid, how much will the client receive? If satisfying the lien will result in none of the proceeds going to the family, then you should use that as a negotiating tactic with the Department of Social Services to seek their

consent to reduce the lien. It is good business sense for the Department of Social Services to reduce the lien. By doing so, there is certainty of payment without the long drawn uncertainty of a trial. If there is a no cause, then the Department of Social Services will get nothing.

You should also investigate whether the facility was paid by insurance. Many insurance contracts provide for reimbursement for expenses the company paid because of someone else's negligence. If an insurance company asserts such a claim, demand a copy of the insurance contract and review it carefully. If you determine that the insurance company has a valid claim to the proceeds, then use the same negotiating tactic that you would use for the Department of Social Services.

I rarely attempt to settle these cases pre-suit. These are complex cases and the carrier will not make an offer until you have established liability. As a result, I typically do not have settlement discussions until most discovery is complete, including depositions.

b. Valuing the Claim

Probably the most difficult aspect to settling these cases is determining their value. Before speaking to the adjuster, I always conduct a verdict search to attempt to find a similar case. I also contact colleagues to determine what they have settled similar cases for.

Most of the value in assisted living facility cases is with respect to past pain and suffering. Accordingly, from the initial interview until the settlement, I cull all of the facts that indicate the resident suffered conscious pain and suffering. I have a discussion

early in the case with the expert and request that they search the record for evidence of pain and suffering. One of the most effective ways of doing this is to determine what, if any, new medications were prescribed and what, if any, increases there were in dosages administered. You should also have a conversation with family and friends that visited the resident to determine if they saw evidence of pain and suffering.

If the resident is alive, the future damages may be very significant. You may have future pain and suffering and medical expenses. There also may be a loss of consortium claim if that is appropriate in your jurisdiction.

One of the benefits of these cases is that they are not medical malpractice cases; therefore, they are less likely to be subject to statutory caps on damages. Additionally, if federal tort reform is passed, it is likely to only affect medical malpractice cases. In that event, assisted living facility cases would still be unaffected.