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Failure to Meet Nurse Staffing Standards: A Litigation Case Study of a Large US Nursing Home Chain

Charlene Harrington, PhD, RN[1] and Toby S. Edelman, J.D.[2]

Abstract

Large for-profit nursing home chains in the United States have generally reported low nurse staffing levels. This historical case study examined a class action litigation case regarding staffing levels, resident rights, and quality outcomes in 12 Arkansas nursing homes owned by a large for-profit chain. The questions were as follows: (1) How did the residents' care needs compare with actual nurse staffing levels? (2) How did the staffing levels compare with federal and state nurse staffing requirements and professional staffing standards? (3) Did the facilities comply with state and federal residents' rights and quality of care requirements? The findings showed staffing levels marginally above state minimum standards, staffing shortages that violated state standards, staffing levels not adjusted for resident acuity, and shortages that resulted in omitted care. Staffing levels were lower than needed according to nursing directors, lower than average facilities in the state, and lower than professional standards. The findings showed many resident grievances regarding basic care and residents' rights, clinical measures of poor quality, and state deficiencies. A large settlement was agreed on to compensate the residents. The case shows that chain's management, as well as the regulatory system, failed to ensure adequate staffing levels that took into account regulatory requirements and professional standards and resulted in violations of residents' rights, health, safety, and well-being.

Keywords
nurse staffing, nursing home chains, litigation, regulation, quality of care, resident rights

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What do we already know about this topic?
Many nursing home staffing studies have shown the positive relationships among staffing levels and resident rights and quality outcomes, but few studies have examined nursing home litigation cases that involve staffing levels and standards.
How does your research contribute to the field?
The study examines a litigation case that challenged a nursing home chain's failure to meet professional standards.
What are your research's implications toward theory, practice, or policy?
Researchers, nursing home managers and owners, and policy makers need to consider professional nursing standards that ensure adequate staffing levels to meet the specific care needs of facility residents.

Introduction

Quality problems have been endemic in nursing homes in the United States.[1-4] Under current government prospective payment systems, nursing homes make choices on how to allocate their resources. About 70% of nursing homes are for-profit facilities with an orientation to maximizing profits for owners and shareholders.[5] The profit incentive is linked to low staffing because for-profit homes and for-profit chains operate with lower staffing and more quality deficiencies (violations) than nonprofit and publicly owned facilities.[6-8] Facilities with the highest profit margins have been found to have the poorest quality.[9] Because federal and state enforcement of nursing home regulations has historically

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been weak in protecting residents,[1-4,10] residents have sometimes used litigation to obtain relief from poor nursing home care.[11,12]

In this study, we examined a class action case that involved the impact of staffing levels on the delivery of care, residents' rights, and quality outcomes in a large for-profit nursing home chain. The plaintiffs were residents of 12 Golden Living nursing homes (hereafter called Golden Living) located in Arkansas during the period of December 2006 through June 2009. The residents alleged that the chain's chronic understaffing practices caused routine and widespread failures to provide quality care and violations of rights in all 12 facilities. The defendants denied the charges, and a lengthy legal process ensued followed by a settlement in 2017.[13,14]

The specific research questions were as follows: (1) How did the residents' care needs compare with actual nurse staffing levels? (2) How did the staffing levels compare with federal and state nurse staffing requirements and professional staffing standards? (3) Did the facilities comply with state and federal residents' rights and quality of care requirements? The study used a single historical case study of the class action against Golden Gate National Senior Care (GGNSC) LLC, which owned Golden Living. GGNSC (formerly Beverly Enterprises) was purchased by Fillmore Capital Partners (a private equity real estate investment trust) in 2006 (for $1.85 billion).[15,16] Golden Living was the third largest for-profit nursing home in the United States in 2016, with 295 nursing homes and more than 30 000 nursing home beds,[17] and is similar to other large for-profit US nursing home chains.[7,15,16,18]

Records were drawn from plaintiff and defendant reports and documents, depositions, and multiple other government sources on resident care needs, staffing levels, regulatory actions, grievances, and quality reports.[13] These documents provide data on the corporate actions, strategies, and outcomes over time. The findings and conclusions should be of interest to nursing home owners, policy makers, researchers, regulators, attorneys, and advocates in addressing staffing and quality issues.

Background

Research on Nurse Staffing

Research evidence on nurse staffing levels and quality. Many research studies have been conducted on nursing home staffing.[19-22] When using complex analytical models and/or longitudinal analyses, research findings consistently show higher staffing levels are related to higher quality of care.[23-25] Higher registered nurse (RN) and certified nursing assistant (CNA) staffing have been associated with improved quality indicators, including physical restraints, catheter use, pain management, and pressure sores.[26] Higher staffing levels and professional staff mix, along with lower turnover and use of agency staff, were found to be associated with higher quality on 15 of 18 measures.[27] The strongest relationship has been found between higher staffing levels and fewer deficiencies (violations of regulations) issued by state surveyors.[22,23,28-30]

Expert recommendations for minimum staffing levels. A Centers for Medicare & Medicaid Services (CMS) study in 2001 established the importance of having a minimum of 0.75 RN hours per resident day (hprd), 0.55 licensed nurse (licensed practical nurse [LVN]/licensed vocational nurse [LPN]) hprd, and 2.8 CNA hprd, for a total of 4.1 nursing hprd to meet federal quality standards.[30] As part of this study, a simulation model was used to determine the minimum number of CNAs needed to provide 5 basic activities of daily living care. The results found a minimum of 2.8 CNA hprd to ensure consistent, timely care to residents.[30] These findings were later confirmed in an observational study.[31]

A more recent simulation study found that 2.8 CNA hprd is needed in nursing homes with low workloads to have less than 10% omissions in care, and 3.6 CNA hprd is needed in nursing homes with high workloads.[32] The simulation evidence clearly established that there are critical ratios of CNAs to residents in nursing homes below which residents have omitted care and are at substantially increased risk of quality problems.[31]

A number of organizations have endorsed the minimum of 4.1 hprd standard, have recommended that at least 30% of total nursing care hours be provided by licensed nurses, and have recommended that RNs should be on duty 24 hours per day.[33-35] Some experts have recommended higher minimum staffing (a total of 4.55 hprd) to improve the quality of nursing home care, with upward adjustments for resident acuity (case-mix).[36]

CMS expected staffing levels adjusted for resident acuity. The CMS Medicare Nursing Home Compare 5-star rating system developed a method to determine what nurse staffing levels are needed for each nursing home based on its resident acuity.[29,30] The CMS calculated "expected hours" of care based on the resident acuity obtained from the Resource Utilization Group (RUG) scores reported by each facility for every resident and CMS's Staff Time Measurement Studies published in 2000.[37-39] The recent analysis by CMS of "expected" staffing levels taking into account resident acuity indicated that the average nursing home should have 4.17 total nursing hprd, including 1.08 RN hprd.[37,39]

Federal and State Staffing Requirements

Federal nursing home requirements. All nursing homes certified for Medicare and Medicaid residents are required to comply with 42 C.F.R. § 483.35 to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.[40] Under these requirements, nursing homes are required to add more staff

when residents require more basic and skilled nursing care. Federal minimum staffing requirements also specify that the director of nursing must be an RN and a full-time employee for 40 hours a week and another RN must be employed for 16 hours a week to ensure coverage 7 days a week (.08 hours for 100 residents). Registered nurses and LVPs/LPNs provide services that require advanced education and training.[40]

All residents must have a comprehensive resident reassessment (minimum data set [MDS]) completed on admission and at least annually and whenever there is a significant change in the resident's condition.[41] The assessments must be completed by an RN in cooperation with the resident's multidisciplinary team and used to develop each resident's individualized, comprehensive care plan. Minimum data set assessments must be submitted quarterly to CMS, and they are used for Medicare payment purposes, which pays more for residents assessed as having higher care needs.

State staffing requirements. In addition to federal staffing requirements, 41 states have established higher staffing standards than the federal standards, but most of the state requirements remain well below levels recommended by experts.[25] The Arkansas Protection of Long-Term Care Facility Residents Act requires that nursing homes comply with the following minimum direct care staffing ratios, determined solely on the basis of the number of residents in the facility (census)[42]:

- Day shift—1 direct care staff to 6 residents and 1 licensed nurse to every 40 residents
- Evening shift—1 direct care staff to 9 residents and 1 licensed nurse to every 40 residents
- Night shift—1 direct care staff to 14 residents and 1 licensed nurse to every 80 residents

The facility must post the daily staffing at the beginning of each shift and sign the staffing sheets and submit a monthly written report identifying all shifts that failed to meet the minimum staffing requirements. The Arkansas Office of Long Term Care (OLTC) may assess a fine for a pattern of staffing violations.[42] All nursing homes are also required to provide sufficient staff to meet the needs of residents on a continuing basis and to adjust direct care staffing levels upward from the minimum standards if residents have higher acuity to meet the needs of residents in the facility.[42] The Director of Nursing is responsible for recommending the number and levels of nursing personnel to meet the needs of residents. Arkansas law and provider agreements require a nursing home to admit only those residents whose needs can be met by the facility.[42]

Methodology

Study design. A historical single-case study was selected for this research because this methodology allows for an in-depth, focused analysis of a nursing home chain. A case study is ideal for examining "what" and "why" questions about a contemporary set of events and allows investigators to analyze real-life events.[43] Standard case study procedures were used to developing research questions and a study design, collecting data, and conducting the analyses. We examined multiple qualitative and quantitative measures to identify confirming and disconfirming evidence.[43]

The data for this article came from voluminous records on file in the Arkansas Circuit Court for the 12 Golden Living facilities over the period of December 1, 2006, through June 30, 2009, with the exception of El Dorado, which was sold in September 30, 2007.[13] Specifically, plaintiffs' counsel conducted 150 depositions in 8 states; reviewed and analyzed thousands of documents, including 180 000 e-mails, 7.5 million time card entries, and 51 million electronic activity of daily living entries, from resident's medical records; and retained and prepared 10 expert witnesses to testify at trial.[44] The data analyses involved the plaintiffs' legal team and a number of experts, including an accounting firm,[45] a team to conduct simulation analyses of resident care and staffing needs,[46,47] as well as medical and other experts.[48] Detailed data as well as reports and summary data from these sources were used by the authors for the article. The data collection focused on 3 major areas described below: (1) resident care needs, (2) nurse staffing levels, and (3) residents' rights and quality of care indicators.

Resident care needs. Two sources of CMS data were used to identify resident care needs: (1) CMS form 672 data reported by each facility to the state at the time of its annual state licensing and certification survey from the On-Line Survey Certification and Reporting System (OSCAR), and (2) monthly CMS MDS resident data from each facility's assessment of each resident at 8 Golden Living facilities on the last day of each month during the 31-month time period.[46,47] While some residents may get worse over time, others improve and are eventually discharged; an average of each resident's monthly status shows the overall resident care needs in the facilities.

Nursing staffing hours. Staffing levels for all RNs, LPNs, and CNAs were determined for the 12 facilities during the period of 2006-2009 from 8 sources: (1) Golden Living's employee time cards, (2) Golden Living's weekly focus reports, (3) minimum staffing reports (MSRs) submitted by Golden Living for each facility to the Arkansas OLTC, (4) all facility MSRs reviewed and corrected by OLTC, (5) Golden Living's time clock adjustment reports which identified nursing staff who did not get a break on their shift, (6) staffing reports (CMS Form 671) made by each facility at the time of annual survey between 2006 and 2009, and (7) depositions and e-mails regarding staffing levels from facility directors of nursing, clinical nurse specialists, and the corporate director of clinical operations.

Residents' rights and quality of care. Arkansas requires facilities to keep a log of all grievances from residents, family, and

other persons by date along with the facility resolution to the grievances and make these available to state surveyors. The grievance logs were obtained from each facility. Arkansas OLTC data were collected on the number of deficiencies and serious deficiencies (those that have the potential for or actually cause harm or immediate jeopardy to residents). Medical records were obtained for 41 residents who were plaintiffs in the class action litigation case. Deposition data and e-mails were obtained for directors of nursing, clinical nurse specialists, and the corporate director of clinical operations.

Analytical plan. The analysis of qualitative and statistical data focused on (1) resident care needs, (2) nurse staffing hours, and (3) residents' rights and quality of care to address each research question. For the resident care needs, a descriptive analysis identified the acuity level of residents in each facility during the study period. The facility workload used each resident's MDS data in each facility, which were based on whether care was needed for 5 basic activities of daily living (ADLs): (1) incontinent and toileting assistance, (2) repositioning assistance, (3) eating assistance, (4) dressing and hygiene assistance, and (5) exercise or range of motion assistance.

The amount of omitted care was estimated using discrete event simulation ("DES"), described in previous research, to calculate the labor burden resulting from a resident's ADL needs quantified through simulation, applying minimum, maximum, and mode times for each ADL task.[32] The simulations of the staffing levels necessary to provide ADL care were estimated using the time needed for each of the 5 basic ADL tasks after categorizing residents into 7 workload categories from lightest to heaviest care using Golden Living resident MDS assessment data.[32] The *actual CNA hours worked* at Golden Living on each day and shift (based on time card data) were used in the simulation and compared with the CNA *hours that were needed* to deliver the basic care.[46,47]

To calculate the actual staffing hours, descriptive statistics were compiled from each facility over time from the employee time cards, weekly focus reports, and MSRs submitted by Golden Living to determine the total number of RNs, LVNs, and CNAs on a per day and per shift basis divided by the census data to compute hprd. The data were used to examine staffing on the specific shifts that each facility reported it failed to comply with state minimum staffing ratios.[45] The MSRs reviewed and corrected by OLTC showed each shift where a facility had not reported a violation of state minimum staffing ratios or "short staffing." Finally, Golden Living staffing data were compared with the average nursing home in Arkansas, with staffing levels recommended by experts, and with staffing levels that CMS expected based on resident acuity.

Each nursing facility's number and type of grievances and facility responses to these grievances were summarized and analyzed. Descriptive data on the number of deficiencies and serious deficiencies were analyzed, as well as the medical records for 41 plaintiffs.[48] Deposition data and e-mails were summarized and categorized for directors of nursing, clinical nurse specialists, and the corporate director of clinical operations to identify quality of care problems and responses to complaints about quality problems and understaffing and whether these resulted in a change in staffing levels at facilities. Because these descriptive quality indicators were not available from other nursing homes in Arkansas, we examined whether the residents' rights and quality problems identified at Golden Living facilities were related to the staffing levels identified in Golden Living facilities.

Findings

Resident Care Needs

Using data from CMS (Form 672s) from the 12 facilities, residents had high needs for bathing (97% needed assistance or were completely dependent), dressing (87%), transferring (78%), toileting (82%), and eating (60%) in the 2006-2009 period (no table shown). Of the total residents, 57% had bladder incontinence, 50% had bowel incontinence, 27% needed help from staff with ambulation, 18% had contractures, and 50% were chairbound. In addition, 38% of residents had dementia, 58% had depression, 25% had psychiatric disorders, and many residents had pressure ulcers (5.7%), pain (24%), weight loss (6%), and psychoactive medications (66%).

The analysis of MDS resident data from 8 Golden Living facilities at the end of each month over 31 months showed that on average, 91.8% of residents needed assistance with toileting, 91.7% need assistance with repositioning, 96.2% need assistance with transferring, and 94.1% needed assistance with transferring (Table 1). In addition, 30% required the assistance of 2 staff members for toileting, repositioning, and transferring. In addition, 37% of residents had swallowing difficulties that required additional time for eating assistance. These overall data showed that Golden Living residents had high needs for basic care.

Staffing Levels

Average staffing hours were marginally above the state minimum requirements. Table 2 shows the staffing hours from weekly focus reports (excluding administrative nurses). The average CNA staffing was 2.08 hprd and total direct care nursing staffing was 2.98 hprd. The average total direct nursing care reported to the state on Minimum Staffing Reports (MSRs) and corrected by the state OLTC was slightly lower (2.93 hprd). Thus, these facilities had total nurse staffing at close to or marginally above the lowest staffing ratios permitted by Arkansas law (a total of 2.78 hprd).

Shift staffing reports showed many shortage of CNAs and violations of state standards. Table 3 shows staffing on Golden Living facilities self-reports (in the MSRs submitted to OLTC) were

Table 1. Average Percentage of Residents With Care Needs Obtained From MDS Data for Each Facility Over 31 Months (December 2006 Through June 2009).

Facility name	Average resident census (N)	Toileting/ changing	Repositioning	Transferring	Feeding	Heaviest workload (categories 4, 5, 7)	2-person assistance (toileting, repositioning, transferring)
Arkadelphia	92	82.8	82.8	96.3	90.2	82.8	28.2
Camden	59	89.8	89.7	92.6	89.9	89.7	21.6
El Dorado (December 1, 2006-June 30, 2007)	55	98.3	89.2	99.7	99.7	98.2	16.0
Harrison	74	89.0	88.8	91.1	89.5	88.8	38.3
Heber Springs	87	89.1	89.0	95.4	93.0	89.0	39.9
Hilltop	113	95.2	95.2	98.9	98.9	95.2	49.3
North Little Rock	116	94.4	94.0	96.1	93.1	94.0	20.1
Rogers	87	95.9	95.9	99.6	98.8	95.9	28.5
Average	85.5	91.8	91.7	96.2	94.1	91.7	30.2

Source. MDS summary data derived from monthly snapshots on all active residents on the last day of each month from each facility obtained from Centers for Medicare & Medicaid Services (CMS). El Dorado reports were from December 1, 2006, to June 30, 2007.
Note. MDS = minimum data set.

Table 2. Golden Living Facility Reports of Average Direct Caregiver Hours Based on Weekly Focus Reports, MSR Hours, and Budgeted Nursing hprd for 2006-2009.

Facility	Average CNA hprd from weekly focus reports	Average total nursing hprd (RN + LPN + CNAs) from weekly focus reports	Average total direct care hprd (RN + LPN + CNAs) from MSRs	Average total nursing hprd budgeted
Arkadelphia	1.97	3.00	2.98	3.13
Camden	2.28	3.07	3.0	3.16
Crossett	2.13	2.89	2.87	2.97
El Dorado	2.07	3.00	2.97	3.08
Harrison	2.08	3.05	3.04	3.15
Heber Springs	1.99	2.87	2.86	3.02
Hilltop	2.11	2.93	2.88	3.08
Hot Springs	1.97	2.98	2.95	3.07
McGehee	2.01	2.90	2.84	3.04
Monticello	2.11	2.97	2.98	3.10
North Little Rock	2.13	3.05	2.90	3.06
Rogers	2.12	3.03	2.95	3.06
Overall average	2.08	2.98	2.93	3.08

Source. Golden Living Weekly Focus Reports, Minimum Staffing Reports (MSRs) reported to the Arkansas Office of Long Term Care, and total budgeted nursing hprd. El Dorado data were for December 1, 2006, to June 30, 2007.
Note. hprd = hours per resident day; CNA = certified nursing assistant; RN = registered nurse; LPN = licensed vocational nurse.

short on CNAs to provide direct care on 3087 shifts and total minimum staffing ratios for total direct care nursing staff were violated on at least 3119 shifts. The OLTC-corrected MSRs revealed that Golden Living facilities were short on CNA staffing on 6260 shifts and that the facilities violated minimum staffing ratios for total staff on 3561 shifts during the 2006-2009 period. Moreover, the shortages and violations occurred in all 12 Golden Living facilities over the time period.

Arkansas OLTC issued deficiencies for inadequate staffing. Throughout the class action period, the Arkansas OLTC issued a total of 53 staffing deficiencies across the 12 facilities and documented specific shifts and days when the facilities had inadequate staffing. Sometimes the pattern of short staffing was for more than 20% to 45% of the shifts, and some fines were issued.

Staffing levels were lower than average facilities in the state. Golden Living facilities had staffing levels that were far lower than the average nursing facility (excluding hospital-based facilities) in Arkansas. Specifically, Golden Living's self-reported average CNA hours were 2.18 hprd compared with an average of 2.66 in Arkansas facilities (or 81% of average) in 2008 (which was similar to the hours in 2007). In

Table 3. Number of Golden Living Shifts With CNA Short Staffing and Total Minimum Staffing Ratio Violations Reported by Golden Living and Identified by Arkansas Office of Long Term Care in 2006-2009.

Facility name	Number of shifts GL reported with CNA shortages	Number of shifts GL reported with total staffing violations	Number of shifts OLTC found with CNA shortages	Number of shifts OLTC found with total staffing violations
Arkadelphia	309	311	331	328
Camden	253	253	282	281
Crossett	369	372	679	444
El Dorado	98	98	149	114
Harrison	211	224	411	238
Heber Springs	285	291	374	338
Hilltop	326	328	1014	410
Hot Springs	310	310	461	310
McGehee	232	237	276	283
Monticello	138	139	186	186
North Little Rock	250	250	913	298
Rogers	306	306	1184	331
Total	3087	3119	6260	3561

Source. Facility submitted MSRs and OLTC reviewed MSRs. El Dorado reports were from December 1, 2006, to June 30, 2007.
Note. CNA = certified nursing assistant; GL = Golden Living; OLTC = Arkansas Office of Long Term Care; MSRs = Minimum Staffing Reports.

addition, the Golden Living reported average total nursing, including the administrative nurses, was 3.42 hprd compared with 3.93 for all Arkansas facilities on December 31, 2008 (or 87% of average).

Resident acuity compared With CNA staffing hours showed omitted care. The simulation model for resident dependency (acuity) compared CNA actual staffing hours with needed CNA hours. For example, during the 31-month period under study, DES testing showed that the Arkadelphia facility had an estimated 168 386 hours of basic care that were omitted (see Figure 1.).[46,47]

Overall, the 8 facilities, including Arkadelphia, examined during every day of the class period (December 2006 through June 2009) had omitted an estimated 33% to 58% of the basic care hours needed by the residents (no figure shown). The cumulative gap between CNA labor hours needed and CNA actual labor hours exceeded 1.2 million hours across the 8 facilities. These findings were consistent with findings from the CNA charting for every resident on each shift, which revealed a high rate of undocumented ADL care. The average missing documentation was 15.6% across all shifts for the facilities reporting, with an overall range of 2.6% to 31.5%.

Staffing levels were below the expected staffing calculated by CMS. In 2009, CMS's 5-star nursing home compare report card calculated that "expected" staffing levels taking into account resident acuity for 11 Golden Living facilities should have been 0.99 RN hprd and 3.96 total staffing hprd (no table shown). The staffing hours reported to CMS were far below this level (0.37 RN hprd and 3.48 total staffing hprd in 2009). Reported RN staffing was only 37% of expected staffing.

Staffing levels were below the levels recommended by experts. An examination of the staffing levels showed that Golden Living facilities did not meet staffing levels for minimum care recommended by scientific studies and the Institute of Medicine recommendations. On average, the facilities ran 15% below the recommended total minimum staffing levels for RNs, LPNs, and CNAs. The total nursing average was 3.48 hprd, compared with the recommended minimum of 4.10 hprd, and CNA staffing was 2.09 hprd, compared with the recommended minimum of 2.80 CNA hprd. Registered nurse staffing (0.37 RN hprd) was only 49% of the minimal level recommended by experts (0.75 hprd recommended).

Staffing levels were inflated. Three data sources suggested that Golden Living inflated its staffing reports to the state. First, CNA staffing levels reported in the MSRs were inflated on 17 336 shifts across the 12 facilities when compared with employee time cards. Second, a total of 394 time clock adjustments at Golden Living data facilities were submitted because nursing staff were not able to take meal breaks related to "insufficient staff." In addition, 69% (270) of the 394 time clock adjustments for short staffing were not reported by Golden Living as short staffing on its MSR shift reports. Third, e-mails at different facilities reported that the company increased nursing staff during its annual state surveys by bringing in staff from other facilities and available managers. Staff members were asked to come early and stay late (and sometimes skip meals), and some put in 12-hour shifts while surveyors were in the facilities. Department heads and managers were asked to stay on the floors and out of their offices and to immediately address surveyor concerns. At least 17 e-mails in 2006-2008 were identified from

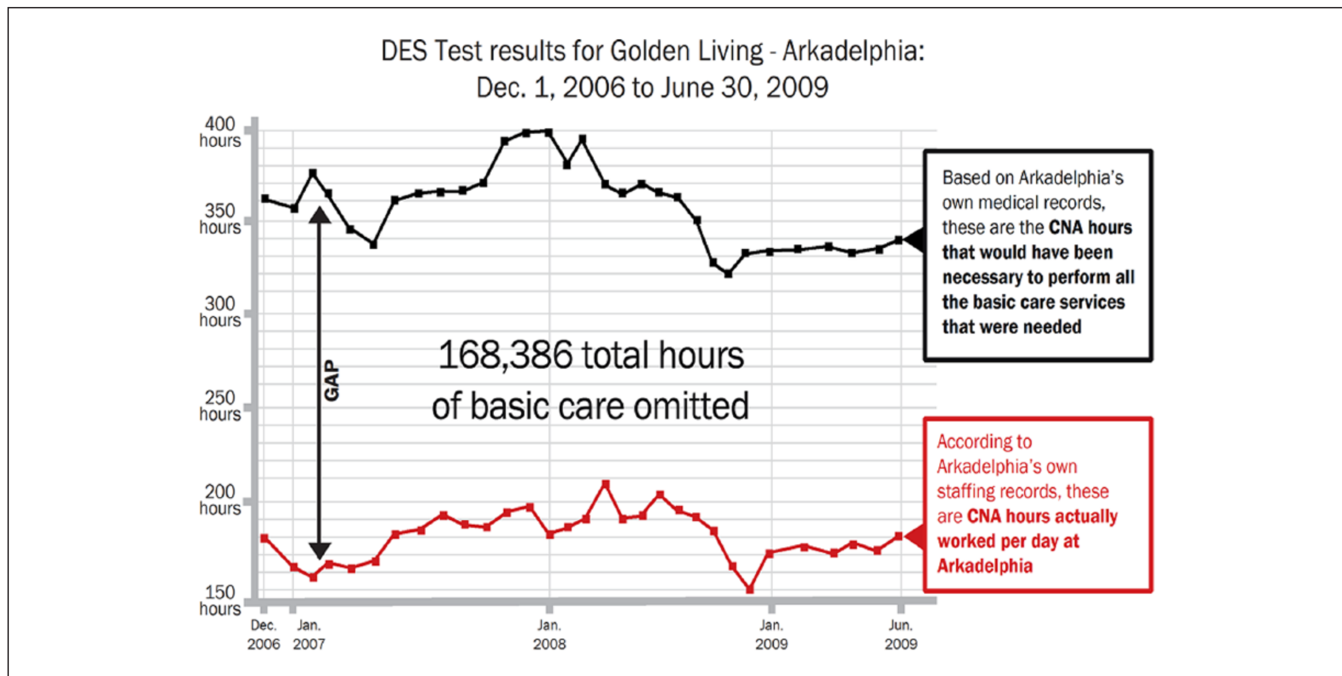

Figure 1. Discrete event simulation (DES) test results for Golden Living—Arkadelphia, December 1, 2006, to June 30, 2009.

corporate leaders regarding staffing up and adjustments for the state surveys.

Nurse staffing levels were not adjusted for resident acuity. A review of Golden Living's policies and procedures found no policies, procedures, instruments, or staffing acuity tool for adjusting the numbers of staff to meet the needs of residents or for taking into account changes in resident acuity. Depositions of 4 directors of nursing and 2 clinical service directors confirmed the absence of procedures or a staffing acuity tool for adjusting staffing to meet residents' acuity/care need levels. Numerous e-mails between the Golden Living facilities and corporate managers revealed that staffing was based on census, not on acuity, and each facility's budgeted staffing. Deposition testimony of directors of nursing reported that the staffing budgets were not based on or adjusted for resident acuity.

Nurses reported frequent understaffing and poor quality care. In depositions, 7 directors of nursing reported that their facilities were understaffed and that it resulted in many staff and resident complaints and poor quality of care. They stated that they reported understaffing to the corporate Director of Operations and asked for more staff, but they were not given additional staffing. Depositions by 3 Clinical Service Consultants who worked directly for the corporate office reported they were aware of facilities repeatedly violating the Arkansas minimum staffing regulations, that facilities were frequently understaffed, and that residents and staff made many complaints. They also reported that the corporate Director of Operations was aware of the understaffing and state violations but that the Director did not agree to increase facility staffing levels or the staffing budgets.

Directors of nursing lacked authority to adjust staffing. Arkansas law required that the directors of nursing be involved in the determination of the numbers of nursing personnel and recommend these numbers based on the needs of residents. Deposition testimony of 3 Golden Living directors of nursing reported they had no authority or involvement in staffing decisions. These directors of nursing and 2 clinical service consultations reported that only the corporate Director of Operations had the authority to increase staffing levels.

Residents' Rights and Quality of Care

Facilities received frequent grievances. There were extensive complaints and grievances filed with Golden Living nursing facilities by residents and their family members and/or caregivers. Out of a total of over 3000 grievances reported, more than 700 grievances were filed by families or residents about lack of staff, basic care, and skilled care that occurred in the 12 facilities over time. According to 2 directors of nursing, the grievances produced by Golden Living to the Court represented only a small portion of the total grievances received by facilities.

The most serious grievances involved failures to provide basic care, including many call lights not being answered in a timely manner and residents not being assisted to the toilet when needed, resulting in incontinence of bowels or

bladder and residents being left in urine and feces for long periods of time. Resident grievances also included not being cleaned and bathed properly or as scheduled, being left in the same soiled clothes for several days, beds that were not made, linens that were often not changed, and bad odors in the rooms and hallways (urine and feces odors). Other grievances were about residents being left in bed and not helped to get up and dressed, poor oral care (including not brushing residents' teeth), not washing and caring for residents' hair, not turning and repositioning every 2 to 4 hours, and not provided assistance with walking. Some residents filed grievances about the lack of adequate assistance at meal times with food and drinks reporting they often did not get enough to eat and drink and did not receive water and fresh water at the bedside. Although the complaints about poor basic care indicated a shortage of CNAs and poor supervision, most resolutions to the grievances were reported by the facilities as planning to give more in-service training to the CNAs.

Grievances about licensed nursing care included not giving pain medications in a timely way, poor pain management, and not giving other medications on time; not sending patients to the hospital soon enough; and not notifying the family members and physicians about changes in conditions, hospitalizations, emergency visits, and appointments. Complaints about the development of skin tears and pressure ulcers were reported along with problems of dirty bandages, and colostomy and catheter bags not being changed. Finally, rudeness and abrasive comments by CNAs and licensed nurses to residents were reported. In addition to written grievances, there were telephone hotline calls regarding understaffing and poor care. Although the grievances at Golden Living facilities could not be compared with grievances at other Arkansas facilities because electronic records were not kept, the grievances identified staffing and quality problems in the Golden Living facilities.

State surveys found problems with quality of care. The Arkansas OLTC issued many deficiencies for poor basic care that violated resident dignity and were associated with inadequate staffing. These deficiencies included the failure to prevent pressure sores and skin breakdown, inadequate assistance with transfers that could result in accidents and injury, inadequate toileting and incontinence care, inadequate bathing and dressing and grooming, inadequate assistance with resident transfers in lifts that caused or could have caused harm and jeopardy, and failure to protect the dignity of residents. The deficiencies cited by OLTC ranged from no actual harm to immediate jeopardy for residents, and many were directly and indirectly related to understaffing. Specifically, El Dorado and North Little Rock were issued immediate jeopardy deficiencies for violating the accident and supervision requirements related to the physical transfer of residents in lifts, a fine was imposed, and a finding of substandard care was issued. These state deficiencies for poor quality were consistent with the low staffing levels reported by Golden Living facilities.

Medical records of residents showed serious quality problems. An expert review of 41 class action residents' medical records showed serious quality problems.[49] These problems included pressure ulcers, contractures, falls, injuries, infections, and other conditions or outcomes regarded by CMS as quality indicators. There were many violations of residents' rights, including the failures to treat pain, failures to notify the treating physician of significant changes, failures to comply with physician's orders, and failures to provide nursing intervention in response to fall risk, weight loss, and skin breakdown. After a posthospital procedure, 1 patient who was groggy from sedation later died of aspiration pneumonia and a broken hip after falling from his wheelchair when he should have been kept in bed and not fed. Many problems identified in the medical records were not reported on the MDS assessments, suggesting deliberate underreporting by staff of quality indicators to CMS.

Previous lawsuits. During the period of 2006-2012, a total of 92 individual lawsuits were separately filed in Arkansas counties against the 12 Golden Living facilities for low staffing and poor quality of care. Although data were not available on the number of lawsuits in other Arkansas facilities, these cases clearly constituted a warning to management about quality problems in its Golden Living facilities.

Corporate leaders knew that staffing levels were insufficient. Golden Living nursing home administrators and the Arkansas Corporate Offices received a number of warnings about understaffing in the 2006-2009 period, which included the short staffing reports, survey deficiencies, e-mails reporting understaffing, and the grievances and deficiencies the facilities received. The corporate knowledge of the problems was confirmed by numerous e-mails between local facility staff and corporate supervisors and in depositions by directors of nursing, clinical service directors, and the facility administrators. Data from depositions of Golden Living nurses linked the quality concerns to low staffing levels. A review of the corporate e-mails revealed corporate pressure to keep staffing levels at or below budget.

In addition, Clinical Service Consultants conducted routine facility visits and facility performance assessments (in part to prepare for state surveys) and reviewed monthly facility scorecard reports sent to them by facilities. The visits, assessments, and scorecard reports showed repeated problems at the Golden Living facilities with falls, pressure sores, weight loss, failure to respond to grievances, failures to provide skilled and basic care, and other quality of care issues. The Clinical Service Consultants prepared reports from their routine facility visits and facility performance assessment that were sent to each facility and corporate Director of Operations. The Clinical Service Consultants

reported the clinical problems were related to low staffing in the facilities as well as poor training and supervision.

Admissions were not reduced when understaffing was reported. Frequent e-mail evidence showed that corporate management exerted consistent pressure to increase the census at all Golden Living facilities. According to depositions by directors of nursing at facilities as well as the marketing directors, there was no self-imposed cut-off of resident admissions regardless of the staffing levels at facilities. Many corporate e-mails encouraged facility administrators to admit residents, even when facilities had staffing violations and shortages. Corporate officials designed and implemented financial bonus programs as incentives to facility leaders to build their census, including payments for every resident admission, with additional bonuses for reaching certain census levels. The resident admission records show that facilities continued to admit residents throughout the class period (with a total of 2219 admissions between December 2006 and June 30, 2009).

Litigation Action and Settlement

In the class action, plaintiffs alleged that Golden Living violated 3 specific requirements: (1) Arkansas Deceptive Trade Practices Act (Ark. Code Ann 4-88-101 et seq), (2) the Protection of Long Term Care Facilities Residents' Act (Ark Code Ann Section 20-10-1201 et seq), and (3) the Defendants' standard admission agreement.[13] The complaint charged that these violations occurred because the nursing homes failed to meet the minimum staffing requirements and violated residents' rights, causing injury to the residents of the facilities. The defendants denied the charges and argued that plaintiffs legally failed to state a claim for punitive damages and failed to establish a prima facie case for punitive damages. The defendants argued that the plaintiffs failed to connect any alleged understaffing to patient outcomes, that the facilities did not repeatedly violate Arkansas staffing laws, and that there was no intentional concealment or false representation to the state OLTC.[49]

Following a lengthy 5-year legal process, a settlement agreement was reached in 2017 for a total of $71 986 816 which included a cash payment for each class member's duration of stay multiplied by the subject days ($55 per patient day × 877 040 patient days or $48 237 000) and $5000 for the contribution of each of the class representatives. In addition, the defendants also agreed to pay $19.295 million in attorney fees and $4.2 million for litigation expenses.[14]

Summary and Discussion

This case study showed a chain with 12 facilities where resident care needs were high and nurse staffing levels were too low to meet the needs of residents. Although Golden Living gave the appearance of complying with federal and state staffing requirements, a careful review found the facilities did not meet the minimum state staffing standards, did not provide sufficient care to meet basic resident needs, did not adjust staffing for resident acuity, and did not meet the necessary nurse staffing levels shown in research and recommended by experts. As a result, residents experienced many quality of care problems, injuries, and deaths, as well as violations of their rights to human dignity.

The low staffing at Golden Living was similar to staffing reported at other large for-profit chains that have been documented to have the lowest staffing levels of any ownership group. Many large for-profit chains appear to use low staffing as a basic corporate strategy for making profits.[7,8,12,15,16,18] This case study should be a cautionary tale that nursing home companies with understaffing are legally responsible for the negative effects on residents. Nursing homes must meet the federal requirements to meet the needs of its residents as well as professional standards to ensure adequate quality of care.[30-35]

Although the staffing levels in the 12 Golden Living facilities were lower than the average nursing home in Arkansas, this study could not determine whether the grievances, deficiencies, medical record review, and litigation history at Golden Living were substantially worse than other comparable facilities in Arkansas. Certainly, the descriptive information showed a pattern of violations of residents' rights and harm and jeopardy to residents associated with its low staffing levels.

In the Golden Living case, the state OLTC documented frequent violations of the state staffing law and issued some penalties and warnings. The penalties imposed were not as strong and not issued as frequently as allowed under the state law. The lack of effective enforcement by state officials allowed the understaffing to persist in the Arkansas Golden Living facilities over the 2006-2009 period. Arkansas' weak regulatory enforcement was consistent with studies that show deficiencies for inadequate staffing levels are rarely issued by state inspectors, and CMS does not have guidelines for penalties for staffing violations.[1-4,10,12] The regulatory failure to ensure adequate staffing and quality in this case had a detrimental impact on residents and led to the class action litigation. Although the settlement of the lawsuit resulted in a large financial penalty to Golden Living, the management employees were not held accountable for the low staffing and poor quality of care. These management employees included the Arkansas Director of Corporate Operations, the Clinical Nurse Specialists, the nursing home administrators, and the nursing home directors of nursing. If the Arkansas regulatory system had more clearly identified the low staffing and quality problems at the time they were occurring, stronger sanctions could have been imposed, including fines for violations and holds on resident admissions. Stronger sanctions may have forced the corporation to hold employees accountable and to take action to improve the staffing.

The findings showed that corporate management was aware of the staffing and quality problems in its facilities from facility reports by managers as well as from regular clinical reviews of residents conducted by corporate Clinical Nurse Specialists, but management actions were not taken to make substantial improvements. Some management practices appeared to contribute to the facility problems, including failure to delegate staff budgeting and management to the facility directors of nursing, verbal pressures from corporate leaders along with financial bonuses to administrators to keep each facility's resident census high and to stay under the corporate staffing budget for each facility, allowing facilities to fall below the state minimum staffing requirements and to inflate their staffing reports, failure to establish a system to determine staffing needs and to set staffing based on resident care needs, and failure to address the quality problems identified by the chain's own Clinical Nurse Specialists, the grievance system, and the state deficiencies.

With the regulatory and management failures in this case, litigation was an option that was eventually used by residents. Although lawsuits represent a potential or actual threat, the impact of litigation on chains may not be as great as might be expected because many chains have liability insurance. Moreover, large chains have extensive legal and financial resources that can be used to fight and prolong litigation cases, making such cases financially challenging to plaintiffs and their attorneys.[12] An aggressive defense may deter plaintiffs, but it may also have deterrent effects on the defense when it is expensive to mount. One corporate strategy for nursing homes with quality and or litigation problems appears to be to sell troubled facilities. A recent study reported that nursing homes that had a transaction (a sale, acquisition, or merger) during the 1993-2010 period were more likely to have deficiencies preceding and following transactions than nursing homes with common ownership.[50] After the class action case was filed, Golden Living sold 13 Arkansas nursing homes in 2009 but remained liable for the actions of its facilities before they were sold.[51] Golden Living also sold 10 nursing homes named in a 2015 lawsuit by the Pennsylvania state attorney general,[52] and recently, the chain reported divesting its operating interest in nearly 200 nursing homes across the country, leaving only about 100 facilities under its management.[53] Because poor quality nursing homes owned by chains are more likely to be involved in sales, researchers have urged greater government regulatory oversight of chains, along with improved ownership reporting and transparency.[7,8,12,50]

The settlement in this Golden Living case has significance beyond its recognition that nursing facility residents who did not receive the care and services needed should receive meaningful compensation. The settlement more broadly illustrates the importance of both professional standards of practice in determining staffing needs at nursing facilities and the new facility assessment process that is required by the revised Medicare and Medicaid Requirements of Participation[54] nationwide.

Since 1991, the nursing standard in the Requirements of Participation has required each nursing facility to have "sufficient nursing staff . . . ."[40] The revised Requirement expands on this language and now provides (new language underlined) that

> The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).[55]

The new facility assessment process, which CMS describes as "a central feature" of its revisions to the Requirements,[55] requires the facility "to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies" and to address, specifically, among other factors, "The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population."[54]

The CMS does not contemplate a one-size-fits-all staffing pattern; it does not mandate uniform staffing ratios that all facilities must meet. Instead, CMS requires facilities to use professional expertise to determine both the specific care and services their residents need and how they can competently meet those individual resident needs.

The Golden Living case shows that rigorous analysis by professional nurses is essential to determining adequate and appropriate nurse staffing levels and competencies. Going forward, nursing facilities must provide nursing staff to ensure that all residents receive care and services to attain and maintain their highest practicable level of functioning and well-being. In the future, nursing homes with low staffing and poor quality may find themselves facing increased risk for regulatory actions and litigation.

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