New York Nursing Home Regulatory Changes 2021

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Hurwitz & Fine, P.C. has extensive experience defending malpractice claims against health care professionals and practice groups, rehabilitation centers, long term and short term adult care facilities. We vigorously protect and defend physicians, clinicians, dentists, nurses and other health care providers in the full range of litigated matters.

Overview

-Statutory Regulations Enacted in 2021
-Purpose of the New Regulations
-Practical Implementation of Regulations for Nursing Home - Facilities
-Penalties for Failure to Comply
-Potential Effects of Regulations on Litigation

Statutory Short Form Power of Attorney (POA)

Adds §5-513 to the General Obligations Law, in effect as of June 13, 2021. Last updated in 2010, the prior POA Form was considered complicated, unduly burdensome to prepare, and prone to improper execution.

- We have often seen defendants' motions for summary judgment denied over issues such as whether the principal and/or signatory understood the form, whether the form had been completed accurately, and whether the POA had been reasonably accepted or refused.

This new law makes several changes to simplify the document, including:

- Allowing 'substantially compliant' language rather than requiring exact wording throughout;
- Providing 'safe harbor' provisions which shield a facility from liability if they accepted a POA form in good faith, without actual knowledge that the signature was not genuine;
- Permitting sanctions against an individual or entity (such as a bank or financial institution) that unreasonably refuses to accept a valid POA;
- Enabling a person to sign at the direction of the principal if he/she is unable to sign; and
- Allowing agents to gift up to $5,000 per year without requiring modification to the form.

The new changes in the law will not impact the validity of an existing POA executed in accordance with the provisions of the current law.

Practically, this is an easily implemented change that should reduce confusion, thereby reducing litigation and unfavorable defense decisions.

Publication of Nursing Home Ratings, Complaints, and Violations

Amid the COVID-19 Pandemic, there has been a public call for greater transparency of nursing home ratings and violations, prompting the passage of two new regulations. Proponents of the Bills said residents and loved ones should be able to review the service rating and prior violations of a facility so they can make an informed choice, likening the process to restaurants that receive service reviews.

Transparency of Violations s.3185

- Adds §2803(13) to the Public Health Law
- In effect as of October 1, 2021
- Requires residential healthcare facilities, as part of the intake application process, to disclose in writing – via a separate document – to potential residents and their representatives, the website where a list of complaints, citations, inspections, enforcement actions, and penalties taken against the facility can be found.
- Violations found on inspection would likely be resolved by the issuance of a citation from the Department of Health (DOH) and the submission of a Plan of Correction by the facility.
- Practically, this should be easily implemented and should have little effect on litigation as this information is already publicly available.

Publication of Nursing Home Ratings s.553

- Adds §2808-e to the Public Health Law
- Takes effect on January 8, 2022
- Requires that the most recent Center for Medicare and Medicaid Services (CMS) rating of every nursing home be prominently displayed on the homepage of the DOH's website and at each nursing home facility's website and displayed at the facility for view by the general public.
- Violations found on inspection – e.g. where a facility displays an older, more favorable review instead of the most recent one - would similarly be resolved by the issuance of a citation from the Department of Health (DOH) and the submission of a Plan of Correction by the facility.
- Practically, this regulation should also be easily implemented by updating the facility's website and displaying their rating at their public notice area.
- As the regulation is enshrined in the Public Health Law, violation could theoretically allow for punitive damages, but it is unlikely that violation of this regulation could result in injury warranting those damages.

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Compassionate Care-Giving s.614A

Adds §2801-h to the Public Health Law and §261-u to the Social Services Law, in effect as of June 1, 2021.

During the COVID-19 pandemic, concerns were raised that de-facto caregivers had been unjustly denied entry to nursing homes, leading to isolation and depression of residents. This Bill now allows compassionate caregiving during times when usual visitation is not appropriate.

Residents are entitled to designate at least two 'personal care-giving visitors' comprising of family, close friends, or legal guardians. The Bill also expands the definition of "compassionate care visitation" to allow for not only end-of-life situations, but also in response to the marked decline of a resident's physical, mental, or emotional wellbeing.

- A marked decline may be indicated by conditions such as depression, increased confusion or cognitive decline, weight loss, or various other changes that signify a negative turn in physical or psychosocial health.

The Bill does list several exceptions to the above:

- A facility may require a written statement from a residents' physician, registered nurse, licensed clinical social worker, psychologist, or psychiatrist, stating that the personal caregiving will "substantially benefit the resident's quality of life…[and] that the personal caregiving visitation will enhance the resident's mental, physical, or psychosocial wellbeing."
- A facility may temporarily suspend or limit personal caregiving. If this occurs, the facility must notify all residents, personal caregivers, and the DOH within 24 hours. For each day of suspension/limitation, the facility must document the specific reason in their administrative records and must provide a means for remote visitation. Personal caregiving may be temporarily suspended or limited in the event of:
    - §A Public Health Emergency related to a communicable disease, and the DOH determines the local infection rates are at a level that presents a serious risk of transmission within local facilities;
    - §The facility is experiencing temporary inadequate staffing which has been reported to the DOH;
    - §An acute emergency situation exists at the facility (e.g. loss of heat, elevator service, or other essential service); or
    - §A caregiver is likely to pose a threat of serious physical, mental, or psychological harm to the resident(s) or facility personnel. This must be documented in the resident's individualized comprehensive plan of care and the resident and other designated representative(s) must also be advised.

Practically, this may mean increased staff to oversee visitation if outwith usual visitation hours, but otherwise it should be implemented without issue.

If failure resulted in litigation, substantial punitive damages may be awarded if the violation caused injury e.g. where documentation shows that a resident is grieving the loss of a loved one and can only be encouraged to eat by a designated caregiver, who is denied access, leading to the resident's malnourishment and acute injury.

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Transfer, Discharge, Voluntary Discharge s.3058

Adds §2803-z to the Public Health Law, in effect from March 19, 2021.

The proponent of the Bill cited a New York Times article which stated that residential health care facilities were inappropriately releasing residents to homeless shelters and other temporary accommodations, despite those facilities not being equipped to continue care for those individuals. Discharge or transfer of a resident is now only appropriate where:

- It is necessary for the health, safety, or welfare of the resident(s);
- The facility discontinues operations; or
- The resident has failed to pay or to arrange payment for their stay.

Prior to initiating discharge or transfer, a facility must use its "best efforts" to secure appropriate placement or a residential arrangement for the resident other than temporary housing assistance (so a resident should not be transferred to a family shelter, shelter for adults, hotel, emergency apartment, domestic violence shelter, or safe housing for refugees).

A resident shall not be transferred to the home of another individual without that individual's written consent, and the facility must also ensure that individual has received and acknowledged the comprehensive discharge plan to address the resident's needs.

At least 30 days prior to discharge or transfer of a resident, the facility must notify the resident, their lawful representative(s), a family member if known, and the long-term care ombudsman (unless discharge/transfer is because the resident cannot be cared for safely or is a danger to others). If the discharge or transfer is initiated because a facility cannot meet the needs of the resident, the resident's clinical record must document:

- The specific needs that could not be met;
- The facility's attempts to meet those needs; and
- The services available to meet those needs at the receiving facility/household.

Practically, facilities should be implementing these standards already and should not be transferring residents to locations where their needs cannot be properly met.

As this regulation is enshrined in the Public Health Law, violation could result in significant punitive damages e.g. where a facility discharges a resident to a temporary shelter without confirming that the resident's medical needs could be met, and the resident suffers injury.

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Common and Familial Assets or Services s.4893A

Amends the Public Health Law §2801-a to include subdivisions 2-b and 3-b, -In effect from April 24, 2021.

This Bill was proposed in response to the public call for enhanced transparency around related assets and operations of nursing home facilities and owner/operators amid the COVID-19 pandemic.

The owner/operator of a nursing home facility is already required to notify the DOH of any common or familial ownership of any corporation, entity, or individual that provides services to the facility.

- The new Bill requires that this information must also be provided to prospective residents, existing residents, residents' representatives, and facility staff.
- The Bill also requires owner/operators to give a 90-day Notice to the DOH prior to entering into any new common or familial ownership as above.

Practically, this will result in additional paperwork and notifications to the DOH and may also result in potential restrictions to using services of choice if commonly or familiarly owned.

While the practical implications are relatively minor, this Bill does give us cause for concern. We are seeing a rise in plaintiffs filing litigation against not just nursing home facilities, but also affiliated corporations and owners/operators personally and individually. Any sense of impropriety regarding a facility's income and assets or use of services – even where such actions taken were entirely legal – could be a difficult barrier to overcome with a jury and raises the risk of significant plaintiff verdicts. It is therefore imperative that facilities comply with this statutory regulation to avoid the appearance of having 'something to hide'.

Standard Staffing Levels s.6346

Adds §2895-b to the Public Health Law, in effect from January 1, 2022.

The catalyst for this Bill was a report from the State Attorney-General which found that nursing homes with low staffing ratings had higher fatality rates during the COVID-19 pandemic. The Bill requires nursing home facilities to employ enough staff to provide each resident with 3.5 hours per day of direct care.

- Two thirds of the mandated hours of care must be provided by a certified nurse aide.
- One third of the mandated hours of care must be provided by a registered nurse or licensed practical nurse.

Nursing homes found in violation of the regulation will face civil monetary penalties by the DOH. Penalties will be imposed from April 1, 2022. There are several mitigating factors when determining penalties for noncompliance:

- Extraordinary circumstances facing the facility e.g. natural disaster or other catastrophic event, a declared national, state, or municipal emergency, or other unforeseen circumstances;
- The frequency and nature of the noncompliance;
- The existence of an acute labor shortage within a particular region – determined by regional labor supply, regional pay rates, bureau of labor statistics, and evidence the facility attempted to procure sufficient staffing.

Concerns have been raised by advocates and lawmakers about the financial impact the legislation could have on some facilities, particularly nonprofit entities with limited revenue options. The size of the state's workforce may also present a challenge to the mandate, which Governor Hochul has attempted to offset by way of Executive Order expanding the permitted pool of practitioners and waiving certain penalties regarding registration.

Insufficient staffing is cited frequently in lawsuits filed against nursing homes as causing or contributing to injury. As always, documentation is key – facilities must diligently document the hours spent providing care to each resident. If facilities are struggling to employ sufficient staff, they must alert the DOH immediately. As this regulation is enshrined in the Public Health Law, failure to comply could result in punitive damages if safe staffing laws were not followed leading to injury.

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Revenue Expenditure

Adds §2828 to the Public Health Law, in effect from January 1, 2022. The Bill requires that:

- Not less than 70% of nursing home revenues shall be spent on direct resident care costs;
- 40% of nursing home revenues must be spent on staff who work directly with patients ('resident-facing staff'), which is included in amount spent on direct care costs above;
- Nursing home profits are limited to not more than 5%.
- Profit in excess of this threshold will be turned over to the DOH for deposit in the nursing home quality pool.

'Direct resident care' is defined to include:

- Non-revenue support services (e.g. maintenance, laundry, food service)
- Ancillary services (e.g. laboratory and pharmacy services)
- Programs directly affecting residents (e.g. crafts and music)

This means that 30% of the revenue remaining must be sufficient to pay all non-direct resident care costs, including administrative costs, capital costs, debt service, taxes (other than sales or payroll tax), capital depreciation, rent and leases, and fiscal services. Some exemptions apply:

- Nursing homes that provide certain specialized services, including behavioral intervention and neurodegenerative services, medically fragile children, residents with HIV/AIDS, and continuing care retirement communities.
- The Commissioner may waive requirements on a case-by-case basis if a nursing home demonstrates that it experienced unexpected or exceptional circumstances that prevented compliance.
- The Commissioner may also exclude on a case-by-case basis extraordinary revenues and capital expenses incurred due to a natural disaster.

Failure to comply with the requirements of this new law will result in monetary penalties, Medicaid deductions, offsets, and/or lawsuits brought by the Commissioner.

Practically, we understand that nursing home facilities are primarily for-profit businesses, so we will likely see facilities close across the state in response to this Bill. We also understand that nursing homes generally do not generate great profits, so there are valid concerns that the remaining 30% will be insufficient to cover non-direct care costs.

This Bill gives us the greatest cause for concern. As discussed above, we are seeing an increase in plaintiffs going after owner/operators personally as well as their affiliated corporations (such as leasing corporations that rent property to the facility) on corporate theories of liability. This new law gives plaintiffs further grounds to issue exorbitant discovery demands - including requests for financial documents, profit and loss statements, and tax returns – which in turn drives up defense costs. As the law is enshrined in the Public Health Law, there is a real risk of this Bill driving up potential punitive damages.

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Bills Delivered to the Governor for Signature

Several Bills have passed the Senate and Assembly and have been delivered to Governor Hochul for either signature or veto. These include:

s.598 – 'Long-Term Care Task Force'

- Creates a 'Reimagining Long-Term Care Task Force' to study the state of both home-based and facility-based long-term care services in the State, and to make recommendations on potential models of improvement to long-term care services for older New Yorkers.

s.612 – 'Long-Term Care Ombudsman Program Reform'

- Expands the current 'Long-Term Care Ombudsman Program' to be more accessible and available to seniors and their families, while promoting the volunteer advocate program and improve interactions between the DOH and the Ombudsman program regarding complaints.

s.1783A – 'Infection Inspection Audit'

- Directs the DOH to establish and implement an infection control inspection audit and checklist for residential care facilities.

s.1784A – 'Quality Assurance Committee'

- Requires adult care facilities to include 'quality assurance committees' in their quality assurance plans.

s.4377 – 'Bill of Rights Translation'

- Mandates a prominent display to inform residents of the Long-Term Care Ombudsman Program and requires the DOH to translate the nursing home residents' bill of rights into the six most common non-English languages spoken in New York State. The Bill aims to increase awareness of the Program so that residents and loved ones may access the support available to them.