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Part 3 3 Part Series of Articles Evaluating the Lavender Verdict

THE LAVENDER TRIAL: COPYCAT CLASS ACTION CASES CONTINUE

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Copycat class action cases continue to be filed throughout California as plaintiff attorneys attempt to capitalize on the Lavender verdict. At present there are at least 10 class actions that have been filed statewide alleging staffing ratio violations that utilize the Lavender case as a model. These suits demand "perfect" compliance despite the ever changing regulatory landscape under which there is the threat of a $500 per resident-per day penalty for any lapse. For a facility with a census of 100 this would equate to a *$50,000 penalty per day* despite the absence of any personal injury. It continues to be the opinion of this writer that such claims should not be sanctioned by our courts given their legal foundation is irreparably flawed. Following is our third and final article analyzing the Lavender case.

SIDESTEPPING THE UNIFORMITY REQUIREMENT FOR CLASS CERTIFICATION IS IMPROPER

Class action lawsuits provide a vehicle for courts to review claims made by large groups of people under the sole circumstance where each person within the class is asserting an identical claim. The first requirement to support any class action is therefore to establish that every member of the class has been harmed by an identical wrong. The uniformity between multiple individual claims allows the group to be bundled together for efficiency and cost effective management. It is this uniformity requirement that caused our courts to decide long ago that claims founded on *patient care* are not suitable for management through a group class action. The reason is simple. Human beings are unique and their need for *individualized care and treatment defeats the uniformity requirement*. No uniformity, no class action.

Plaintiff attorneys pursuing cases against skilled nursing facilities have sidestepped the uniformity requirement by bootstrapping the 3.2 NHPPD (nursing hours per patient day) ratio to patient rights requirements as outlined in Title 22 §72527. The fallacy of this argument is apparent by a simple reading of §72527 which itself contains no reference to a specific nursing staff ratio. We can also look to the Department of Public Health's All Facilities Letter published on January 31, 2011 where the Department notes "[T]he minimum 3.2 NHPPD *does not assure that any given patient receives 3.2 hours of nursing care*…." The fact is, both federal and state legislators have recognized there is no empirical data establishing that care is improved at any artificially set staffing mark above 2.3 PPD.[i] California's 3.2 ratio was set with the "hope" that it would improve care but otherwise has no more of a relationship to the adequacy of any individual person's care than the number of lawyers it takes to screw in a light bulb. Unless each individual within the class is empowered to make a claim for 3.2 nursing hours for their personal care, there is no individual *right*. No individual right, no class action.

When evaluating uniformity it is also important to recognize that the fundamental design of the counting process has undergone numerous ideations in a host of All Facility Letters and DPH policies published over the years. While the recent DPH All Facilities Letter outlines with more specificity than ever before

the manner in which the 3.2 ratio will be audited, this has been an evolving project. An example of the evolution is seen in the 3 versions of the newest staffing audit protocol DPH published in a short six week time span (December 10, 2010 through January 31, 2011). This changing regulatory landscape itself defies uniform evaluation over the protracted multi-year claims made in the current wave of class action complaints.

IMPACT OF THE NEW AUDIT PROCESS: IS THE NEW POLICY *LEGAL*?

In our Fall 2010 newsletter I discussed the enforceability of the 3.2 staffing statute in light of the absence of implementing regulations which the statute itself mandates the Department of Public Health adopt.[ii] There is a symbiotic relationship between statutes which broadly dictate conduct and implementing regulations that provide the details necessary for compliance. The adoption of any new law, whether a statute or regulation, requires lawmakers follow a plethora of other laws that dictate the rulemaking process. To put it simply, even DPH has to follow rules when they make rules.

Now remember back to October 2007 through January 2009 when there were a number calls for public comment on several proposed regulations designed to implement shift ratios. The political wheels generated a call for mass participation by industry insiders as a number of new regulations passed through the formal adoption process. Title 22 §72038, which provided *for the first time* a definition for "**Direct Caregiver**", was part of this adoption process. To be sure, DPH doesn't engage the public process for adopting new regulations pursuant to its' own good will. In fact the call to action that led to the adoption of the regulation defining "Direct Caregiver" came as a result of a lawsuit filed by a civil advocacy group that demanded DPH follow the rules and adopt these regulations.[iii] What is troubling however is that the implementation of the "Direct Caregiver" definition pursuant to Title 22 §72038 was delayed because the state couldn't pay for the additional care providers required to meet compliance. Fast forward to January 2011 and the newest All Facilities Letter which outlines the staffing audit process. Here you will find the same language used to support the adoption of §72038[iv] duplicated in the new guideline. The budget appropriation on which §72038 hinges has never come to pass and the rulemaking process has now effectively been skipped.

Now I have no quibble with those of you who are simply trying to co-exist with the enforcement agency who has authority to make or break you in a very real sense every day. But in my world the law should be respected, particularly by the government and particularly when the entire staffing metric is being used by plaintiff attorneys in a way that has a potential to annihilate the entire industry. Let's remember that it took the Department of Public Health three attempts before they honed in the final, final, final version of the new audit guidelines. Guidelines that weren't available to the Lavender Court or during the bulk of the class periods associated with the 10 new class action cases. It's fine if compliance is somewhat of a moving target. Dealing with human beings should be flexible. But if the process creates a legal vacuum that fertilizes litigation and empowers plaintiff attorneys, it's time for someone to demand legal protection for our facilities. Until then, the low hanging fruit on which the plaintiff attorneys feast will continue to thrive.

About the author:
Founder and Shareholder of Wroten & Associates, Ms. Wroten's experience covers a broad spectrum of complex litigation encompassing all areas of healthcare liability including high exposure and class action claims of elder abuse, fraud, and corporate unfair business practices. Ms. Wroten's experience includes the successful defense of individual healthcare providers, independent long term care facilities, ancillary service providers, as well as related corporate enterprises and their executives.

Ms. Wroten started her legal career as a Deputy District Attorney for Orange County where she prosecuted gang, child and spousal abuse cases. Thereafter, she spent 15 years as a litigator for a prestigious healthcare defense firm where she was a shareholder and lead her long term care practice area. Ms. Wroten founded Wroten & Associates in 2006 to better meet the growing challenges of the long term care industry. Wroten & Associates is designed to provide personal service at rational rates.

Ms. Wroten is a sought after speaker who is dedicated to the education of the healthcare industry and legal community. She has been an invited lecturer for the Defense Research Institute, Irvine Medical Center, Chapman University College of Law, and the Association of Southern California Defense Counsel.

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REFERENCE NOTES

[i] See "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final" prepared by Abt Associates Inc. and Letter of Tommy Thompson to Congress.

[ii] Health & Safety Code §1276.5(a) states "The department shall adopt regulations setting forth the minimum number of equivalent nursing hours per patient required in skilled nursing and intermediate care facilities…. However …the minimum number of actual nursing hours per patient required in a skilled nursing facility shall be 3.2 hours…."

[iii] See Foundation Aiding the Elderly and Shelia Whittaker v Department of Health Services, Case No. CGC-06-456231.

[iv] January 31, 2011 All Facilities Letter 11-19, Part II Guidelines, § 1: Definitions subsection (e): "Direct Caregiver means a registered nurse, as referred to in §2732 of the Business and Professions Code; a licensed vocational nurse, as referred to in §2864 of the Business and Professions Code; a psychiatric technician, as referred to in §4516 of the Business and Professions Code; and a certified nurse assistant, or a nursing assistant participating in an approved training program, as defined in HSC §1337, while performing nursing services as described in CCR Title 22 72309, §72311, and §72315…."

Compare to Title 22 §72038:
"Direct Caregiver means a registered nurse, as referred to in §2732 of the Business and Professions Code; a licensed vocational nurse, as referred to in §2864 of the Business and Professions Code; a psychiatric technician, as referred to in §4516 of the Business and Professions Code; and a certified nurse assistant, or a nursing assistant participating in an approved training program, as defined in HSC §1337, while performing nursing services as described in CCR Title 22 72309, §72311, and §72315….Initial implementation of this section shall be contingent on an appropriation in the annual Budget Act or another statute, in accordance with Health and Safety Code §1276.65(i)."