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## Legal Considerations For Assisted Living Facilities

Y. Tony Yang

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# LEGAL CONSIDERATIONS FOR ASSISTED LIVING FACILITIES

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## I. BACKGROUND

The elderly population in the United States will expand drastically over the next few decades; indeed, the number of persons aged 65 or older is expected to swell to approximately nineteen percent of the nation's population by 2030 – a staggering statistic in light of the fact that the present population of elderly people constitutes fewer than 13 percent.<sup>1</sup> Largely because of this fact, long-term care for this population is becoming increasingly important. Traditionally, elderly persons that lost the ability to fully care for themselves would enter a healthcare facility known as a nursing home.<sup>2</sup> However, a relatively new alternative exists in the form of the assisted living facility (“ALF”).<sup>3</sup> ALFs are the fastest growing form of residential care for the elderly.<sup>4</sup> Between 1998 and the present, the total number of ALFs in the United States increased from around 11,459 to nearly 40,000.<sup>5</sup> This option

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<sup>1</sup> See *Aging Statistics*, NAT'L ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERV., [http://www.aoa.gov/Aging\\_Statistics](http://www.aoa.gov/Aging_Statistics) (last visited Feb. 23, 2015).

<sup>2</sup> See *Assisted Living Compared to Nursing Homes*, ASSISTEDLIVINGFACILITIES.ORG, <http://www.assistedlivingfacilities.org/resources/quiz-what-type-of-care-is-right-for-me-/vs-nursing-homes> (last visited Feb. 23, 2015).

<sup>3</sup> See *id.* (“[A]ssisted living residences have become more popular in the last few decades.”).

<sup>4</sup> See Eric M. Carlson, *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care*, NAT'L SENIOR CITIZENS LAW CTR. (May 2005), <http://www.nslc.org/wp-content/uploads/2011/07/Critical-Issues-in-Assisted-Living.pdf>.

<sup>5</sup> See Zhipeng Lu, *Investigating Walking Environments in and Around Assisted Living Facilities: A Facility Visit Study*, 3 HERD 58, 59 (2010).

originated as a “market response to emerging demographic trends . . . and consumer demands,” and as such, is expected to bear the brunt of the expected growth in elderly populations.<sup>6</sup>

## II. ALFs VS. TRADITIONAL NURSING HOMES

Traditional nursing homes and ALFs differ in a variety of ways. Most prominently, traditional nursing homes provide a much higher level of care for elderly patients typically incapable of living on their own.<sup>7</sup> This manifests in substantial supervision over patients, most of whose physical or cognitive impairments are advanced enough to require such a level of care.<sup>8</sup> In comparison, ALFs typically allow patients a far greater degree of independence than their nursing home counterparts, while still maintaining an appropriate amount of supervision.<sup>9</sup>

ALF residents do not generally require the high levels of care that are typically associated with nursing home patients; as such, they usually conduct themselves with a certain level of autonomy. However, most ALF residents do suffer from physical or mental limitations: for example, more than half of ALF residents require bathing assistance.<sup>10</sup> Because of this, ALFs typically provide a range of services that promote quality of life and independence, including personal care, meals, medication management, social services, social interaction, transportation, laundry, housekeeping, and emergency response.<sup>11</sup> Essentially, ALFs bridge the gap for seniors between purely independent living and traditional nursing homes.

Although ALFs and nursing homes are the most prominent elder residential care facilities, independent living facilities deserve a brief mention. These are facilities for seniors who require the least amount of medical care and desire independence and community living; independent living facilities might offer full apartments in a community setting.<sup>12</sup> They “are most appropriate for seniors who do not need assistance with daily activities, such as dressing or bathing.”<sup>13</sup> These facilities provide shared activities and meals in a community setting, and also offer other amenities like transportation and housekeeping.

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<sup>6</sup> Patrick A. Bruce, *The Ascendancy of Assisted Living: The Case for Federal Regulation*, 14 *ELDER L.J.* 61, 68 (2006).

<sup>7</sup> *Assisted Living and Nursing Home Facilities*, LIVESTRONG FOUNDATION, <http://www.livestrong.org/we-can-help/managing-your-life-during-treatment/assisted-living-and-nursing-home-facilities> (last visited June 8, 2014).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> Carlson, *supra* note 4, at 8.

<sup>11</sup> *Assisted Living and Nursing Home Facilities*, *supra* note 7.

<sup>12</sup> See *Senior Living Options*, ASSISTED LIVING FED’N OF AM., [http://www.alfa.org/alfa/Senior\\_Living\\_Options.asp](http://www.alfa.org/alfa/Senior_Living_Options.asp) (last visited Feb. 23, 2015); see also, *Independent Living Facilities*, LARIMER CNTY. OFF. ON AGING, [http://www.larimer.org/seniors/independent\\_living.pdf](http://www.larimer.org/seniors/independent_living.pdf).

<sup>13</sup> *Id.*

## III. LEGAL ISSUES

ALFs face a distinct set of legal issues similar to other healthcare or residential care facilities like nursing homes and hospitals. However, as a relatively modern concept, the body of law governing ALFs is considerably less developed than traditional concepts like nursing homes. The legal concerns in this area stem primarily from state laws licensing and regulating ALFs,<sup>14</sup> although there are various statutory and common law tort issues that arise in relation to caring for individuals with impairments.

## IV. STATE REGULATION AND LICENSURE

To understand the role that states play in regulating ALFs, it is important to first realize that assisted living is “not defined in any meaningful way by federal law.”<sup>15</sup> Furthermore, the federal government plays a very limited role in setting standards that govern ALFs; the process is primarily controlled by the states.<sup>16</sup> Although the federal government does little to regulate these entities, it does affect assisted living through funding.<sup>17</sup> The federal government helps to pay for assisted living through Medicaid’s Home and Community-Based Services.<sup>18</sup> In light of the growing elderly population, federal Medicaid spending on assisted living is likely to increase dramatically, though federal authorities have remained hesitant to regulate the field.<sup>19</sup>

Both the definition of assisted living and the ALFs regulatory scheme vary from state to state.<sup>20</sup> Moreover, ALFs receive significant funding from their residents, thereby requiring a smaller contribution from the federal government, relative to other care facilities.<sup>21</sup> Medicaid defrays nursing home costs for eligible patients. However, as mentioned, federal spending related to assisted living is increasing.<sup>22</sup> Not only is Medicaid implicated, but so too are housing and veterans subsidies, as well as some short-term Medicare coverage.<sup>23</sup>

Regardless of federal funding, the primary responsibility for assisted living regulation remains with the states. As such, all states affirmatively regulate ALFs in

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<sup>14</sup> See Karl Polzer, *Assisted Living State Regulatory Review 2013*, NAT’L. CTR. FOR ASSISTED LIVING 5 (Mar. 2013), [http://www.ahcancal.org/ncal/resources/Documents/2013\\_reg\\_review.pdf](http://www.ahcancal.org/ncal/resources/Documents/2013_reg_review.pdf).

<sup>15</sup> Carlson, *supra* note 4, at 8.

<sup>16</sup> Polzer, *supra* note 14, at 5.

<sup>17</sup> *Is It Time for Federal Regulation of the Assisted Living Industry?*, CTR. FOR MEDICARE ADVOCACY (Sept. 10, 2013), [http://www.medicareadvocacy.org/old-site/News/Archives/SNF\\_07\\_03.22.AssLivRegulation.htm#\\_edn1](http://www.medicareadvocacy.org/old-site/News/Archives/SNF_07_03.22.AssLivRegulation.htm#_edn1).

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> Bruce, *supra* note 6, at 69.

<sup>21</sup> *Id.* at 70.

<sup>22</sup> See *Is It Time for Federal Regulation of the Assisted Living Industry?*, *supra* note 17.

<sup>23</sup> See *Cost of Assisted Living*, ASSISTED LIVING FED’N OF AM., [http://www.alfa.org/alfa/Assessing\\_Cost.asp](http://www.alfa.org/alfa/Assessing_Cost.asp) (last visited Feb. 23, 2015).

some capacity. Regulation can generally be grouped into three basic categories: (1) states that regulate ALF licensure, (2) states that regulate ALF standards of care, and (3) states that create a cause of action against ALFs.<sup>24</sup> Many states also have so-called “elder abuse” or “vulnerable adult” statutes that affect ALFs to varying degrees.<sup>25</sup>

#### A. State Regulation of Licensure

States that regulate licensure often make the type of individuals ALFs may treat the focal point of their licensing regulations. There are a couple of methods of accomplishing this; namely, states can either become “single-level” states or “multi-level” states.<sup>26</sup> In a single-level regime, a state will license just one type of ALF, which is typically entitled to accept or keep any resident, so long as the resident does not have a health condition that under the regulations would foreclose his treatment at an ALF.<sup>27</sup> Examples of single-level states include Connecticut, Illinois, Indiana, Iowa, and Massachusetts.<sup>28</sup>

Multi-level systems seem to be trending. In a multi-level regime, “some [ALFs] are licensed to care for residents only up to a particular care need.”<sup>29</sup> Carlson indicates that these might be classified in a number of different ways—perhaps as simply as “low, moderate, and high.”<sup>30</sup> Under this regime, a resident can live in a particular “level” ALF up to and until his care needs exceed those provided for under that particular ALF’s license. At least sixteen states have implemented multi-level care systems, including Arkansas, Florida, Idaho, Mississippi, Montana, and Texas.<sup>31</sup>

Texas provides an informative example: Texas regulations classify ALFs as either “Type A,” “Type B,” or “Type C” facilities.<sup>32</sup> Type A facilities require residents be “physically and mentally capable of evacuating the facility without physical assistance from staff,” and “not require routine attendance during nighttime sleeping hours.”<sup>33</sup> Type B facilities, on the other hand, permit residents who may require: “staff assistance to evacuate,” “attendance during nighttime sleeping hours,” and “assistance in transferring to and from a wheelchair.”<sup>34</sup> As such, if a resident’s condition deteriorates such that he or she is unable to evacuate the ALF during an emergency, that patient must be transferred to an ALF that holds a Type B license.

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<sup>24</sup> See ERIC M. LARSSON & JEAN A. TALBOT, *CAUSE OF ACTION AGAINST ASSISTED LIVING FACILITY FOR INJURY OR DEATH OF RESIDENT* 8–9 (2d ed. 2014).

<sup>25</sup> *Id.*

<sup>26</sup> Carlson, *supra* note 4, at 8.

<sup>27</sup> *Id.* at 19.

<sup>28</sup> *Id.* at 40.

<sup>29</sup> *Id.* at 19.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at 39–40, 42.

<sup>32</sup> 40 TEX. ADMIN. CODE § 92.3 (2014).

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

This type of multi-tiered licensure creates a set of distinct legal issues that mostly relate to the conditions under which ALF operators discharge residents. One of the primary legal characteristics of ALFs across the country is the expansive amount of discretion ALF operators are afforded, particularly in discharging residents.<sup>35</sup> Indeed, in thirty-nine states, ALF residents can be discharged involuntarily at the sole discretion of ALF operators.<sup>36</sup> This broad discretion gives rise to two potential legal issues: (1) “too-soon discharge”, and (2) “too-late discharge.”<sup>37</sup> In too-soon discharge, one of the very few places where federal law is implicated in assisted living, an ALF operator may refuse to install a particular type of emergency equipment a patient needs, and instead simply elect to discharge the patient.<sup>38</sup> In this circumstance, the patient may have a claim under the Americans with Disabilities Act.<sup>39</sup>

Far more important for the purposes of this article, though, is too-late discharge. In too-late discharge, the ALF retains a resident for longer than it should; it then becomes incapable of providing the level of care necessary to treat a deteriorating patient.<sup>40</sup> According to Carlson, this is “the source of many serious assisted living problems.”<sup>41</sup> It can be the result of an ALF improperly trying to maximize revenues or, more benignly, as a mistake or oversight. One example of too-late discharge occurred in Georgia, where a 70-year-old patient became bedridden but was not transferred from an ALF to a nursing home.<sup>42</sup> She died of infection caused by bedsores.<sup>43</sup> In other words, according to Kardon, “[p]atients who should have been moved to a higher level of care may suffer avoidable, calamitous harm.”<sup>44</sup>

#### B. State Regulation of Standards of Care

There are also a number of states that regulate actual standards of care for ALFs. This is done “in conjunction with licensure.”<sup>45</sup> Most states regulate ALFs by reference to some of the following areas: disclosures, ALF scope of care, third-party scope of care, move-in and move-out requirements, management of medication,

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<sup>35</sup> Carlson, *supra* note 4, at 43.

<sup>36</sup> *See id.* at 49–52.

<sup>37</sup> *See id.* at 9.

<sup>38</sup> *See id.* at 9 and 44.

<sup>39</sup> *Id.* at 9; *see* 42 U.S.C. 12101 *et seq.*

<sup>40</sup> LIFE CARE PLANNING LAW ASSOCIATION, THE LIFE CARE PLANNING MARYLAND ASSISTED LIVING GUIDE 2, <http://www.lcplfa.org/sites/default/files/documents/Life%20Care%20Planning%20Maryland%20Assisted%20Living%20Guide.pdf>.

<sup>41</sup> Carlson, *supra* note 4, at 8.

<sup>42</sup> John Kreiser, *Assisted Living, Erratic Regulation*, CBS NEWS, Nov. 13, 2006, <http://www.cbsnews.com/news/assisted-living-erratic-regulation>.

<sup>43</sup> *Id.*

<sup>44</sup> Martin S. Kardon, *Special Challenges in Assisted Living Facility Cases*, TRIAL MAGAZINE, Oct. 1, 2012 at 2.

<sup>45</sup> LARSSON & TALBOT, *supra* note 24, at 17.

facility requirements, patient capacity, staff training and hiring levels, continuing education, and payment policies.<sup>46</sup>

Mississippi for example, among other things, regulates: (1) physical facilities such that “[n]o facility may be licensed until it shows conformance to safety regulations,”<sup>47</sup> the scope of care where “the provision of personal care and the addition of supplemental services to include....the provision of medical services ...and emergency response services,” and it regulates the permissible number of beds in a facility.<sup>48</sup>

### C. State-Created Causes of Action

Finally, some states create statutory causes of action for various harms suffered by ALF residents. These typically either expand existing causes of action in tort, or provide specific, occasionally exclusive new causes of action for injured ALF residents. Florida has implemented a state statute allows residents to sue ALFs for violations of the state’s resident bill of rights.<sup>49</sup> This Florida law provides the only mechanism for residents to vindicate their rights when injury or wrongful death occurs in an ALF.<sup>50</sup> In one such case, a Florida resident was injured after slipping in a pool of urine in the bathroom of his ALF; he brought suit against the ALF based on the statutorily-created cause of action.<sup>51</sup> Further statutory causes of action can also be found in states with wrongful death or elder abuse laws.<sup>52</sup> An illustration of a cause of action found in an elder abuse statute can be seen in a 2004 case from California, where a husband and son of a nursing home resident with Alzheimer’s disease sued the nursing home under the state’s elder abuse statute after the patient was killed in an altercation with another patient.<sup>53</sup> A factually similar case, but in the context of a wrongful death cause of action and occurring in an ALF, occurred in Florida in 2006.<sup>54</sup> While statutory causes of action in individual states can provide relief to injured ALF residents, more commonly plaintiffs will sue under a common law tort regime.

So by way of licensure, regulation, and statutory causes of action, states can define and specify the scope of and extent to which ALFs are subject to liability for harms done to patients. These varying state laws are overlaid atop traditional tort law, defining standards of liability beyond what tort law provides.

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<sup>46</sup> Bruce, *supra* note 6, at 70.

<sup>47</sup> MISS. CODE ANN. § 15-3-1 (2014).

<sup>48</sup> *Id.*

<sup>49</sup> FLA. STAT. § 429.28 (2014).

<sup>50</sup> Melvin B. Wright, *Statutory Tort Claims Against Assisted Living Facilities in Florida*, COLLINS, GILBERT WRIGHT & CARTER, [http://www.thefloridafirm.com/files/2013/03/statutory\\_tort\\_claims\\_assisted\\_living\\_facilities\\_florida.pdf](http://www.thefloridafirm.com/files/2013/03/statutory_tort_claims_assisted_living_facilities_florida.pdf).

<sup>51</sup> *Mang v. Country Comfort Inn, Inc.*, 559 So.2d 672 (Fla. Dist. Ct. App. 1990).

<sup>52</sup> LARSSON & TALBOT, *supra* note 24, at 4.

<sup>53</sup> *See Intrieri v. Superior Court*, 12 Cal. Rptr. 3d 97 (Cal. Super. Ct. 2004).

<sup>54</sup> *Pollock v. CCC Invs. I, LLC*, 933 So.2d 572 (Fla. Dist. Ct. App. 2006).

## V. TORT LAW

Even in states lacking a statutory cause of action related to assisted living ALFs can still face significant legal risk for harms caused based on actions brought in common law tort, particularly those concerning negligence, the most common claim against ALFs.<sup>55</sup> Neglect in ALFs is widespread, and “can result in falls, fractures, sexual or physical abuse, pressure sores or other skin breakdown, malnutrition, depression, immobility, and even death.”<sup>56</sup> Indeed, horror stories regarding ALF negligence are prevalent. In 2004, a Michigan ALF resident with Alzheimer’s disease found his way into an unlocked kitchen cabinet and drank an entire bottle of bleach, killing himself.<sup>57</sup> In another case, a Pennsylvania Alzheimer’s resident wandered away from her ALF and drowned in a canal.<sup>58</sup> What legal standards are ALFs judged with respect to negligence cases, and how do these differ between states?

The legal standard for negligence is universal: to be liable for negligence, (1) the defendant must have owed the plaintiff a duty, (2) the defendant must have breached the duty, (3) the plaintiff must have suffered an injury, (4) that was proximately caused by the defendant.<sup>59</sup> In the context of an ALF the elements of negligence look similar: (1) the ALF owed a duty to the resident to adhere to a particular standard of care, (2) the ALF breached that duty, (3) the resident was injured, and (4) the resident’s injury was caused by the ALF’s breach of duty.<sup>60</sup>

As previously discussed, an ALF’s duty to its residents may be established by a state statute, whether ALF-specific, an elder abuse statute, or something else entirely.<sup>61</sup> But generally, an action against an ALF will likely proceed through a claim of.

Using the 2004 Michigan case involving an ALF and the death of a resident discussed above, it is possible to analyze a hypothetical negligence claim against the ALF. First, the resident’s representative would likely claim that the ALF was responsible for keeping patients with cognitive impairments away from dangerous chemicals. Second, the plaintiff will claim that by failing to secure the bottle of bleach from impaired residents, the ALF breached that duty. Third, the decedent’s representative would show that death was the resulting injury. And finally, the plaintiff will claim that keeping an unsecured bottle of bleach in the kitchen was the proximate cause of death.

As previously mentioned, ALFs have a significantly less developed jurisprudence than nursing homes. This is, in part, because ALFs are relatively new concepts. Additionally, ALF residents are intentionally provided with more independence than traditional concepts like nursing homes. As such, this requires

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<sup>55</sup> Jeffrey J. Downey, *Increasing Safety in Assisted Living*, TRIAL MAGAZINE, Aug. 1, 2004.

<sup>56</sup> *Id.*

<sup>57</sup> See Kreiser, *supra* note 42.

<sup>58</sup> *Id.*

<sup>59</sup> RESTATEMENT (SECOND) OF TORTS § 281 (1965).

<sup>60</sup> LARSSON & TALBOT, *supra* note 24, at 19.

<sup>61</sup> See *Infra* pp. 4–6 State Regulations and Licensures.

trade-offs; namely, that by increasing independence for ALF residents, ALF operators relinquish a great deal of control over their residents that can jeopardize their safety. Thus, ALFs in many states are either unwilling or not permitted to admit residents that suffer from impairments that require advanced levels of care.<sup>62</sup> Therefore, applications of traditional negligence standards might be more difficult to determine since it is not always clear to the level of duty operators owe any particular patient or what the scope of that duty might be. That said, some in-depth analysis of each element of a resident versus ALF negligence claim will prove informative.

Perhaps the most important aspect of the ALF negligence inquiry concerns the existence and breadth of the ALF's duty to its residents. It must first be noted that all persons owe a general duty to exercise reasonable care to avoid injuring others.<sup>63</sup> However, the duty an ALF owes to its residents derives from the particular nature of the relationship between the two parties.<sup>64</sup> When attempting to define a duty, courts might look to a host of variables including foreseeability of harm, relative certainty of injury, connection between conduct and injury, moral blameworthiness of the ALF, policies to mitigate harm, and the consequences of imposing a duty.<sup>65</sup>

Courts in some states have held that the ALF's duty to its residents is the same as that of a landlord to his or her tenant<sup>66</sup> or that of a business owner to an invitee.<sup>67</sup> Other courts have based the existence of the duty on the contractual relationship between the ALF and its residents: Failure on the part of the ALF to provide the level of care cited in the initial contract can then constitute a basis for liability.<sup>68</sup> Other courts have predicated the existence of the duty on the simple fact that ALFs are in the business of providing care to somewhat vulnerable persons.<sup>69</sup>

Because there is no uniform definition or standard form contract for these facilities, and because overall legal structures differ so widely between states, the actual duty of care owed to residents will likely depend in large part upon individual circumstances. Thus, for example, the existence of the duty might be deemed to have arisen via a landlord-tenant relationship in a Michigan; whereas, in Massachusetts, a court would decide that the ALF's duty exists as a result of its contract with the resident.<sup>70</sup> This distinction is very important, because the actual

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<sup>62</sup> Downey, *supra* note 55.

<sup>63</sup> RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 6 (2010).

<sup>64</sup> LARSSON & TALBOT, *supra* note 24, at 12.

<sup>65</sup> See, e.g., Glanda v. Twenty Pack Mgmt. Corp., 2008 WL 4445257 (E.D. Mich. Sept. 29, 2008).

<sup>66</sup> Am. Ret. Corp. v. Stanley, 2004 WL 1405686, at \*5 (Tex. App. June 24, 2004); Washnock v. Brookdale Senior Living Inc., 2014 WL 495414, at \*3 (E.D. Mich. Feb. 6, 2014).

<sup>67</sup> Selvin v. DMC Regency Residence, Ltd., 807 So. 2d 676, 680 (Fla. Dist. Ct. App. 4th Dist. 2001).

<sup>68</sup> LARSSON & TALBOT, *supra* note 24, at 13–14.

<sup>69</sup> Selvin, 807 So. 2d at 676.

<sup>70</sup> Washnock v. Brookdale Senior Living Inc., 2014 WL 495414, at \*3 (E.D. Mich. Feb. 6, 2014); LARSSON & TALBOT, *supra* note 24, at 12.

scope of the duty is informed in large part by the relationship that gave rise to it in the first place. For instance, if one particular ALF entered into a contract with a certain resident under which the ALF agreed only to provide room and board, its duty would be far more constrained than if the contract provided that the ALF would diligently monitor patients for dangerous bedsores.<sup>71</sup>

Once the source of the duty has been established, the scope of the duty—the standard of care—must be determined. As suggested above, the standard of care an ALF owes to any particular resident can be informed by the source of the duty, whether contractual or otherwise. But other considerations come into play, as well: standards of care might be determined by “relevant local statutes and regulations governing [ALFs], as well as specific aspects of the resident’s condition and features of the [ALF’s] environment.”<sup>72</sup> As an illustration, one court determined the duty of care owed by a Michigan ALF to its injured resident by referencing a state licensing regulation.<sup>73</sup> That court noted that “[i]t is well-established in Michigan law that violation of an ordinance or of administrative rules and regulations is evidence of negligence.”<sup>74</sup>

In other cases, the applicable standard of care might be determined by reference to the ALF’s own rules and practices.<sup>75</sup> For example, if an ALF’s internal rules require employees to make hourly bed checks on residents, any failure to do so might constitute a breach of duty. In still other instances, the resident’s condition upon check-in might help a court to determine a standard of care:<sup>76</sup> because the standard of care is defined by relation to foreseeable harm to the resident, admitted residents with higher care needs have more easily foreseeable injuries, courts will likely render an ALF liable for not adequately providing for said patient. In *Farr v. Alternative Living Services, Inc.*,<sup>77</sup> a Wisconsin court allowed the jury to consider that an ALF breached its duty of care by allowing a resident with dementia to get frostbite by permitting them to wander outside in cold weather.<sup>78</sup> In that case, the ALF’s knowledge of the plaintiff’s mental impairment was a contributing factor in setting the standard of care owed to her; stated differently, the ALF staff was arguably charged with ensuring that residents with Alzheimer’s not be left unsupervised in the cold.<sup>79</sup>

Application of common law negligence to ALFs becomes more clear-cut once the nature of the duty and the applicable standard of care are established. As

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<sup>71</sup> See Downey, *supra* note 55, at 355 (“If the facility agreed to provide only room and board, the defense will argue that its duties are comparable to those of a landlord in an apartment building.”).

<sup>72</sup> LARSSON & TALBOT, *supra* note 24, at 15.

<sup>73</sup> See *Glanda v. Twenty Pack Mgmt. Corp.*, 2008 WL 4445257 (E.D. Mich. Sept. 29, 2008).

<sup>74</sup> *Id.* at \*10.

<sup>75</sup> LARSSON & TALBOT, *supra* note 24, at 15.

<sup>76</sup> *Id.* at 17.

<sup>77</sup> 253 Wis. 2d 790 (Ct. App. 2002).

<sup>78</sup> *Id.* at 793.

<sup>79</sup> *Id.* at 795.

discussed above, an injured resident must next show that an ALF did not properly adhere to the standard of care. Where the injury is arguably attributable to a resident's cognitive or physical impairments, a breach of duty is eminently more provable if the ALF "was shown to have actual or constructive knowledge of physical or mental limitations on the resident's part."<sup>80</sup> A breach of duty is even easier to establish when, as in the Michigan bleach case above, the standard of care is partially defined by reference to a state regulation.<sup>81</sup> Then, an injured resident only has to show that the ALF did not follow the regulation. The same analysis would apply in cases where the standard of care is defined by way of ALF internal rules.

Finally, the resident would need to show both causation and injury. These do not merit a great deal of discussion; indeed, the injury element is met in nearly every lawsuit and the issue of causation is so fact-specific that particular examples provide little value. It suffices to say that residents will find ways to argue that injuries suffered while living in an ALF were, in some sense, caused by the ALF. In the bleach-drinking report discussed above, for example, the resident argued that failure to secure the bottle of bleach was the proximate cause of the Alzheimer's patient's injuries.

One final consideration for negligence claims should be discussed. As in most legal regimes, defendants faced with negligence claims generally have the opportunity to assert particular defenses.<sup>82</sup> In the ALF-resident relationship, these defenses are likely to focus on the resident's assumption of risk or contributory negligence.<sup>83</sup> The ALFs might admit some negligence in caring for a resident, but then assert that there was some degree assumption of risk or dangerous behavior that ultimately caused the injury.<sup>84</sup> For example, in cases where the duty and standard of care owed to residents arises by virtue of a landlord-tenant relationship, such as where the ALF contracts to provide minimum care to a seemingly competent elderly individual, the resident might be deemed fully cognitively operational by a court, which would render an ALF's assertion of such a defense more effective depending on the nature of the injury.<sup>85</sup> The concept of "negotiated risk" might also be a factor, in situations where the ALF argues that the resident in question actually negotiated

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<sup>80</sup> LARSSON & TALBOT, *supra* note 24, at 17.

<sup>81</sup> See *Glanda v. Twenty Pack Mgmt. Corp.*, 2008 WL 4445257 (E.D. Mich. Sept. 29, 2008) at \*12.

<sup>82</sup> LARSSON & TALBOT, *supra* note 24, at 3 (defenses including: (1) the assisted living facility conformed to the applicable standard of care; (2) the resident's negligence was a factor contributing to injury or death; (3) The resident assumed the risk that was the cause of the injury or death; or (4) there was no proximate causal relationship between the assisted living facility's conduct and the resident's injury or death). *Id.*

<sup>83</sup> *Id.* at 22.

<sup>84</sup> *Id.* at 22–23.

<sup>85</sup> See *Downey*, *supra* note 55, at 3; see also *Leichter v. Cambridge Dev., LLC*, 90 A.D.3d 557 (N.Y. App. Div. 1st Dep't 2011).

away the ALF's liability for certain injuries *ex ante*—at the time of the original contract.<sup>86</sup>

## VI. CONCLUSION

In sum, it is difficult to classify the legal issues facing ALFs writ large. This is primarily because regulation and legal regimes concerning ALFs are completely fragmented, existing almost exclusively on a state-by-state basis. It is clear that individual state regulation bears serious examination, particularly with respect to regulations defining ALF standards of care, as well as applicable licensing measures. Presently however, ALFs face a much higher degree of legal risk in the more traditional areas of common law tort, particularly negligence. Similarly, claims or questions may also arise from contract-based theories.

Federal law is only indirectly implicated; indeed, those ALFs that deal in some small way with public payers like Medicare and Medicaid may be impacted by the federal government; and the otherwise overwhelming discretion given to ALF operators may also implicate some ADA concerns. On the whole, however, it is clear that federal policy makers have not yet decided to subject ALFs to a similar level of regulatory scrutiny as more traditional healthcare facilities. But as the population of elderly people increases, and more families begin to explore options for long-term care for their elderly loved ones, federal regulation may provide an solution to fill regulatory gaps caused by the otherwise balkanized legal regime. Such federal regulation might come in the form of increased use of public healthcare funds to pay for ALFs, or in the form of a Congressional statute recognizing that U.S. residents prefer a national standard rather than a patchwork regulatory regimes.

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<sup>86</sup> See generally Eric M. Carlson, *Protecting Rights or Waiving Them? Why "Negotiated Risk" Should Be Removed from Assisted Living Law*, 10 J. HEALTH CARE L. & POL'Y 287, 287 (2007).