Nursing Home Staffing Data

A Guide for Attorneys

Table of Contents

Why staffing matters for liability & remedies	**2**
Expected staffing tied to resident needs (case-mix)	**2**
Practical guide	**3**
Federal citation quick refs (add to briefs)	**5**
Evidence checklist for discovery & trial	**5**
Framing your theory of the case	**6**
Pre-suit record control & leverage	**7**
Red flags & cross-examination prompts	**7**
Sample questions	**8**
Citations you'll likely need (quick list for pleadings)	**8**
Boilerplate for demand letters / pleadings (drop — in paragraph))	**8**
Sample discovery requests	**9**
Practical tips	**9**

The Long Term Care Community Coalition (LTCCC) is a non-profit organization dedicated to improving care and quality of life in nursing homes and assisted living. Visit www.nursinghome411.org for a wide range of free resources including our Dementia Care Toolkits, Nursing Home Data Center, Fact Sheets on nursing home care standards, Abuse, Neglect, and Crime Reporting Center, and Family Resource Center.

Visit www.nursinghome411.org/staffing-resource-center/ for our companion to this guide, LTCCC's Case Intake Worksheet, links to the staffing data, and expected staffing methodology.

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Why staffing matters for liability & remedies

Staffing is a proximate driver of quality and safety — Higher RN, CNA, and total nursing hours per resident day (HPRD) correlate with fewer pressure injuries, infections, rehospitalizations, and deaths. Courts and regulators routinely link harm to inadequate staffing.

Under federal law, facilities must have **sufficient nursing staff with appropriate competencies and skill sets** to ensure each resident attains or maintains the **highest practicable** well-being **based on individual assessments and care plans** — considering the number, acuity, and diagnoses of residents.

Facility assessment — Each facility must conduct, update, and use a facility-wide assessment **to inform staffing numbers by unit and shift** and to plan for contingencies (e.g., shortages). Failure to align staffing with the assessment supports negligence and regulatory non-compliance.

KEY LITIGATION ANGLES

- **Breach of statutory/regulatory duties** (sufficient/competent staff; annual performance reviews and 12 hours in-service incl. dementia and abuse prevention).
- **Causation** via missed care/omissions (falls, weight loss, pressure injuries) tied to deficient HPRD and competency gaps.
- **Notice** from public datasets and the facility's own reports (Payroll-Based Journal staffing data, Quality Measures, deficiencies).
- **Punitive damages**. Frame understaffing as an intentional, profit-motivated practice — chronic staffing below acuity-based needs to cut labor costs and boost margins. Pair expected vs. actual staffing with your avoided-labor-cost model to **show recklessness and corporate indifference** that a jury can punish.

Expected staffing tied to resident needs (case-mix)

Concept: Each facility's residents have measurable care needs summarized by a **Case-Mix Index (CMI)**. Expected staffing is the HPRD reasonably required to meet those needs.

WHAT "EXPECTED STAFFING" MEANS — AND WHY IT MATTERS

What it is. *Expected Staffing* is a facility-specific benchmark for the **RN, CNA, and Total HPRD** reasonably required to meet resident needs at that facility. It adjusts for acuity using the facility's case-mix (PDPM nursing CMI), so a higher-need population will have a higher expected HPRD than a lower-need one.

How it's derived. LTCCC's expected staffing uses the facility's reported case-mix to translate resident needs into hours of nursing care by staff type. In plain terms: **more complex residents → more nursing time**. This approach is grounded in federal resident-assessment data and long-standing research that links specific staffing levels — especially RN and CNA time — with core outcomes like pressure injuries, infections, weight loss, hospital transfers, and mortality. For more information on

the methodology, visit https://nursinghome411.org/wp-content/uploads/2025/04/LTCCC-Summary-of-Methodology-to-Identify-Expected-Nursing-Home-Staffing-Levels-April-2025.pdf.

WHY IT'S VALUABLE IN PRACTICE

- It provides a **needs-adjusted yardstick**, not a one-size minimum — letting you argue adequacy relative to *this* facility's residents.
- The LTCCC staffing reports include a **color-coded "Deviation from Expected" column**, so you can quickly spot quarters where **Actual < Expected** and quantify the shortfall.
- **Systematic negative deviation** supports breach and causation theories: if the home is consistently below what its own acuity requires, necessary care tasks are predictably **missed, rushed, or late**.
- It's easy to **cite and replicate**. You can pull the same quarter's expected values and show the math (**Deviation = (Actual − Expected) / Expected**) alongside clinical harms and missed care.

ALTERNATE PATH: STATE MINIMUM STAFFING "SAFETY NET"

Most states have a quantitative minimum staffing requirement. Importantly, these **state standards do not supplant the federal requirement** that facilities provide sufficient staffing to ensure that every resident is able to attain and maintain their highest practicable well-being. However, an attorney can support a case based on PBJ numbers that don't meet those minimums. Use PBJ to show repeated non-compliance (look especially at weekends and holidays). For state requirements, see https://theconsumervoice.org/wp-content/uploads/2024/06/CV_StaffingReport_AppB_Chart.pdf.

Practical guide

PAYROLL BASED STAFFING REPORTS

Use the PBJ-based staffing data at **www.nursinghome411.org/data/staffing/** to quickly compare **actual** vs **expected** staffing and assess **deviation**.

Steps

1. **Open** NursingHome411 → **Data** → **Staffing** — choose the quarter and your state/county/facility.
2. **Export** the row(s). Capture at least: **RN, LPN, CNA, Total HPRD**, **contract %**, **turnover**, **weekend staffing**, and the **Expected RN/CNA/Total** HPRD (methodology summary is on the page).
3. **Review the color-coded "Deviation from Expected" column**. This shows how close or far the facility is from its expected staffing (based on acuity), making outliers easy to spot.
4. **Compute/confirm Deviation** if needed: **(Actual – Expected) / Expected**. Systematic negative deviation evidences inadequate staffing for resident acuity.

5. **Cite it**. Drop the Actual, Expected, and Deviation values (and note the color tier) into your demand letter, complaint, or expert report.

PROVIDER DATA REPORTS (ONE — STOP SHOP)

Use the Provider Data Reports at www.nursinghome411.org/data/ratings-info/ to access information on ownership, CMS ratings, fines, penalties, and expected staffing for each facility — helpful for pattern-and-practice and punitive damages arguments.

FRAUD & FALSE REPORTING — AUDIT PBJ VS SOURCE RECORDS

Why this matters. PBJ is the public dataset CMS uses for daily staffing and Five-Star — but facilities sometimes over-report. Counsel routinely finds reported hours that exceed actual hours worked (double-counting, management time booked as direct care, off-site hours, or "ghost" shifts). Do not rely on PBJ alone; audit it against timecards, payroll registers, daily assignment sheets/staffing reports, and agency invoices for the same dates.

- Download the raw daily PBJ for the facility/period: CMS Data → Payroll-Based Journal Daily Nurse Staffing (daily hours & census). URL: https://data.cms.gov/quality-of-care/payroll-based-journal-daily-nurse-staffing.
- **Request and align**. Timecards/punch logs, payroll registers, agency rosters/invoices, and daily staffing/assignment sheets by date and shift.
- **Reconcile by day and staff type** (RN/LPN/CNA); flag hours with no punch, management/admin time recorded as direct care, agency gaps (invoice vs schedule), and weekend/holiday anomalies.
- **Quantify variance**. Over-reporting % = (PBJ hours − Verified hours) / PBJ hours, rolled up by week/quarter.
- **Tie to harm & intent**. Show Verified HPRD < Expected HPRD (from LTCCC) and PBJ overstated hours — supporting fraud/misrepresentation and, where appropriate, FCA/UDAP counts.
- PBJ PUFs / methodology overview: https://data.cms.gov/resources/pbj-public-use-files.

CORROBORATION

Collect care plans, assignment sheets, timecards/agency invoices, and the latest **Facility Assessment** and in-service logs — compare to PBJ and expected staffing.

USE CASES

- Tie **specific harms** (e.g., missed toileting → avoidable UTIs/pressure injuries) to **CNA HPRD shortfalls**.
- Tie **assessment/care-planning failures** and **infection prevention** lapses to **RN and total HPRD shortfalls**.

- Show **knowledge & notice** when the facility's quarterly data repeatedly under-perform expected levels.

Federal citation quick refs (add to briefs)

- **Sufficient/competent staff**. 42 C.F.R. § 483.35 (F-725).
- **Nurse aide competency/training**. 42 C.F.R. § 483.35(d)-(e) (F-728, F-730, F-947).
- **RN on duty ≥ 8 consecutive hours each day, 7 days/week** (and 24-hour licensed nurse coverage), plus a full-time DON (subject to small-facility exceptions) – Use PBJ daily RN hours and schedules to spot non-compliance quarters and add as a separate count or per-se breach in your pleadings. 42 C.F.R. § 483.35(b) (F-727)
- **Facility Assessment**. Facilities are required to have an efficient process for consistently assessing and documenting the necessary resources and staff that the facility requires to provide ongoing care for its population that is based on the specific needs of its residents." 42 C.F.R. § 483.70(e) (F-838)

Tip: Add your state analogues as a sidebar (e.g., minimum direct care hours, RN on-duty requirements).

Evidence checklist for discovery & trial

DISCOVERY MUST-HAVES TO VERIFY ACUITY & STAFFING

- **PBJ data** for all quarters bracketing the injury window — raw and as posted on LTCCC's website. The raw daily PBJ files can be downloaded from CMS (or facility PBJ submissions).
- Facility timecards/payroll registers/daily assignment sheets to reconcile with PBJ data.
- MDS PDPM nursing case-mix & HIPPS codes for each resident during the incident window — validates the acuity inputs behind Expected HPRD.
- **CMI source docs**: MDS/PDPM extracts, HIPPS codes, and the facility's acuity reports.
- **Staffing plan & schedules** by unit/shift; assignment sheets; float logs.
- **Facility daily census** (by unit/shift) for the incident window.
- **Facility nurse-staffing postings**: Facilities are required to post, on a daily basis at the beginning of each shift, the total numbers and actual hours worked by nursing staff directly responsible for resident care per shift. Facilities must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater. Capture photographs and obtain logs of these postings to compare against PBJ and timecards.
- **Facility Assessment** (current + preceding year) and updates; contingency staffing plan.
- **Training & competency**: annual performance reviews, 12-hr in-service logs (incl. dementia & abuse trainings), skills checklists, preceptor notes.

- **Agency contracts** and weekly invoices; credential files.
- **Quality indicators**: Pressure injury logs and staging audits; weight-loss flags; infection control rounds; falls with injury; ER transfers and rehospitalizations.
- **Marketing/advertising materials** (website captures, brochures, admission packets) that make staffing or care-quality promises. These support UDAP/misrepresentation counts.

Framing your theory of the case

Duty — Federal regs require **sufficient, competent staff** based on resident acuity; facilities must plan staffing **by unit/shift** and update with changing needs.

Breach — Show persistent **negative deviation** from expected HPRD; RN coverage gaps; training/competency failures; repeated survey deficiencies; ownership-driven understaffing (bonuses tied to labor cuts; high related-party payments).

Causation — Connect missed care/omissions (falls, UTIs, pressure injuries, malnutrition, dehydration, sepsis) to staffing shortfalls and inadequate supervision; use chart audits, assignment sheets, and witness accounts.

Damages — Pain and suffering, loss of dignity, medical costs, wrongful death, and — where allowed — **punitive damages** for reckless staffing policies.

Misleading advertising / UDAP (Unfair, Deceptive, or Abusive Acts or Practices) – Facilities often market "robust staffing" or "person-centered care," yet operate below expected staffing for their acuity — or over-report PBJ hours. Pair the marketing claims with (a) LTCCC expected-vs-actual deviation (color tier and %), and (b) your PBJ audit results. This supports consumer-protection/UDAP and false-advertising claims where state law allows, in addition to negligence, regulatory violations, and, where appropriate, False Claims Act theories.

Example of the use of case mix & acuity in a staffing suit:

The California Attorney General's complaint in ***People v. Sweetwater*** discusses acuity/case-mix and staffing practices. https://oag.ca.gov/system/files/attachments/press-docs/Sweetwater%20Complaint.pdf

Financial motive & damages narrative (quantifying savings from understaffing)

Purpose. To show motive/intent, quantify how much the facility saved by chronically staffing below expected (or below verified actuals).

- For each day: Shortfall Hours = max (0, Expected HPRD − Verified HPRD) × Census.
- Wage cost avoided (daily) = Σ(Shortfall Hours_RN × RN wage+fringe) + Σ(Shortfall Hours_LPN × LPN rate) + Σ(Shortfall Hours_CNA × CNA rate).
- Total avoided labor cost = sum over the incident window; compare to related-party payments/bonuses in the same period for motive.

- If the PBJ audit finds over-reporting, re-state HPRD on verified hours and recompute the shortfall; include weekend dips and turnover as foreseeability proof.

Corporate control & liability (knowledge — notice — control)

- **Budgets & targets**. Show corporate-level budget approvals, labor targets, and staffing "productivity" dashboards that drove local HPRD below expected staffing — evidencing control from the parent/management company.
- **Monitoring & notice**. Use chain-level reports (Five-Star, PBJ variance, turnover, weekend dips) and internal emails to show ongoing notice of understaffing and resulting harms.
- **Policies & incentives**. Highlight compensation tied to labor "savings," related-party payments, and directives limiting RN/CNA coverage — tie to missed care and outcomes.
- **Liability theories**. Plead and prove agency/alter-ego/enterprise, negligent/reckless understaffing, and (where available) consumer-protection or FCA counts against corporate entities.

Public enforcement add-ons. Consider **False Claims Act** /state analogs (billing while non-compliant with Requirements of Participation), **consumer protection** counts, and restitution/disgorgement.

Pre-suit record control & leverage

- **Preservation letter** within days of intake: PBJ source files, schedules/assignments, Facility Assessment, care plans, training files, agency invoices, surveillance, call-bell logs, and EHR audit trails.
- **Early data snapshot** from NursingHome411 to lock in expected-vs-actual HPRD around the incident window.
- **Pattern & practice**: Pull Provider Data Report, ownership web, prior deficiencies/fines; look for turnover and weekend dips.
- **Damages framing**: Pair clinical course (e.g., weight loss → pressure injury → sepsis) with specific missed tasks that could not be completed at reported staffing levels.

Red flags & cross-examination prompts

- **RN coverage thin** on evenings/nights; **DON/Admin counted** in RN totals despite non-care roles.
- **High contract hours** substituting for core staff — ask about onboarding, supervision, and continuity.
- **Weekend staffing dips** vs weekdays; chronic **turnover**.

- **Facility Assessment** referencing needs (e.g., dementia/behavioral health) **without** matching training hours or staffing by unit/shift.
- **In-service "check-the-box"** without remediation for identified weaknesses.

Sample questions

- "Show where your Facility Assessment's staffing by unit and shift is implemented in weekly schedules."
- "Identify which staff received dementia training before being assigned to the memory care unit."
- "Explain why your CNA HPRD averaged 2.4 when your residents' CMI called for 3.2 — who missed care?"

Citations you'll likely need (quick list for pleadings)

- 42 C.F.R. **§ 483.35** (Nursing Services — sufficient/competent staff; F-725).
- 42 C.F.R. **§ 483.35(d), (e)** (Nurse aide competency & training; F-728, F-730, F-947).
- 42 C.F.R. **§ 483.70(e)** & **§ 483.70(b)** (Facility Assessment; leadership involvement; F-838).
- **Survey guidance** (SOM Appendix PP) on sufficient staffing and facility assessment.
- LTCCC **Expected Staffing** methodology and quarterly reports.
- For public enforcement: **False Claims Act** (31 U.S.C. §§ 3729–3733) /state analogs; **consumer protection** statutes.

Boilerplate for demand letters / pleadings (drop — in paragraph))

*"Federal regulations require this facility to provide sufficient nursing staff with appropriate competencies to meet the assessed needs of each resident and to ensure the highest practicable well-being. See 42 C.F.R. § 483.35 and § 483.70. During **[Q#-YYYY]**, Respondent reported **[RN/CNA/Total]** HPRD for **[Facility]**, which is **[X%] below** the **expected** RN/CNA/Total HPRD (case-mix adjusted) reasonably required for its resident acuity (CMI **[value]**). This persistent shortfall, corroborated by **[missed care/harm]**, evidences breach of duties of care and regulatory compliance, proximately causing preventable injury."*

If applicable, add: *"This persistent shortfall is further corroborated by verified staffing audits showing over-reporting in PBJ compared to timecards, payroll, and daily staffing records, evidencing misrepresentation to consumers/payers."*

Sample discovery requests

1. All PBJ submissions and CMS feedback files for **[Q-1 through Q+1]** surrounding the incident window.
2. The complete Facility Assessment and any updates for the 12 months before the incident and 12 months after.
3. Unit-level staffing schedules and assignment sheets for the unit(s) where **[Resident]** resided for the same period.
4. Staffing policies, contingency plans, and communications addressing shortages or use of agency staff.
5. Training logs, competency checklists, and remediation records for all staff assigned to [Resident].
6. Agency contracts, weekly invoices, and credential files for temporary nursing staff.
7. Quality, infection control, and incident logs related to **falls, pressure injuries, infections, weight loss, dehydration, rehospitalizations**.

Practical tips

- Align **injury windows** with **quarterly PBJ** periods when possible.
- Request **unit-level** schedules if facility claims adequate building-wide HPRD.
- Emphasize **competency** (not just headcount) — dementia care, abuse prevention, infection control.
- Use **turnover + weekend dips** to argue foreseeability and failure to plan.

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