
CARE TRANSITIONS AND NURSING HOME LITIGATION

Between Care Settings

Staffing, Handoffs, and the First Night After Transfer

BY MICHELLE CARROLL · FOUNDER & CEO, LEXCURA SUMMIT

A lot of harm happens while patients are in motion. An older man leaves the hospital for a skilled nursing facility late in the afternoon. His discharge plan changed three medications and says he needs help every time he gets out of bed. The facility is short on the evening shift. By morning, he's on the floor.

Staffing usually gets talked about as numbers: how many nurses, how many residents each. The numbers matter. But to explain what happened to one person, you also need to know what work he actually needed, what the receiving team actually knew, and whether the setup let anyone respond in time.

THE STAFFING RULES CHANGED

In 2024, CMS finalized the first federal minimum staffing standards for nursing homes, including a registered nurse on site 24 hours a day and minimum hours per resident day. They didn't last. After court challenges and a congressional delay, CMS repealed the 24/7 RN requirement and the hours-per-resident-day floors in an interim final rule published December 3, 2025, effective February 2, 2026.

What's left still matters a great deal. Facilities must have enough nursing staff with the right skills to meet each resident's needs (42 C.F.R. § 483.35). They still need an RN on site at least 8 straight hours a day, 7 days a week, a full-time RN director of nursing, and a licensed charge nurse each shift, with limited waivers. They still have to complete a facility assessment (§ 483.71) sizing up their residents and the staff and skills needed to care for them. And they still report Payroll-Based Journal staffing data to CMS and post daily staffing.

With no federal number to point to, "enough" gets measured against how sick the residents actually are and against the facility's own assessment of what it needed. That makes the facility assessment, the PBJ data, and the resident's documented needs more important, not less.

BOTH SIDES OF THE HANDOFF HAVE OBLIGATIONS

The hospital, under its discharge planning rules (42 C.F.R. § 482.43), has to send the next provider the necessary medical information about the patient's current illness and treatment, goals of care, and treatment preferences. A discharge summary that says a drug is on hold in one paragraph and lists it as active on the next page is the hospital's documentation problem.

The facility has to have physician orders for the resident's immediate care at admission (§ 483.20(a)). It must write a baseline care plan within 48 hours with the instructions staff need to care for him (§ 483.21(a)), and a full assessment within 14 days. The accidents rule requires an environment as free of hazards as possible and adequate supervision and assistance devices to prevent accidents (§ 483.25(d), cited on surveys as F689). Pharmacy services requirements, including drug regimen review, apply to how admission medications get reconciled (§ 483.45).

AHRQ's TeamSTEPPS handoff tool describes a handoff as passing along information, authority, and responsibility, with a real chance to ask questions and confirm understanding. AHRQ's IDEAL discharge planning approach treats the patient and family as partners. Neither is a legal standard, but both describe what a working handoff looks like, which makes it easier to see what was missing.

A FICTIONAL CASE

An older man is discharged after an acute illness. He's much weaker than before and can't clearly explain what was done in the hospital. The plan includes medication changes, help with walking, and follow-up labs. He arrives at the facility at 5:30 p.m.

One medication instruction in the discharge summary is unclear. His daughter tells the admitting nurse he needs help every single time he gets up. The transfer form just says "assist with mobility," with no level of help given. Overnight he tries to get to the bathroom alone and falls.

Those facts don't tell you why he fell. They tell you where to look.

THE FIRST FEW HOURS

This is when the gap between what the hospital knew and what the facility knew is widest. Find out when he arrived and when the admission nursing assessment was done, what information got to the facility before he did and what came with him, what the admission fall-risk assessment found and what it triggered, whether he looked different on arrival than the hospital described, and when admission orders were obtained. A plan that made sense at discharge may need to change if he got worse in transit or on arrival.

Pay close attention to how uncertainty was handled. If the mobility instruction was vague, did anyone call the hospital or the attending to clarify? Was something put in place while the question was open, like a bed alarm, more frequent rounding, or a bedside commode? Could the

night shift reach anyone who knew the answer? Those questions explain the process without assuming every vague instruction led to unsafe care.

MAKE THE STAFFING EVIDENCE MEAN SOMETHING

Staffing evidence only matters once it's tied to this patient's needs and a specific stretch of time.

A schedule shows who was supposed to work. It won't show call-offs, who got pulled to another unit, who stayed late, or who was covering two assignments. Time-and-attendance records, assignment sheets, and PBJ data show who was actually on the floor.

Workload depends on acuity. A resident who needs an occasional reminder is a very different assignment from a newly admitted, deconditioned man who needs hands-on help and frequent checks. Two units with the same census can have completely different workloads, and a headcount comparison misses that.

Agency and float staff may be fully qualified and still not know the facility's escalation routes or charting system. If that matters in your case, look at the orientation and support they actually got. Don't assume temporary staff gave poor care, or that permanent staff had everything they needed.

And competing demands belong in the story. If his aide was handling another resident's emergency when he fell, that goes in the chronology, followed by questions about coverage, how priorities were set, and what protections were in place for a high-risk new admission in the meantime.

Short staffing can be part of the explanation. It can't be the whole explanation. You still have to connect the resource problem to a specific task, a specific window of time, and a plausible effect on this man.

MEDICATION MIX-UPS AT TRANSFER

Reconciling medications at transfer is a known danger point. The hospital may have stopped a drug, changed a dose, or started a short course, while the facility is also holding an older med list. You have to figure out which list actually guided what he was given and how conflicts were resolved.

The records can mislead. An order doesn't prove the drug was given. A MAR entry doesn't tell you why that order was chosen. Sorting out a disputed dose may take the admission orders, order history, MAR, pharmacy review notes, any clarification calls, and relevant monitoring.

Say the hospital meant for a blood thinner or blood pressure medication to be held until repeat labs, and says so in the narrative, but the med list shows it as active. If the facility gave it, look at the inconsistency, whether anyone had a chance to clarify it, and most importantly whether that

dose had anything to do with the fall or its consequences. A discrepancy can be completely real and still unrelated to the injury. Presenting it as if it explains everything weakens an otherwise careful analysis. Each concern has to earn its place on its own.

| LISTEN TO THE FAMILY, CAREFULLY

Families often know the patient's baseline better than anyone in the building: that he usually walks on his own, handles his own pills, knows everyone. That's valuable when the facility has only a short transfer summary.

Treat family accounts like any other evidence. What did the family member see directly, when, and what did they tell staff? Was it written down? Does it line up with the hospital therapy notes? Did his ability change over the day? "He seemed off" becomes useful once it's tied to a specific behavior and time.

That's why Baseline Profiling has its own place in the Lexcura Clinical Intelligence Model. Without a reliable baseline, you can mistake new impairment for something longstanding, or a chronic limitation for a sudden decline. Either mistake distorts what reasonable care would have required.

| WATCHING FOR CHANGE

A care plan is where you start, and a changing patient needs a changing plan. Say he got more confused as the evening went on. Was that new since arrival? What else was going on: vitals, pain, urinary symptoms? Was the practitioner told? Facilities have to notify the physician and the resident's representative of a significant change (§ 483.10(g)(14)).

"MD notified" leaves a lot unsaid: what was reported, when an answer came, what happened next. Follow each call through to the decision it produced, or pinpoint where the evidence runs out. Sometimes more records show the right thing was done. Sometimes they confirm a long stretch with no needed response. Those are very different findings, and they should be described differently.

| CONNECTING IT TO THE FALL

Each concern, whether an incomplete mobility handoff, a late assessment, or help that wasn't there, has to be tested against how he actually fell. Was he headed to the bathroom? Had he used his call light, and how long did it take to answer? Were the care-planned precautions actually in place? What realistically would have prevented it?

Acute illness, medication effects, poor judgment, and weakness don't automatically cancel out care failures. They do mean you have to explain how everything interacted instead of pinning it on one unsupported cause.

The response after the fall is its own sequence: how quickly he was assessed, neuro checks if he may have hit his head or nobody saw the fall, imaging, and how injuries were handled. Keeping prevention and post-fall response separate shows where the evidence is strong and where it needs more work.

RECORDS WORTH REQUESTING

- Hospital discharge summary, discharge med list, PT/OT notes, and the transfer form
- Facility admission orders, admission nursing assessment, fall-risk assessment, and baseline care plan
- MAR, pharmacy admission review, and any medication clarification notes
- Nurse and aide assignment sheets, time-and-attendance records, and PBJ data for the relevant shifts
- Call-light logs, if the system keeps them, and bed or chair alarm records
- The incident report and post-fall assessment (privilege rules vary by state), and change-of-condition notices
- The facility assessment and survey history for related citations, including F689

A good early review leaves you with a clear picture of what he needed, how the handoff went, and which decisions need a closer look. It flags missing records that could change that picture, and it acknowledges what the facility did right. You can see how good a handoff was by looking at what happened next.

SOURCES

- CMS, *Repeal of Minimum Staffing Standards for Long-Term Care Facilities*, Interim Final Rule, Federal Register Doc. 2025-21792 (Dec. 3, 2025), effective Feb. 2, 2026
- 42 C.F.R. §§ 482.43, 483.10(g)(14), 483.20, 483.21(a), 483.25(d), 483.35, 483.45, 483.71
- AHRQ, *TeamSTEPPS: Handoff*; AHRQ, *IDEAL Discharge Planning*

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case that grew out of a care transition and want the handoff rebuilt, the staffing evidence tied to the patient's actual needs, and each concern tested against how the harm happened, we'd welcome the conversation.

Michelle Carroll

FOUNDER & CEO, LEXCURA SUMMIT

