Prevailing in Nursing Home Fall Cases

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The key to a prevailing in a nursing home fall case is **case selection**. Good fall cases have a number of common elements: the resident was at a high risk for falling, the nursing home staff *knew* that the resident was at risk for falling, staff failed to implement basic safety protocols to protect the resident and as result, the resident fell and sustained a catastrophic injury or death. For a great case, gather additional evidence to show that the fall was the result of an institution-wide problem, such as understaffing, and pick cases with residents and family members that the jury will love.

What follows is a basic outline of what to look for when selecting fall cases, common defense arguments, discovery strategies and relevant state and federal regulations to help you not only select the right case, but develop the evidence to tell the most powerful story at trial.

1. Risk Factors for Falls

A. Medical Conditions

(1) Cognitive Impairment
(2) Incontinence
(3) Low Blood Pressure
(4) Injuries Affecting Ability to Walk
(5) Diabetes
(6) Visual Impairment
(7) Balance Problems
(8) Age
(9) Generalized Muscle Weakness
(10) Recent Hospitalization
(11) Fear of Falling
(12) Infection
(13) Cardiovascular Disease
(14) Sun-Down Syndrome
(15) Acute Exacerbation of a Chronic Illness
(16) Depression

B. Medications

(1) Use of more than four medications

(2) Cardiovascular Medication

a. Diuretics
b. Anti-Arrhythmic Agents
c. Antihypertensives

(3) Pain Medications

(4) Psychoactive Medications

a. SSRI Antidepressants
b. Benzodiazepines
c. Atypical Antipsychotics
d. Chemical Restraints

(5) Parkinson's Disease Medications

(6) Anticonvulsants

(7) Coumadin / Anticoagulants

C. Environmental Factors

(1) Lighting
(2) Floors
(3) Time of Day

D. History of Prior Falls

2. Evaluation of Potential Fall Cases

A. Was resident at a high risk?

B. Where did the resident fall?

(1) Room
(2) Public Area

C. When did the resident fall?

(1) Time of Day
(2) Weekend or Weekday

D. Was the fall witnessed or unwitnessed?

E. What type of fall was it?

F. Can the resident testify concerning the circumstances of the fall?

G. Was the injury serious or catastrophic? (Brain bleed, fractured hip, etc.)

3. Proper Protocols

A. Assessment: Was a complete, accurate and timely fall risk assessment completed?

(1) Forms filled out correctly?
(2) All risk factors noted?
(3) Check the facility's *own* policies and procedures for a complete list of fall risk factors that should have been taken into account during each fall risk assessment.

B. Interventions: Were proper and timely fall-risk interventions put into place?

(1) Was an "interim" care plan put into place upon admission?

(2) Was a complete care plan put into place by day 21 of the admission with proper fall risk interventions noted?

(3) Was the care plan reviewed at least every three months and with each significant change in conditions?

(4) Were the interventions appropriate?

a. Bed Alarms
b. Tab Alarms
c. Floor Alarms
d. Bed Lowered
e. Fall Mats
f. Resident Moved Closer to Nurse's Station
g. Hip Protectors
h. Toileting Program
i. Mobility Programs
j. Increased Supervision
k. Transfer Interventions (Hoyer Lift, etc.)
l. Use of Assistive Devices (Merry Walker, etc.)
m. Physician-Approved "Restraints" (Wheelchair Seatbelt, etc.)
n. Individualized Plan

C. Reevaluation and Reassessments

(1) Were the interventions reviewed at least every three months?

(2) Were the interventions reviewed and reassessed with every "significant change in condition"?

D. Proper Response

(1) Did the facility timely notify the treating physician?
(2) Did the facility timely notify the responsible family member?
(3) Did the facility conduct a proper investigation?
(4) Did the facility provide timely and appropriate medical care?

a. Fractures

i. Was a thorough assessment conducted? (Range of Motion, etc.)

ii. Were x-rays ordered?

b. Head Injuries

i. Were neurological checks initiated to check for closed head injury and brain hemorrhage?

ii. If resident was on Coumadin and sustained a visible head injury, was he or she sent to the emergency room to rule out a bleed?

c. Are there any other delays of treatment or failure to monitor the resident after the fall?

4. Damages

A. Are the injuries significant?

B. Do you have photos of the injuries?

C. What other issues resulted from the fall injury?

(1) Pressure Wounds
(2) Permanent Decrease in Function
(3) Pneumonia
(4) Contractures
(5) Malnutrition or Dehydration
(6) Death

D. Is there evidence of fraud or a cover-up?

5. Common Defenses

A. This fall was simply an accident. Elderly people fall all the time.

B. Facility staff cannot watch residents 24/7. It is impossible and there is no legal duty to do so.

C. Staff cannot provide one-on-one care.

D. The resident's condition made the injury inevitable.

E. Causation Issues. For example, which came first, the stroke, or the fall that caused a brain bleed?

F. The resident herself caused the injury. We told her not to get up without pressing the call light for help and she did it anyway.

G. Alarms don't prevent falls.

H. The fall did not cause the injury. For example, the resident had a "spontaneous fracture" due to her osteoporosis; not due to any fall.

I. We cannot use restraints.

J. People with Alzheimer's and other forms of dementia do not experience pain the same way the average person does.

K. The resident was already on heavy pain medication (due to arthritis, for example) and thus, they were not suffering terrible pain, despite the delay in treatment.

L. The resident was already on hospice (or was old) and was going to die anyway.

6. Discovery Strategies

A. Make your case about an institution-wide problem; not an isolated incident.

B. Prove as much of your case as you can through the other side's witnesses. TRIAL GOLD!

C. Videotape your depositions. Get staff to admit, on camera, what the facility's policies and procedures were, and that they were not followed.

D. Use discovery to counter every potential defense argument.

E. Use Rule 30(b)(6) and Rule 34 corporate depositions to ensure that the corporate representative is prepared to give you the information you requested. Here are some sample topics to include in your corporate deposition notice:

(1) STAFFING: Staffing levels, quotas, how staffing levels are set, and the number/goal per shift, per floor/wing, firings, terminations, resignations and change in managerial and resident care staff and the reasons therefore during the relevant time period.

(2) EMPLOYEES: Personnel Files, what is kept in them, disciplinary action against employees, incentive programs, compensation rates for employees, etc. during relevant time period.

(3) POLICIES AND PROCEDURES: Facility policies and procedures in place during relevant time period.

(4) BUDGET: Cost reports, profit loss statements, profits, amount spent on staffing, food, bonuses, etc. during relevant time period.

(5) PAYROLL: Time card system description, how hours are documented, pay rates for employees, bonuses, and identification of all documents which contain information concerning hours actually worked, etc. during the relevant time period.

(6) CENSUS: Daily Census information during the relevant time period.

(7) ACUITY: Acuity levels, how determined, whether tracked, whether reported to outside parties such as Medicare and where documented, etc. during relevant time period.

(8) SUPERVISION: Monitoring and oversight of proper care and treatment of residents, tracking of issues such as falls, pressure wounds, infections, internal policies and procedures, training, and chart audits, etc. during relevant time period.

(9) MINIMUM DATA SET SHEETS: MDS sheets, who filled them out, how they are filled out, what information is gathered, risk utilization group rates, and case mix indexes, etc. during the relevant time period.

(10) RECORDS: Resident charts, how organized, what is contained within the chart, what other documents concerning resident care are contained outside the chart and identification of the names of other documentation that may not be with the resident chart, etc. during the relevant time period.

(11) STAFF TO STAFF COMMUNICATION: Description of any system for staff to communicate to each other concerning residents when changing shifts or for any other reason, etc. during the relevant time period.

(12) RECORD DESTRUCTION: Records destruction policy and procedures, how records are maintained, for how long, when destroyed, what are destroyed, how destroyed etc. during relevant time period.

(13) SURVEYS: Inspections conducted at the facility, policies and procedures for response, responses to citations, etc. during the relevant time period.

(14) CONSULTANTS: Whether outside consultants are brought in to assess any issues related in any way to care and treatment of residents, if so who they are , what they are assessing, etc. during the relevant time period.

(15) COMPLAINTS: Any and all information concerning complaints made by employees, staff, or others concerning care and treatment of residents at the facility, whether they are documented, whether there is a procedure to voice complaints, complaint cards, resignation letters, how addressed, etc. during the relevant time period.

(16) STAFF TRAINING: policies and procedures concerning staff training, how often what topics, in service, sign-in sheets, documentation, when is additional training added, how are staff monitored to ensure care and treatment is provided in accordance with policies and procedures, etc. during the relevant time period.

(17) QUALITY ASSURANCE: whether there is special committee for quality assurance, who was on the committee, tasks, the process, etc. and any and all other committees established to address quality of care and treatment issues, etc. during the relevant time period.

(18) QUALITY INDICATOR REPORTS who prepares, what information is gathered, from what sources, how long kept, how documented, what topics, who shared with etc. during the relevant time period.

(19) FALL PREVENTION: Policies and procedures concerning falls, response to falls, fall assessment, proper transfers, use of other devices such as gait belts, Hoyer Lifts, etc. during the relevant time period.

(20) GOVERNING BODY: was there one, who was on it, what governing body was supposed to do, etc. during the relevant time period.

(21) NURSING ASSESSMENTS: policies and procedures concerning nursing assessments, how often, what is documented, etc. during the relevant time period

(22) INCIDENT REPORTS: policies and procedures concerning incident reports, what triggers one, what forms are used, how are they supposed to be filled out, where are they sent, what is shared with the resident and/or the family member, POA or responsible party etc. during the relevant time period.

(23) DOCUMENTATION: policy and procedure in place for proper documentation of resident care and treatment during the relevant time period, including how to fill out all forms, etc.

(24) CALL LIGHT SYSTEM: How it works, whether it is recorded, how it is monitored, etc. during the relevant time period.

(25) VIDEO SYSTEM: whether one existed during the relevant time period, how it worked, whether it was recording, whether recordings are saved, the locations of the cameras in the facility, etc. during the relevant time period.

(26) EMAILS: Whether staff were able to communicate by email concerning resident care and treatment, if so, the policies and procedures concerning such emails, destruction policy, emails to corporate, etc. during the relevant time period.

(27) SUPPLY COMPANIES used by facility for special beds, alarms, etc. during the relevant time period.

(28) DRUG DISPOSITION LOGS and all policies and procedures concerning proper documentation or drug disposition, etc. during the relevant time period.

(29) PRESSURE WOUNDS: policies and procedures concerning pressure wounds, tracking, assessment, dietary, intake/output, turning and repositioning, wound care, proper documentation of wound(s) and wound care, skin sheets, bath sheets, monitoring for potential pressure wounds, hygiene issues related to pressure wound care, special mattresses and/or pads, when used, how documented, etc. during relevant time period.

(30) NOTIFICATION TO RESIDENT'S PHYSICIAN: all policies and procedures concerning when a resident's physician is to be notified,

what constitutes a "significant change in condition", etc. during the relevant time period.

(31) BLADDER AND BOWEL CARE: all policies and procedures concerning care and treatment and proper documentation concerning bladder and bowel care, toileting program, foley catheter care, signs and symptoms of urine and bowel issues, etc. during relevant time period.

(32) ORGANIZATION CHART: Identification of organization chart, all job titles and job duties, specific to each floor and wing, etc. during relevant time period.

(33) FORMS: Identification and explanation of all forms contained in the Plaintiff's nursing home chart, the purpose of each form and how each form is supposed to be filled out etc. during the relevant time period.

(34) INFECTIONS: all policies and procedures concerning care and treatment and proper documentation of infections, such as MRSA, VRE, pneumonia, urinary tract infections, tracking, signs and symptoms, etc. during relevant time period.

(35) HOSPICE CARE: all policies and procedures concerning hospice care and care and treatment provided to residents while on hospice care status, etc. during relevant time period.

(36) BATHING: all policies and procedures concerning how often residents are bathed, different bathing options available, Bath Flow Sheets and how they are supposed to be filled out, etc. during relevant time period.

(37) DIETARY: all policies and procedures concerning dietary care and treatment, intake/output, care and treatment of residents at risk for malnutrition or dehydration etc. during relevant time period.

(38) TRANSFERS: all policies and procedures concerning proper transfers and apparatus used, criteria for different methods (such as a slide board, Hoyer lift, gait belts, Maxi-Slide Kit), etc. during the relevant time period.

(39) CORPORATE STRUCTURE: Defendant's corporate structure during the relevant time period.

(40) AUDIT TRAILS for [CLIENT'S] complete Facility chart.

(41) INCIDENT INVOLVING INJURIES: all policies and procedures concerning proper handling of all incidents involving an injury during the relevant time period.

(42) The circumstances concerning the incident that occurred on or about [DATE] in which Mrs. [CLIENT] fell, was dropped or lowered to the floor of her room, including the names of persons who witnessed the incident, and the names of all staff members who documented and investigated the incident.

(43) DISCOVERY RESPONSES: Defendant's Discovery Responses in this case.

7. Federal Regulations: 42 CFR Part 483 Subpart B - Requirements for Long Term Care Facilities (§§ 483.1 - 483.95)

Key Sections:

A. 42 CFR § 483.13

Residents have a right to be free from abuse and neglect and the facility must not employ individuals who either have a history of abuse or are not in the State registry

B. 42 CFR § 483.20(d)(3)(1)

Requires that the care provided meets professional standards of quality

C. 42 CFR § 483.30

Requires the facility to have sufficient qualified nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care

D. 42 CFR § 483.20(b)(1)

Requires that the facility must make a comprehensive assessment of the resident's needs

E. 42 CFR § 483.20(b)(iv)

Requires that when a significant change occurs, the facility perform a reassessment

F. 42 CFR § 483.25(h)(1)

Requires that the resident's environment remain free of accident hazards

G. 42 CFR § 483.25(h)(2)

Requires that each resident receives adequate supervision and assistance devices to prevent accidents

8. State Regulations

A. Nursing Home Residents' Bill of Rights (N.J.S.A. 30:13–5)

B. Standards for Licensure of Long-Term Care Facilities (N.J.A.C. 8:39)

C. General Licensure Procedures and Enforcement of Licensure Regulations (N.J.A.C. 8:43E)

Good Luck on Your Cases!