Letting elders down:

Falls and traumatic brain injuries at long-term care facilities

By Kathryn Stebner and George Kawamoto

With the prevalence of understaffing in many long-term care facilities, falls by elderly and dependent adult residents are all too common. Sadly, these falls often cause life-changing or life-ending harm such as traumatic brain injuries. Here, we present three case studies regarding different types of long-term care facility settings to illustrate similarities and differences.

Case Study #1 – AJ's fall at a skilled nursing facility

In a recent case, we represented the family of "AJ,"[1] an elderly resident with advanced dementia who died from an acute intracranial hemorrhage caused by an unsupervised fall at a skilled nursing facility in Northern California. The owner of the facility admitted at her deposition that she and her staff had previously known AJ was at high risk for falling and required monitoring and assistance with transfers and ambulation at all times. AJ had also required working bed and chair alarms to be used to alert staff whenever he attempted to ambulate by himself. Indeed, in the owner's words, "he was a high fall risk no matter where he was" and was "never supposed to walk unattended" at the facility due to his conditions.

Shockingly, despite knowing AJ's needs, the facility owner and staff admitted he was regularly left to walk the facility corridors and common areas by himself. Discovery revealed that as a result of this reckless neglect, AJ had suffered at least six unsupervised falls at the facility before his final and fatal fall.

AJ's last fall at the facility happened during the early morning hours of the NOC (nocturnal) shift. Although the owner later intentionally truncated security video footage from that morning, the remaining footage still showed AJ walking by himself with his walker down a hallway. A certified nursing assistant glanced at AJ before turning away and leaving. Just before the video footage ended, AJ is seen falling backwards and hitting his head on the concrete floor.

Our site visit of the facility and review of the floor plan and other documents revealed that AJ had moved far from his room and away from any nursing stations. Nursing staff testified that when AJ was found on the ground, he was first taken back to his room and placed into bed. His condition was never assessed by a registered nurse or physician at the facility. Over six hours later, defendants finally called 911 because staff from the next shift, who were not informed of AJ's fall, were shocked to find him unresponsive. At the hospital E.R., AJ underwent repeated CT scans and was ultimately diagnosed with a closed fracture of the vault of the skull, a closed fracture of the base of the skull, extensive multicompartmental acute intracranial hemorrhages, and several intraparenchymal hematomas. He died as a result of his injuries a few days later.

In addition to other claims, the crux of our case was plaintiff's claims of elder neglect under California Welfare and Institutions Code section 15610 et seq.[2] Certainly, AJ's fall and resulting death was no "mere accident" as defendants wished the world to believe.[3]

Egregiously low staffing

Like so many other defendants, the owner testified at her deposition that she staffed the facility to meet the acuity of the

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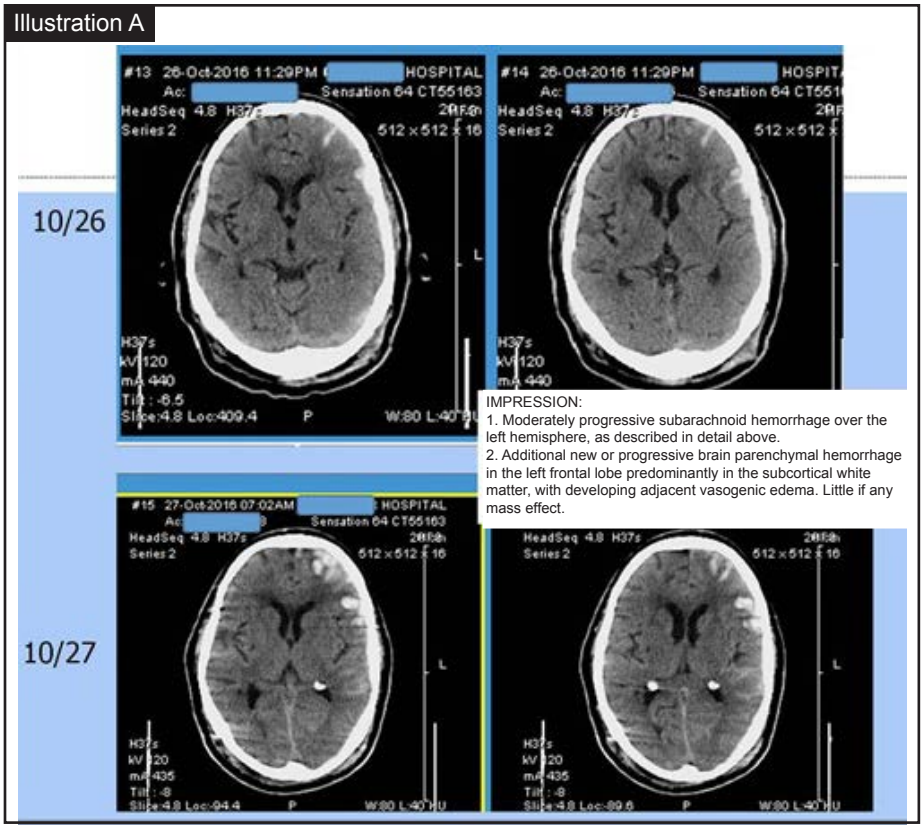
Illustration A



residents. However, she eventually admitted she had no objective or written basis for doing so. In fact, documents revealed the staffing at the time of AJ's admission to the facility was as low as 3.21 Nursing Hours Per Patient Day (NHPPD), a mere 0.01 NHPPD above the State-mandated bare minimum at the time. On top of that, a review of the facility's cost reports submitted to the state and federal government revealed an increasing trend over the last several years, like in many other chain-operated skilled nursing facilities, for the owner to target higher acuity, short term Medicare patients. Why? To increase revenues, which lead to greater profits. High need patients have the highest reimbursement rates of any payor type, especially for ancillary services.

Nurse staffing is critical to the provision of basic care in skilled nursing facilities. Studies have demonstrated a direct and positive relationship between nurse staffing levels and the quality of nursing home care, and residents are at a substantially higher risk of insult and/or injury if staff is inadequate to care for the collective needs of the resident population.[4]

As referenced above, California skilled nursing facilities have legal obligations to provide adequate nurse staffing. Under California regulations, the minimum requirement is 3.5 Direct Care Service Hours Per Patient Day ("DHPPD"), of which a minimum of 2.4 DHPPD shall be performed by certified nurse assistants.[5]

Although this requirement represents the bare minimum nurse staffing permitted in California, many facilities are seeking waivers. Skilled nursing facilities are under additional requirements under Federal and State regulations to provide sufficient qualified nursing staff to meet resident needs.[6] In 2002, the federal government increased the minimum recommended level of skilled nursing facility staffing to 4.1 nursing hours per patient day. For facilities that have high patient acuity (i.e., need levels), even higher staffing may be required.

In AJ's case, we found and interviewed ex-employees who stated that the facility owner often received complaints from staff and families about low staffing at the facility for years and did nothing. Moreover, the owner had known for a long time about her staff's lack of sufficient training, as evidenced by their repeated citations for failing to know and implement their own fall prevention protocols but did nothing about it.

Repeated falls and no changes

Over the course of his admission to defendants' facility, AJ suffered at least seven unsupervised falls. Despite these numerous falls, defendants failed to properly assess or adequately care for AJ, review his care plan, or implement new fall prevention interventions to keep him safe. In skilled nursing facilities, a resident's care plan, such as for preventing falls, must be individualized for each resident, updated with changes in condition, implemented appropriately, and be well documented.

Additionally, other redacted facility records revealed a myriad of falls by other residents at the facility. However, there was no evidence that defendants increased their overall nurse staffing levels, conducted staff trainings or in-services, or otherwise made any changes to try to reduce the high frequency of falls at their facility.

Reprimanded by the state for not implementing fall prevention precautions

The facility had a long track record of being cited by the state for failing to implement fall prevention interventions such as bed alarms. In our case, the facility owner admitted she "did away with alarms because they were upsetting and distracting." The alarms were "upsetting and distracting" because the owner had failed to employ enough staff to respond to them. The owner tried to justify her decision by stating AJ was given a call light and reminders to ask for staff to help before ambulating – which were obviously inappropriate and inadequate for a person with dementia.

Repeated statements of deficiencies from the California Department of Public Health ("DPH")

It was no surprise the facility received multiple deficiencies as a result of inadequate resident care. *This revealed a deadly pattern*. Each statement of deficiency was signed by the owner.

Fraud and CYA over resident care

Discovery in AJ's case revealed that after his falls, defendants focused on creating, manipulating, and destroying evidence to cover up their potential liability rather than providing AJ and other facility residents with the care they needed (a common occurrence in elder abuse cases and a topic for another article). For example,

they altered video footage of AJ's subject fall. They also back dated, altered, and destroyed documents in AJ's resident chart regarding his conditions, fall risk, and falls. Not only did their own documents reflect contradictions, but their description of the subject incident and staff statements were significantly inconsistent with third-party EMT and hospital reports.

Unsurprisingly, there was no shortage of evidence of ratification by managing agent in this case. Despite (1) racking up an atrocious track record with the State, (2) allowing AJ to fall at least seven times and causing his death, and (3) being subject to numerous prior lawsuits arising from elder neglect, the owner brazenly denied that anything was wrong. The owner knew that AJ died as a result of the unattended falls at the facility and yet failed to conduct an accurate and thorough investigation into what actually happened. Nor did the owner make any changes at the facility after falls and death. As noted above, defendants instead fraudulently created, manipulated, and destroyed evidence to try to evade liability – unsuccessfully.

Unfortunately, cases like AJ's are all too common. Many in the long-term care industry will go to any means necessary to increase profits, even if that means their elderly residents are left to pay the tab. And many facility owners and operators are getting away with it. They must be held accountable.

Case Study #2 – BJ's fall at a small six-bed RCFE

It is important not to forget about the increasing prevalence of resident harm at RCFEs (residential care facilities for the elderly, also known as assisted living facilities). Approximately 300,000 elderly Californians currently live in RCFEs – in small six-bed facilities, large facilities with a hundred or more rooms, or something in between. While we are all familiar with stories of elder abuse and neglect in skilled nursing facilities, wrongful conduct in RCFEs may be more pervasive and less publically known. As residents and family members go to greater lengths to avoid moving into skilled nursing facilities, the care needs of the resident populations at RCFEs have increased significantly over the years. Residents who were in skilled nursing facilities are now in RCFEs. While the acuity of residents has increased, we are seeing in our cases that the staffing levels have not.[7]

In another case, we represented the family of "BJ," an elderly resident with advanced dementia who had resided a small, six-bed RCFE in Northern California. Upon admission to the facility, BJ was known by the defendants' owners, managing agents, and staff to be at high risk for falls, disoriented, possessing a propensity for wandering and food-seeking behavior due to his dementia and other medical complications. During his admission, BJ required assistance from defendants to perform all of his activities of daily living.

Section 87615(a)(5) of the California Code of Regulations provides that "[r]esidents who depend on others to perform all activities of daily living for them" shall not be admitted or retained in a RCFE. RCFEs can lawfully retain residents who require complete and total assistance only upon approval by the state

through waivers and exceptions. Defendants were unable to produce any evidence that they obtained a waiver for BJ.

Moreover, defendants were aware BJ could not be left alone or remain unsupervised, that he was at high risk for falls, and that he required care, supervision, monitoring and fall precautions to be implemented due to this condition. Yet defendants failed to provide such care, neglected to fulfill their obligations and duties, and were careless in their supervision of him.

The director's performance and candidacy for bonus pay was measured on the ability to adhere to the corporate budget.

During the period of the Northern California fires in October 2017, defendants evacuated BJ to an evacuation center located on the county fairgrounds. One of the defendant owners admitted during deposition that defendants kept the residents from several of their small RCFEs at the evacuation center for over a week without making any attempt to find an alternative placement for them. Defendants failed to promptly relocate their vulnerable residents, including BJ, who had dementia and other conditions, much earlier to another facility. Defendants also failed to notify family members about their inability to find a safe, alternative placement. Defendants knew BJ was disoriented even in familiar settings due to his condition, so a strange, new setting like the evacuation center left him totally bewildered and lost. The likelihood that he would be at risk of injury was high. Yet, defendants left BJ unsupervised and unassisted, and sleeping in a simple cot, which led to his unsupervised fall in the middle of the night. He was found on the cement floor near his cot with catastrophic injuries, including a subdural hematoma and cervical fracture.

In deposition, defendants admitted they did not take adequate steps to prevent BJ's falls, properly assess or adequately care for him. Indeed, the defendant owners admitted they had failed to even have a care plan in place for BJ prior to his fall, in violation of Title 22 regulatory requirements. For example, they:

- Failed to provide comprehensive care and supervision to its residents, including BJ, as required by 22 C.C.R. § 87464;
- Failed to properly monitor the residents, including BJ, and have a care plan or update his care plans upon a change of condition, as required by 22 C.C.R. § 87463(b);
- Failed to ensure that residents, including BJ, are regularly observed for changes in physical, mental, emotional and social functioning and that appropriate assistance is provided when such observation reveals unmet needs," as required by 22 C.C.R. § 87466;
- Failed to maintain RCFE personnel in sufficient numbers at all times, and competent to provide the services necessary to meet resident needs, including BJ's, as required by 22 C.C.R. § 87411(a); and
- Made false and/or misleading statements regarding the services and staffing Defendants would provide to residents, including BJ, in violation of 22 C.C.R. § 87207.

There was no shortage of evidence of reckless neglect and ratification in this case. The defendant facility had an abysmal record of repeated citations from the California Department of Social Services ("DSS") for noncompliance with resident care regulations before and after BJ's subject fall. Despite allowing BJ to fall multiple times and racking up an atrocious track record with the State, defendants demonstrated brazen lies under oath about their reckless conduct. For example:

- Photographs and defendants' own contradictory deposition testimony revealed the owners lied under oath about how far BJ was from a caregiver when he fell. Indeed, the falsehoods also pertained to how many caregivers were present and awake at the time of the fall, as well as the location of BJ's cot in relation to a caregiver station at the time of the fall.
- Defendants' deposition testimony regarding BJ's condition just before and after the subject incident directly contradicted documentation by third-party EMTs.
- Defendants' deposition testimony contradicted material facts in their own incident report submitted to the State regarding BJ's incident.
- Defendants admitted in deposition that they failed to retain documentation required by Title 22, including staffing, training, and resident care documents.

As a kicker, the defendant owners (who were not persons with disabilities) chose to park their car in not one but two parking spaces for persons with disabilities on the day of their deposition.

Case Study #3 – CJ's fall at a large 100+ room RCFE

In another recent case, we represented the family of "CJ," an elderly RCFE memory care resident with advanced dementia who also died from an acute intracranial hemorrhage caused by an unsupervised fall at a large RCFE operated by a corporate chain in Northern California.

According to defendants' own documents, they were aware that CJ was a high fall risk upon admission and needed to be supervised at all times when ambulating due to his dementia and history of falls. CJ's resident care plan also noted he required a fall management program, which required supervision and assistance for resident safety and fall prevention.

Defendants marketed their facility to assess and meet resident needs. Title 22 requires facilities to ensure there is an adequate number of staff to care for residents. However, the longtime director of the facility admitted in deposition:

- No system was employed at the facility to ensure adequate staffing.
- Even if the needs of residents at the facility would vary, this would not affect the facility's staffing levels.
- Indeed, staffing levels were set based on resident census according to a preestablished budget issued by defendants' corporate home office.
- The director's performance and candidacy for bonus pay was measured on the ability to adhere to the corporate budget.
- Although staff expressed the need for more staffing at the facility, no changes in staffing were made.
- Although residents suffered various incidents and injuries, no changes in staffing were made.

Here, CJ's last and final fall at the facility occurred while he and a few dozen other residents of the facility's memory care unit were assembled in a large activity room. One activity director was present to supervise all of the residents, whom the facility director admitted were all at high risk for

falls. Another staff member, a medication technician, coincidentally was present but was focused only on administering medication to a particular resident on the medication schedule. Simply put, there was not enough staff to supervise and assist CJ as required. As a result, he suffered an unwitnessed fall and a fatal traumatic brain injury. A CT scan of his head at the E.R. showed significant subdural and subarachnoid hemorrhages and a skull fracture caused by the traumatic force of his fall. The emergency room doctor deemed CJ to have suffered a "fatal traumatic event" and that he was "non-salvageable" due to injuries caused by the fall. He died several hours later.

Further notes on common defense arguments

During the litigation of these cases, defendants raised common defenses as to causation:

- The fall did not cause the brain bleed; instead, a stroke caused the fall.
- The initial CT scans did not show a significant bleed, if any.
- The brain bleed was an old injury not caused by the subject fall.

This brought to light the importance of a few key factors. First, the importance of reviewing the diagnostic films taken after the subject injury. Notably, patients on blood thinners are at increased risk (2.5%) of a delayed brain bleed from a fall, even after an initial CT scan is negative.[8]

Thus, treaters will often take repeat CT scans of an elderly patient's brain over the course of a few days after a fall. For example, the CT scans shown in Illustration A – the first set taken on the day of the fall and the second set taken one day after the fall – show a "moderately progressive subarachnoid hemorrhage" and "additional new or progressive brain parenchymal hemorrhage ... with developing adjacent vasogenic edema." In other words, the bleed from a traumatic brain injury can continue to blossom out through the brain tissue and become more apparent in the days or weeks following the subject fall. This development over time revealed the injury was acute rather than a chronic injury.

Furthermore, it is important to retain qualified experts to carefully review the treaters' opinions. Ask questions comparing the location of the brain bleed in comparison to the site of impact. Look for corresponding soft tissue evidence of the impact from the fall (e.g., lacerations, bruises) as well as any skull fractures, etc. This, in addition to the brain bleed, can help shed light on the severity of the impact. Moreover, review whether the parts of the brain affected by the traumatic brain injury comport with any clinical changes (e.g., as reflected in the medical records and family testimony) – for example, was the traumatic brain injury to the dominant hemisphere, did it affect the locations for speech, motor, or cognitive functions, was a PEG tube required because the patient lost the ability to swallow, etc.?

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In short, it is important to work with people who have extensive experience with these types of cases. We exclusively represent elders, dependent adults, and their families. Over the last 30 years, we have filed lawsuits against various types of long-term care facilities in California based on allegations of wrongdoing, whether to an individual or a class of persons. Lawsuits act as a deterrent and are an important part of a multi-faceted effort to bring about systemic change for our elders and dependent adults in long-term care facilities. ■

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[1] All elders' names are altered for privacy.

[2] California Welfare & Institutions Code § 15610.57 defines "neglect" as:

(a)(1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

(2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) Failure to prevent malnutrition or dehydration.

A plaintiff who is seeking the enhanced remedies of Welfare and Institutions Code § 15657 must prove reckless neglect by clear and convincing evidence. CACI 3104 requires that plaintiffs seeking such enhanced remedies must prove "recklessness/malice/oppression/fraud" by clear and convincing evidence. CACI 3113 offers clarification of this standard by providing the following definition of recklessness:

> [Name of defendant] acted with "recklessness" if [he/she] knew it was highly probable that [his/her] conduct would cause harm and [he/she] knowingly disregarded this risk.

[3] Deaths related to falls are considered by the Center for Medicare and Medicaid Services (CMS) as "never events," defined by the National Quality Forum (NQF) as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility."

[4] See e.g., Aaronson, Zinn, & Rosko, 1994; Bliesmer, Smayling, Kane, & Shannon, 1998; Castle & Fogel, 1998; Cohen & Spector, 1996; Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000; Porell, Caro, Silva, & Monane, 1998; Schnelle, Simmons, Harrington, Garcia, & Bates-Jensen, 2004; Unruh & Wan, 2004.

[5] See Cal. Dept. Pub. Health All Facilities Letter 19-16, which became applicable to the audit period beginning Jul. 1, 2019; see also Cal. Health & Safety Code §§ 1276.5 and 1276.65; Cal. Code Regs. Tit. 22, § 72329.1.

[6] E.g., 42 C.F.R. § 483.35; Cal. Health & Safety Code § 1599.1(a); Cal. Code Regs. Tit. 22, § 72501(e); see also Cal. Code Regs. Tit. 22, § 72327(a).

[7] Kathryn Stebner has separately presented and written on elder abuse cases against Residential Care Facilities for the Elderly. See, e.g., Kathryn Stebner, "Practice and Procedure in Actions Against Residential Care Facilities," Chapter Five, *California Elder Law Litigation: An Advocate's Guide* (Co-Author with Peter Lomhoff), Continuing Education of the Bar, CA.

[8] See Clifford Swap, MD, "Risk of Disk of Delayed Intracerebral Hemorrhage in Anticoagulated Patients after Minor Head Trauma: The Role of Repeat Cranial Computed Tomography," *Perm J.*, 2016 Spring; 20(2): 14–16.