2019 CLM Cyber, Management and Professional Liability Conference
July 10, 2019 to July 12, 2019
Boston, MA

Putting out the Fires: Mediation Strategies and Tactics for Aging Services Claims with Inflammatory Fact Patterns

I. Getting the Dangerous Aging Services Case to Mediation

The Legal Playing Field for Aging Services Cases, an Overview

Nursing Home Litigation involves claims that generally sound in negligence, medical malpractice and violations of statutory patient rights. The Federal Nursing Home Reform Act is part of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) which codified certain rights that all residents in skilled nursing facilities and extended care facilities must be afforded. Many states have established a statutory framework that is particularly hostile to nursing home facilities. Issues of concern in the care of the nursing home population--and thus the focus of litigation-- include adverse drug events, falls with injury, pressure ulcers, faulty medical equipment, tube feeding problems, restraint usage, malnutrition, dehydration, elopement and abuse/assault. Plaintiffs bringing claims against nursing homes seek and obtain punitive damages in many of the forums across the country.

By contrast, there are no federal regulations or standards for Assisted Living Residences ("ALR"). This places the onus on states to regulate these facilities. Nearly all of the states have stepped in to regulate at least one aspect of the ALR mandate and some have gone further. But since none have created a private right of action for statutory violations and most1 ALRs do not provide actual care or treatment, negligence is the predominant theory of liability in these cases. Usually the genesis of an ALR claim is a fall or ulcer development in a resident who is deteriorating both physically and cognitively over the course of living at the facility for several years.

A Rising Flood of Potential Litigants

Into this hospitable litigation climate comes a burgeoning population of potential plaintiffs who are poised to overwhelm the resources of the carriers and law firms that must defend these facilities. As will be demonstrated herein, the defensibility of the cases does not improve with time and discovery. Thus, the early evaluation and resolution of these claims is critical to staying ahead of the tide.
Aging Services claims are one of the fastest growing segments of health care litigation. This is primarily a function of an increasing pool of potential litigants in the form of an aging population that continues to grow and is poised for an explosion when the baby boomers saturate the market. In 2015, there were

[1] Enhanced Assisted Living is a term used to describe ALRs who handle a patient population requiring assistance with 2 or more ADLS, more than intermittent medical care or treatment and/or are incontinent of bladder or bowel.

nearly 17,000 nursing homes in the United States that were providing care for 1.7 million residents. Those figures are expected to quadruple to 6.6 million residents by 2050. Much of this growth will be prompted by the aging of the Baby Boomers, who in 2030 will be aged 66 to 84. In addition to the Baby Boomers, those born prior to 1946—the "oldest old"—will number 9 million people in 2030. By 2050, the oldest old will consist of 19.4 million people. Among the population aged 65+, 69% will develop disabilities before they die, and 35% will eventually enter a nursing home.

Unlike traditional medical malpractice litigation, the injured party is often not the person bringing an aging services claim. Generally, it is the children, spouses and extended family of Nursing Home and Assisted Living residents who reach out to an attorney. To meet this increased pool of potential litigants, the plaintiff's bar is making a concerted marketing push. Utilizing traditional mediums and search engine optimization, plaintiff's firms lure in potential clients with images and words that invoke visceral response in their target audience. Generally, the ads pull at the heartstrings of loved ones who may bear unresolved guilt over the original placement of individuals in group living situations. Frequently, the nominal plaintiffs have a poor grasp on the medical and functional status of their loved ones and thus possess unrealistic expectations. The formulation of a solid mediation strategy requires consideration of these psychological components.

Committing to the Decision to Mediate

Like all litigation, consideration of one's adversary and the venue can significantly impact the defense assessment of potential liability and verdict exposure. Plaintiffs' firms that specialize in nursing home litigation tend to push minimum settlements for certain types of cases. The defense practitioner and claims should be wary of valuing a case based solely upon prior resolution results for "similar" cases. Often litigators and claims people are plagued by "perspective bias" and "positive illusions". Perspective bias is where someone defending a claim has difficulty removing themselves from that "defense" role to take an objective view of the dispute2. Positive illusions refers unrealistic optimism, exaggerated perceptions of personal control and overconfidence in one's ability that they are viewing the facts correctly3. In Aging Services claims, the defense side is plagued by the opposite of "perspective bias" and "positive illusion" in that the statutory environment and jury pool is so generally hostile that defense counsel and claims tend to overly pessimistic especially where there are inflammatory factors.

Similarly, defenders of these claims usually resort to heuristic analysis of how similar claims have been resolved in the past. In cases with inflammatory fact patters, this can be dangerous since valuation can be negatively exaggerated. The defense should be aware of plaintiff's expectations to achieve the same value for basic fact patterns and use it as a tool to pursue a more favorable result. Not every Stage IV sacral ulcer with 3 months of pain and suffering should be settled for the same amount. The practitioner needs to develop the facts that may favorably distinguish the case from plaintiff's expectations. Since we recognize that problematic facts may be revealed during discovery that will increase the value above plaintiffs' benchmark for a particular type of case, mediation is a necessary step in cases with inflammatory fact patterns.

[2] See, Birke, Richard and Fox, Craig R., *Psychological Principles in Negotiating Civil Settlements* Harvard Negotiation Law Review [Vol.4:1 Spring, 1999].

[3] Id.

When choosing a mediator, time and effort should be expended to identify mediators with styles that combine critical analysis of the case and involved medicine with a knack for working to bring emotional sides together. While that may seem obvious, everyone on the defense side can cite to examples where they have heard a mediator express the same bias against nursing home facilities that has been espoused by the jury pool at large.

Additionally, in a mediation forum where wins and losses are not so easily defined, it is imperative that the case is timely and accurately assessed with a frank discussion of verdict exposure and settlement value. Where possible, claims and defense counsel should be on the same page as far as valuation is concerned before consideration of inflammatory factors. Having your client frankly describe what a "win" would be on the case being mediated creates a realistic motivation for defense counsel and facilitates development of a defense theme whose success or failure can be measured and used as a learning tool in future matters.

In a world with a small pool of real players in the plaintiff's bar, mediation should be broached early and often in aging services claims. In this way, plaintiff's counsel will be less likely to guess at a motivator for the desire to resolve a particular case when it is broached regularly in all cases. In an industry where defense counsel may be concerned about showing fear or weakness, this tactic gives cover to true motivations on a particularly problematic case.

II. Mediation Details

Pre-Mediation Submissions

A clear, concise and convincing presentation is imperative in an aging services claim. Strengths should be highlighted, and obvious weaknesses should be confronted in your confidential statement. By marshalling the voluminous evidence as Exhibits in the most efficient manner possible, a practitioner can maximize the possibility that the mediator will naturally gravitate toward your position when faced with a less organized adversary.

In an aging services claim, the statutory framework should be explained and highlighted in the most favorable light to your client. In Nursing Home cases, the plaintiff will frequently cite to the enumerated rights in the Federal Nursing Home Reform Act as a basis for liability. Since these rights are broadly defined with little detail as to the conduct required, plaintiffs often resort to the promulgations of the Centers for Medicaid and Medicare Services (CMS) to "surveyors", those persons who are charged with inspecting facilities and issuing citations for assorted violations. Plaintiffs will frequently contend that these "State Operations Manuals" or Guidance to Surveyors establish the standard of care in several areas since they are organized in a system of corresponding F-Tags that are associated with particular statutes. While the first reflex is to argue that they are not the standard of care, the better position to use the CMS pronouncements as a sword and shield where appropriate. As will be discussed more fully below when dealing with the specific fact patterns, it is best to lay out this argument early to season the mediator to be receptive when you introduce the facts that are in your favor.

Opening Presentations

The debate over an Opening Presentation continues to rage and has boiled down to a matter of preference. In cases where there is an inflammatory fact pattern, the goal is to tamp down the flames. An Opening Presentation may serve as accelerant where the involved party attends. Where the preference (if not condition) to mediate is that the plaintiff decision maker attends, it is recommended that any presentation be restrained and calculated to avoid any chance of driving the plaintiff further from the table. Where you are faced with the prospect of mediating without the plaintiff present, then some more latitude is available--with the caveat that aggression is often counterproductive at this stage of the proceedings.

The prospect and contents of an Opening Presentation should be discussed with claims personnel with input sought to formulate a cohesive strategy. Often defense counsel feels compelled to put on a show and “flex muscles” because their client is present. A frank discussion prior to the mediation will often alleviate any compulsion to over reach in an Opening Presentation that is far more likely to drive parties apart than bring them together.

Initiating Negotiations

The likelihood of a successful mediation decreases when the parties walk in without an initial demand and meaningful offer on the table. A meaningful initial offer primes the negotiation pump and should represent the biggest money move of the defense toward resolving a claim with inflammatory fact patterns. The old paradigm of meeting an unreasonable demand with an equally unreasonable offer adds negative feelings to a resolution process we hope to be less about emotion and more about the valuation of a case. The beneficial psychological impact on the plaintiff who walks in with money on the table will likely pay dividends when the final number is reached.

III. Mediating the Dangerous Fact Patterns, Real World Examples

Pressure Ulcer Development with infection and amputation

- 60-Year-Old Male with History of insulin dependent Type II diabetes, ischemic stroke with Left sided hemiparesis, cognitive impairment, peripheral vascular disease, diabetic neuropathy, hypertension with recent history of fall at home secondary to deconditioning and dehydration, admitted to hospital for observation.
- Now admitted to skilled nursing facility from hospital 3 days after admission for short-term rehabilitation with left shin skin impairment described initially redness on Nursing Admission Assessment but all documents after Admission day 3 reflect “Stage III Pressure Ulcer present on admission”. Local care consistent with Stage III ulcer initiated three days after admission.
- CNA accountability records for positioning, incontinence care and check skin integrity contain multiple gaps and inconsistencies.
- ADL status-Assist of 1 for bed positioning, assist of 2 for transfers, total assist for eating, dependent on wheelchair for locomotion, incontinent of bladder and bowel.
- Mental status-alert and oriented to person only, Brief Interview for Mental Status (BIMS) score of 6--not competent to make healthcare decisions;
- Assessed to be “at risk” for pressure ulcers; the Care Plan for skin integrity reflects that “turn and positioning every 1 hour” was implemented but there is a notation of “Modified” with date from Day 5 of admission;
- Spends most of day in wheelchair and resists staff efforts for turning positioning in bed and incontinent care;
- Day 5—Stage IV ulcer to left shin; wound and vascular consults ordered.

- Day 10-Elevated WBC, temperature, and wound with foul drainage. Recommended transfer to hospital but Advanced Directives reflect “do not hospitalize” and proxy refused transfer or antibiotics; consults declined.
- Day 13- Change in mental status, family reverses and consents to transfer. Discharged to Hospital to rule out sepsis.
- Diagnosed with wound infection, gangrene and amputation recommended. Family delays decision for 2 weeks before BKA amputation performed. After BKA and antibiotics, the patient recovers from infection and sepsis and is discharged to another facility for long term placement. Plaintiff is still alive.

Confront and Contrast Multiple Documentation Errors

The most treacherous and dreaded aspect of nursing home litigation is the Resident Chart. Anyone who has handled a nursing home claim has lamented the accuracy, reliability and completeness of the chart. Increased nursing home litigation has increased the volume of documentation without a corresponding improvement in accuracy or reliability. Litigators already know to immediately obtain a complete copy of the chart directly from the insured once a Business Associate Agreement pursuant to HIPAA and HITECH Acts has been secured. However, assuring completeness is more difficult in a nursing home setting. A complete chart now requires a practitioner to collate an Electronic Medical Record (EMR), a traditional handwritten chart and an assortment of worksheets from multiple specialties.

Documentation errors must be identified early so that the missing information can be substituted via other documents, evidence or areas of the chart. A nursing home chart contains in excess of 20 categories of documents, so it is not uncommon for a provided chart to be missing some critical component in one section, but the necessary information documented elsewhere. Nursing Care Coordination forms the basis of those nursing home claims sounding in negligence and statutory violations. Every resident in an SNF and ECF must be assessed for a constellation of treatment and care concerns. Residents are evaluated for the risk or potential for falls, pressure ulcers, dehydration, elopement, dementia, infection, incontinence, depression etc. Once assessed as being at risk in these areas, a Comprehensive Care Plan is formulated which highlights certain goals and interventions which must be implemented to address these care concerns. Although many departments may be involved in care planning, including but not limited to dietary, social services, rehabilitation, and medical, we will focus on the nursing department since it is most relevant to the majority of cases. The nursing staff, comprised of the Certified Nursing Assistants (CNAs), the Licensed Practical Nurses and Registered Nurses, are charged with the implementation of these interventions. Some treatment is directly provided by the LPN and RN staff and recorded on the Treatment Administration Record (TAR) or Medical Administration Record (MAR) as well as documented in traditional Progress Notes. The nurses also prepare a Resident Care Profile for each resident. The RCP is an instruction sheet of sorts for the CNAs that effectively outlines the care plan intervention responsibilities of the CNAs. As tasks are completed, CNAs make entries in the various accountability documents which can be very detailed as to each task or a general statement that the planned ADL care was provided. A targeted evaluation of the chain between these documents is critical to evaluating the likelihood of a successful defense. The chain between Assessment-Care Planning-Resident Care Profile-Accountability Charting and TAR/MAR should not be broken. Any deterioration in condition or adverse event should trigger a reassessment of some type and generate a new care plan or documented rationale as to why no change was necessary. The more gaps in the nursing flow chain, the more dangerous continued discovery becomes.

A critical analysis of the EMR system should be included in all work-up and utilized at mediation to defuse the allegations of documentation. Acquiring the audit trail and metadata early will allow for analysis and potential use in defense of claims of incomplete or inaccurate charting. Similarly, highlighting the input and output shortcomings of the EMR system. Input shortcomings are focused on how information is provided to the system. Considerations of what is “free type” versus drop down menu selection or box checking can be critical in explaining away shoddy documentation. Additionally, the output relied upon during the litigation phase (voluminous repetitive printouts) is confusing to witnesses who are often seeing the data in this format for the first time in a litigation context. Defense litigators should become familiar with the EMR system and obtain screenshots of the terminal to demonstrate that the information that practitioners at the facility are actually seeing in real time.

Use Department of Health surveys and staffing ratios to show compliance

A claims person and litigator can quickly evaluate the insured facility by reviewing the database maintained by the Center for Medicare and Medicaid Services (CMS). The Nursing Home Compare data tool found at https://www.medicare.gov/nursinghomecompare/search.html provides invaluable information concerning your client facility. The first step for every litigator and claims person should be a review of the data compiled by CMS. Not only can this be an accurate indicator of care trends, it can identify facilities that are more likely to be a target of a lawsuit and more likely to fair poorly during the ensuing litigation. Since this tool is readily available to the public, it can provide a roadmap for plaintiffs who are formulating their litigation strategy. The website compiles the following data for every nursing home in the United States who accepts Medicare or Medicaid reimbursement: for profit status, ownership group and services provided; inspection data from both annual surveys conducted by the state DOH pursuant to federal mandate and complaint based inspections; identification of deficiencies, Deficiencies that resulted in actual harm to residents, fines and plans of correction; quality of care ratings in many areas including pressure ulcer prevention, falls, urinary tract infections, discharges to the hospital etc. and staffing level evaluations and comparisons.
Importantly, the data provided is to be taken with a grain of salt since often the quality of care indicators can be a product of resident demographics and proximity to certain acute care health systems. Nonetheless, the data provided is critical to quickly identify your insured’s litigation vulnerabilities and strengths to utilize at mediation in response to claims by plaintiff’s counsel about the general condition of the facility or staffing levels.

Notably, this CMS and other state information can be just as dangerous to your adversaries’ experts who often will come from the nursing home industry. While perhaps not utilized during mediation, the staffing shortcomings of an expert challenging the facility can be brought to light to defuse plaintiff’s claims.

CMS Guidance F-Tag 686 Skin Integrity, unavoidability and terminal ulcers

The operative statute for all pressure ulcer cases states as follows:

> Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— (i) A resident receives care, consistent with

> professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing [emphasis added].

The statute provides the basis for all pressure ulcer defenses by suggesting that some ulcers are unavoidable despite compliance with professional standards of practice. Assuming that the facility correctly identifies the risk factors, the standard of care requires that each risk be addressed if possible. CMS issued the State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Facilities on November 22, 2017. This document discusses skin integrity under F-Tag 686 and acknowledges that:

> Not all risk factors are fully modifiable or can be completely addressed. Some risk factors, such as a permanent lack of sensation to an area, may not be modifiable. Some potentially modifiable risk factors, such as malnutrition or uncontrolled blood sugars, may take time to correct, despite prompt intervention. Other risk factors, such as pressure, can be modified promptly. Not all risk factors are fully modifiable or can be completely addressed. Some risk factors, such as a permanent lack of sensation to an area, may not be modifiable. Some potentially modifiable risk factors, such as malnutrition or uncontrolled blood sugars, may take time to correct, despite prompt intervention. Other risk factors, such as pressure, can be modified promptly4.

The CMS Manual also outlines the possibility of Kennedy Terminal Ulcers which by definition are unavoidable and represent a complete defense to an allegation of a failure to prevent.

A practitioner intending to mediate a skin ulcer case should be prepared to utilize CMS' guidance to surveyors to educate a mediator and defuse plaintiff's claim that statutory liability is a foregone conclusion.

Highlight Prior Activities of Daily Living (ADL) Limitations, Pre-existing Impairment of Ambulation and Medical Decision Making of Family

In aging services claims, co-morbidities are relied upon heavily to both formulate a liability and causation defense. While that remains true in a mediation setting, greater emphasis should be placed upon the impact of pre-admission or pre-negligence functioning as a way to offset plaintiff's pain and suffering valuation. An amputation claim in a non-ambulatory resident has less "value" from a functional standpoint. Additionally, the family's decision-making concerning interventions and advanced planning should be incorporated in a mediation presentation. While certain decisions not to agree to hospitalization, feeding tubes etc. may be understandable, their impact on a failure to mitigate damages should not be ignored when trying to reach a number to resolve a case.

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[4] See, F686 (State Operations Manual Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

Additionally, family members are often poor historians regarding their loved one's medical condition and limitations. Highlighting these factors during mediation can provide ammunition to a mediator who is arguing that plaintiff's expectations are not realistic and do not take into consideration the limitations that were unavoidable regardless of the negative outcome during his or her residency.

Woman Assaulted in Assisted Living Facility by Staff Member

- 65-year-old woman (Resident) with impaired short-term memory secondary to hypoxia from prior myocardial infarction admitted as a resident (more than 8 years) by family who is comprised of husband and 2 adult children;
- Family does not live locally and visits less than once per year;
- Care plan calls for recreational therapy;
- She is deemed by her private attending physician to not be competent to make health care decisions; she is alert and oriented to person and place only;
- Recreational therapist (RT) is a 55-year-old male who plays cards, games and assists residents with arts and craft projects; Has been working with resident for 1 year;
- Resident has drawn notes with hearts with RT's name; Resident calls RT her "boyfriend" to her roommate;
- 2 days before incident, RT changed his relationship status on a popular social media site to "Its complicated". The same day, he posted a poem about forbidden love and commented that he had "fallen in love with a client". Several other employees of the facility including the Recreational Therapy Supervisor are "friends" of his on the social media site.
- RT's personnel file is immaculate with glowing references and clean background checks;
- Resident's roommate has PT from 3:15 to 4:00 p.m.;
- On day in question, RT is off duty but signs into facility at security desk at 3:30 p.m.;
- Video shows RT go directly to Resident's room and closes door at 3:35 p.m.; Video shows CNA 1 on duty knocking on door at 3:40 p.m. before opening, entering and then immediately leaving and shutting door.
- CNA 1 in Statement states, "I saw Resident engaged in sexual act and thought she was with her husband". CNA 1 mentions this to CNA 2 who tells her that "Resident's husband is in Europe".
- Video shows both CNAs walking to nurse's station at 3:50 p.m., and nurse immediately walks to Resident room knocks on door and enters by 3:51. Nurse and RT leave room by 3:53 p.m. Nurse is observed walking into Supervisor's office at 3:53 p.m.
- In statement, the Nurse said that upon entering the room she observed the Resident and RT fixing their clothes. The Nurse asked what was going on and the Resident said, "who I am with is none of your business".
- Two state troopers were on premises due to an unruly visitor in an unrelated matter. The Supervisor approached them and asked them to assist her in evaluating whether a resident had been sexually assaulted.
- The troopers investigated the incident and spoke to RT and the Resident. RT was placed under arrest. RT was terminated immediately. Resident's attending physician advised the district attorney investigator that he did not feel the resident was capable of consent to sexual relations. RT was ultimately charged and pled guilty to endangering the welfare of an incompetent person.
- Testing for sexually transmitted diseases was negative and Resident does not recall the encounter but has asked where RT has been lately.
- Resident's husband was called by the Nursing Supervisor several times the same afternoon/evening but did not speak to him before State Police spoke to him the following morning.

Personnel Files to offset social media postings that raise concerns

The Courts are broadening the discoverability of social media accounts in litigation. The litigation practitioner should coordinate with claims about retaining a social media investigator early on to identify potential accounts and review the public portions of said accounts for relevant information. From the defense perspective, frank conversations with facility staff regarding social media should be incorporated into the attorney's initial repertoire. Staff personnel should be reminded not to post anything concerning the litigation and that information contained in the accounts can be used by plaintiffs. There have been many cases where staff at a facility are commenting in social media on patients, how overworked they are or criticizing other personnel.

Defense counsel and claims handlers should obtain copies of the personnel files of critical employees both to identify any concerns and formulate a defense. Plaintiffs utilize personnel records to explore in service training, credentialing, prior complaints and whether a pattern of disciplinary action exists. However, the same documents can be utilized to establish that the facility was not on notice of any propensity or specific conduct that would give rise to concerns.

Video surveillance of common areas to recreate timeline

Video footage from facility surveillance is becoming more prevalent as more and more nursing homes install public area cameras. Since many systems do not store footage indefinitely, it is important in fall and abuse cases to quickly identify and preserve these images. Even where a fall or suspected abuse occurs in a private area away from the camera, public area surveillance can assist in establishing a timeline and documenting the comings and goings of facility personnel. Since many of these cases rely upon allegations that staff took "minutes" or "hours" to respond, video footage can make or break a defense.

Post-assault investigation and facility response.

Incident/Accident or Adverse Event Reports provide critical data concerning the timing, witnesses and critical information from an abuse or fall incident or other event such as unexplained injury, elopement etc. These documents are generally discoverable in the majority of jurisdictions if prepared in the ordinary course of business.

Incident/Accident Investigation Summaries are related to incident reports but often are characterized differently in the facility. Since residential healthcare facilities are under an obligation to self-report instances of suspected abuse, they must go further than just completing an incident report. These Investigation Files contain critical information including employee statements and detailed witness recollections. Since many facilities try to characterize these documents as Quality Assurance documentation, disclosure is often discretionary and varies by jurisdiction. Facilities are reluctant to exchange these documents, but they can be critical evidence to demonstrate to a jury that each event is taken seriously, investigated and used to improve care and prevent recurrences. Even where there may be privilege concerns and a fear of opening the floodgates to a category of documentation, these records are often crucial in filling the gaps in documentation and witness memory. Similarly, these documents will be relied upon extensively by any mediator to defuse the anger at a facility and the oft stated goal of plaintiffs to "make sure this does not happen to someone else".

Man Suffering Fall in Nursing Home with Head Injury and Death

- 95 year old man with moderate to severe dementia admitted for short term rehabilitation at a nursing home after a 7 day hospital admission secondary to a DVT and placement of an IVC filter; Admitted to nursing home with medical history of congestive heart failure (32% ejection fraction), Stage 4 Chronic Kidney Disease, failure to thrive, depression, anxiety and hypercoagulation;
- Lived at home by himself for 16 hours a day (8 hours of Home Health Aide coverage) before his most recent hospital admission;
- Assessed to be a fall risk and multiple interventions implemented including low bed, call bell within reach, 2-hour toileting, PT and OT evaluation and placement on a floor ambulation program; no bed alarms instituted.
- After an incident where he was observed to have partially slid out of his wheelchair, he was placed on ½ hour checks;
- ADL status is assist of 1 for transfers, independent in eating, assist of 1 for ambulation without wheelchair; assist of 1 for toileting.
- On day in question, he was found on the floor in the hallway with occipital bump and scrape;
- Video shows the resident wheeling himself out of day room (where a CNA is stationed) at 4:15 to a point down the hallway that is 20 feet past his room; Video shows multiple staff personnel walk past him while sitting in the hallway in his wheelchair between 4:15 and 4:25;
- Video shows him stand up from his chair at 4:30 and suddenly fall over striking his head violently on the base of the wall as he fell and then 2-3 twitches; Nurse 1 can be seen in the forefront of the video making entries on a mobile computer stand with her back to the resident;
- Video shows Nurse 1 turning around at 4:33, observing the resident on the floor and then going to immediately assist the resident who was able to sit up, then stand before being returned to his wheelchair.
- Investigation statements from the assigned CNAs document toileting was last performed at 3:30 p.m. and that he was last observed in day room at 4:15 p.m. and that the CNA assigned to the day room asked Resident if he needed anything as he wheeled out and he said he was "ok". His assigned CNA also documented that he did not stay in his room much and spent most of his day wheeling about the unit or in the day room.
- After assessment, the nurses contacted the on duty attending and she ordered Neuro-checks every 15 minutes and transfer to the hospital to rule out an intracranial bleed due to the fact he was on blood thinners. All neuro checks were negative at the nursing home and during transport to the hospital where he was diagnosed with a stable sub-arachnoid bleed. No focal neurologic deficits were noted and there were no complaints of pain offered by the Resident at the hospital. He was awake and talking throughout hospital admission.
- The family completed a MOLST form that withheld virtually all care except food by mouth and he was discharged after 4 days to a hospice facility where he deteriorated until death 2 weeks later due to cardiopulmonary arrest. Notably, all of his medications had been discontinued as instructed in the MOLST.
- The family contacted the local Department of Health and filed a complaint. His son also sent a letter to the facility complaining that when he visited his father, he smelled of urine and no one responded to his call bell. He blamed the facility for "killing his father" a week before he was to return home.

Challenge video surveillance showing violent fall with head strike

Footage depicting the moment of injury is often inflammatory but highly relevant material that will change the tenor of a case. However, closer analysis of the footage may reveal frame rate and resolution limitations that alter the timing of the fall or make it appear more violent. Often retention of

a video surveillance expert who can analyze the footage and highlight the technical details so that a response can be fashioned for mediation and potential future litigation.

Additionally, the footage prior to and after the "jarring" fall may be ultimately more valuable to the defense. Footage showing other personnel in the hall, high traffic and interactions with staff may solidify a defense based upon adequate supervision and appropriate monitoring. Additionally, the facility response to the fall may demonstrate that the staff was attentive to the resident and confirm post-fall neurological findings if it shows the resident talking and moving around.

Use the layout of facility to establish adequate level of supervision

Just as defense counsel would want to highlight to a jury the layout of the facility, the mediator should also be provided such information. Demonstrating the placement of the resident's room with respect to the nurse's station, dayroom, therapy rooms, administration offices, the front desk and other high traffic areas all support the defense theme that the resident was not left alone.

Emphasize balance of "homelike" environment and self-determination with Accident Avoidance

Every fall claim against a nursing home will cite to the Federal statute concerning accidents:

> … Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:, …(d) Accidents. The facility must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25 [emphasis added].

Balanced with the statutory framework that addresses accidents, there are other statutory provisions which establish that a Residential Health Care facility must provide its care in a "homelike" environment that explicitly recognizes the right of a resident to maintain his or her individuality. The relevant statute is as follows:

> (a) Residents rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.
>
> > (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
> >
> > …..
>
> (i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide— (1) A safe, clean, comfortable, and homelike

environment, allowing the resident to use his or her personal belongings to the extent possible.42 C.F.R. § 483.10 [emphasis added].

At mediation, the defense should advance the theme that it executed a reasonable balance between limiting the risk of accidents and maintaining a homelike environment. Having a homelike environment includes not having unreasonable restrictions such as bed alarms which contribute to an institutional environment. While a fall that ostensibly results in injury is certainly a negative outcome, that fact alone does not establish liability as a violation of the Public Health Law.

Neutralize Plaintiff's suggested interventions-siderails, constant supervision, mats and alarms

When mediating a fall case, the practitioner should be prepared to neutralize each proposed intervention in an effort to demonstrate that defensibility is greater than perceived by the mediator and plaintiff. The defense theme is that the interventions proposed by plaintiff are either unreasonable or so restrictive to the resident as to constitute a restraint that they cannot serve as a basis for liability. As discussed supra with respect to skin intervention, CMS promulgates a Guidance to Surveyors that addresses many of the devices proposed by plaintiffs including bed alarms which have transitioned from frequent use as a fall prevention device to a limited use and characterization as a restraint since at least 2017[5]. Virtually every device suggested in fall cases carries significant risks and may not be appropriate for all residents in all situations. Since the federal statutes are so broad, a strong argument can be made that nursing judgment allows for a selection from among multiple interventions in the care planning tool box. Utilizing this argument at mediation will counteract plaintiff's contention that the failure to provide a particular intervention constitutes negligence per se.

IV. After the Mediation

In the event a case settles during mediation, it is important that any post resolution agreement includes a provision for satisfying the liens. Additionally, the resolution should address confidentiality. Jurisdictions treat confidentiality agreements differently premised upon whether separate consideration is provided for the confidentiality. Therefore, a frank discussion with your client is appropriate about the limitations of such agreements.

Just because a mediation is not successful does not mean it was a failure. Often the mediation is a catalyst to further discussions where a seasoned mediator can bring the parties together even after walking out the door. A good mediator is proactive in using the failed mediation as a step in the right direction and will continue to try to bring the parties together even in the most contentious of circumstances.

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[5] F689 (State Operations Manual Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17) §483.25(d) Accidents. Notably, while CMS finally issued this proclamation in November 2017, it incorporates by reference scholarly articles and studies going back as far as 2005, 2007 and other CMS Publications going as far back as 2009. In this way a standard of care argument that alarms are not necessarily appropriate can be made going back for nearly 15 years of falls.