Nursing Home Litigation Exposure: Creating Individualized Care for Dementia Residents

Attorney Kristen Lojewski
Alzheimer's Association
Wisconsin State
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- Nearly 10 years in practice
- Former prosecutor
- nursing home abuse and neglect prosecution for half my career
- Law firm owner – Lojewski Abuse & Injury Law

(414) 999-3771
protectwi.com
Kristen@lojewskilaw.com

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TODAY'S ROADMAP

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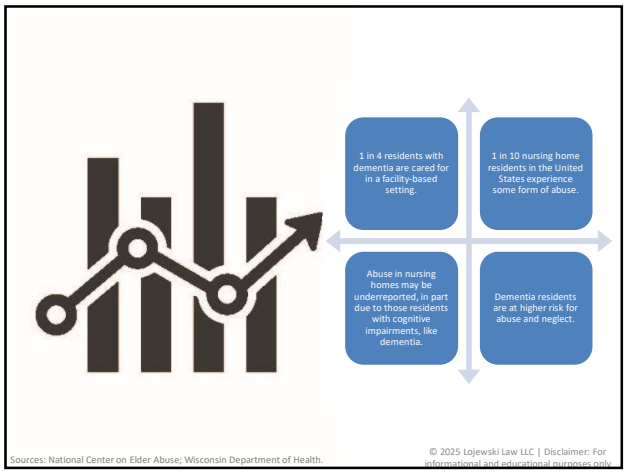
1 in 4 residents with dementia are cared for in a facility-based setting.
1 in 10 nursing home residents in the United States experience some form of abuse.
Abuse in nursing homes may be underreported, in part due to those residents with cognitive impairments, like dementia.
Dementia residents are at higher risk for abuse and neglect.
Sources: National Center on Elder Abuse; Wisconsin Department of Health.
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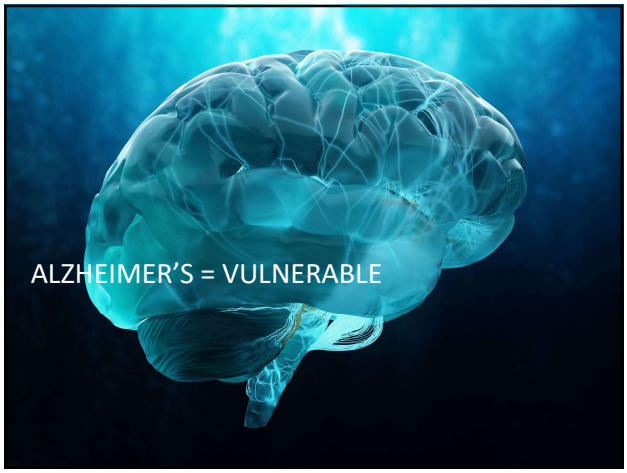
ALZHEIMER'S = VULNERABLE

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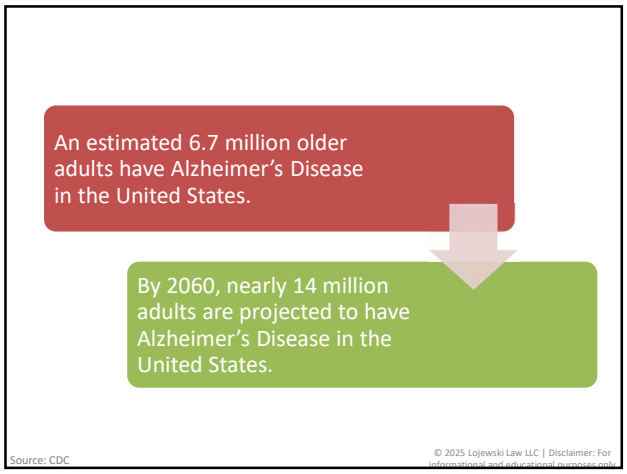
An estimated 6.7 million older adults have Alzheimer's Disease in the United States.
By 2060, nearly 14 million adults are projected to have Alzheimer's Disease in the United States.
Source: CDC
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AWARENESS TO PREVENT HARM

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LEGAL FRAMEWORK

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OBRA

- Federal Law
- Nursing Home Reform Act
- Guarantees the right to be free from abuse and neglect
- Minimum staffing requirements for facilities that participating in Medicare and Medicaid
- 3.48 hours per resident/day
- Adequate training to provide care and services to residents
- Residents must be treated with dignity and respect

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Wisconsin DHS 132

- Regulates licensed nursing homes in Wisconsin
- DHS 132.60: Resident Care
- DHS 132.62: Nursing Services
- DHS 132.63: Dietary Service
- DHS 132.33: Housing Residents in Locked Units
- Violations can lead to citations, lawsuits, or federal funding loss.

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DHS 132.60: RESIDENT CARE

- Plan of care based upon *individual* needs of the resident
- Promote the maintenance of skin integrity and to prevent the development of bedsores
- Significant changes in condition must be reported to nurse in charge and appropriate action taken
- Provided diets as prescribed
- Administer medications as ordered
- Physical/Chemical restraints only if written orders by a physician

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DHS 132.62: NURSING SERVICES

Discusses staffing in nursing homes

Each nursing home must have a full-time Director of Nursing (DON), and the DON must be an RN

Charge nurse must be on duty at all times

If fewer than 60 residents, the DON and charge nurse on duty can be the same person

Charge nurses supervise the care of all residents

Adequate nursing personnel to care for the specific needs of each resident

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UNDERSTAFFING

=

ONE OF THE LEADING REASONS NEGLECT OF RESIDENTS OCCUR

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DHS 132.63:
DIETARY SERVICE

Nourishing, palatable, well-balanced diet that meets daily nutritional and *special dietary needs* of each resident

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Wisconsin DHS 83

Regulates Community-Based Residential Facilities, often memory care facilities

- DHS 83.12: Investigation, notification, and reporting requirements
- DHS 83.35: Assessment, individual service plan and evaluations
- DHS 83.20: Department-approved training
- DHS 83.21: All employee training
- DHS 83.22: Task specific training
- DHS 83.37: Medications
- DHS 83.36: Staffing requirements
- DHS 83.32: Rights of Residents

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DHS 83.12: Investigation, Notification and Reporting Requirements

- Shall take immediate steps to ensure the safety of residents when an allegation of abuse or neglect of a resident
- Investigate and document any allegation
- Injuries of unknown sources must be investigated, including injuries that were not observed by anyone, the injury is suspicious, or the resident cannot adequately explain the source of the injury
- Must send a written report to the Department of Health Services (DQA) within 3 working days when:
  - Serious injury resulting in hospital stay/ER visit occurs
  - Anytime a resident's whereabouts are unknown
  - Law enforcement is called as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees
- A significant change in the physical or mental condition of a resident, as well as an allegation of physical, sexual, or mental abuse or neglect requires the facility to report to the physician and legal representative of the resident *immediately*

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DHS 83.35: Assessment, Individual Service Plan and Evaluations

- An assessment of the resident's needs, abilities and physical and mental condition must occur before admission, with changes in needs, and at least annually
- A written temporary service plan must be created upon admission. This is to meet the immediate needs of a resident.
- Within 30 days after admission, a comprehensive individualized service plan must be developed based on the assessment of the resident
  - This includes the methods for delivering the care and who is going to deliver the care
  - The resident and/or legal representative must be involved or the legal representative must sign the service plan
- Service plan must actually be implemented and also reviewed and revised based on a resident's needs

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DHS 83.20: Department-approved Training

- Standard precautions
- First aid
- Procedures to alleviate choking
- Medication administration and management, if managing, administering, or assisting with medication
- Must maintain documentation of the training
- Wisconsin Chapter 50 mirrors some of these requirements for CBRFs as well

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DHS 83.21: All Employee Training

- Adequate Training must occur for all employees in the following areas:
  - Resident Rights
    - Restraints
    - Retaliation
    - Coercion
    - Complaint and grievance procedures for the CBRF
  - Challenging behaviors
    - Elopement
    - Aggressive behaviors
    - Suicide prevention
    - Self-injurious behaviors
    - Resident supervision
    - Changes in condition

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DHS 83.22: Task Specific Training

- Employees who perform the following job duties must receive adequate training:
  - Assessment of residents
  - Development of individual service plans
  - Assistance with activities of daily living
  - Determining nutritional needs, menu planning, food preparation and food sanitation

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LACK OF TRAINING OR INADEQUATE TRAINING IS ANOTHER MAJOR REASON NEGLECT OCCURS IN FACILITIES

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DHS 83.37: MEDICATIONS

- Written practitioner's order for any medications
- Document list of medications, dosage, direction for use and changes in condition
- Review of the resident's medication regimen
  - 30 days before/after admission
  - Significant change in medication
  - Every 12 months
- Psychotropic medication
  - Resident should be reassessed more frequently (quarterly) for possible side effects
  - Should be listed on resident's service plan
  - Documentation in chart for things like effectiveness and monitoring for inappropriate use (like for staff convenience or for discipline rather than needed by resident)
- Any errors, adverse reactions, or resident refusals must be documented in chart
- Residents may self-administer medications unless they are deemed incompetent or lack the physical/mental capacity to do so

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DHS 83.36: Staffing Requirements

Less regulated than nursing homes

"Sufficient numbers on a 24-hour basis to meet the needs of the residents"

CBRF shall ensure:

-Administrator or designated qualified resident care staff in charge is on premises daily

-At least one qualified resident care staff present when residents are present in CBRF

-At least one qualified resident care staff on duty and awake ***if at least one resident in CBRF is in need of supervision, has risk of elopement, has dementia, etc.***

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DHS 83.32: Rights of Residents

- Coercion or discouragement to exercise resident rights is prohibited
- Retaliation is prohibited
- Freedom from mistreatment (physical, mental, sexual abuse & neglect, financial exploitation, misappropriation of property)
- Freedom from seclusion
- Freedom from chemical restraints
- Freedom from physical restraints (unless prior approval)
- Receive medication
- Prompt and adequate treatment
- Live in a safe environment with the least restrictive conditions necessary
- Not to be photographed, filmed or recorded without informed, written consent by resident or resident's legal representative

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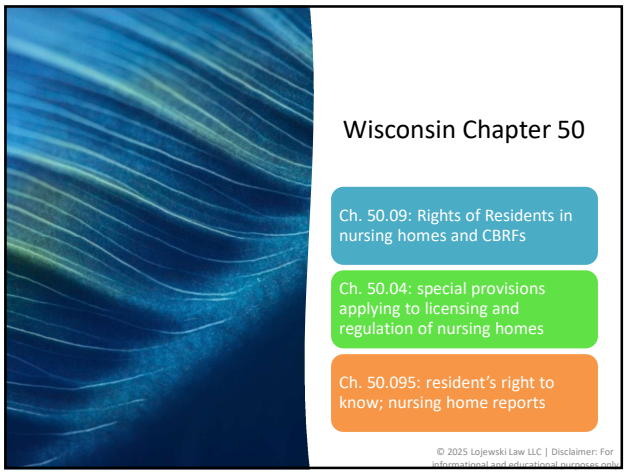
Wisconsin Chapter 50
Ch. 50.09: Rights of Residents in nursing homes and CBRFs
Ch. 50.04: special provisions applying to licensing and regulation of nursing homes
Ch. 50.095: resident's right to know; nursing home reports
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CH. 50.09: RIGHTS OF RESIDENTS
APPLIES TO BOTH NURSING HOMES AND CBRFS (WHICH INCLUDES MANY MEMORY CARE FACILITIES)
BE TREATED WITH COURTESY, RESPECT, AND DIGNITY
PRIVATE AND UNRESTRICTED COMMUNICATION WITH PEOPLE LIKE FAMILY, PHYSICIAN, AND ATTORNEY
BE FREE FROM MENTAL AND PHYSICAL ABUSE, AND BE FREE FROM CHEMICAL AND PHYSICAL RESTRAINTS EXCEPT AS AUTHORIZED
RECEIVE ADEQUATE AND APPROPRIATE CARE
BE FULLY INFORMED OF RESIDENT'S CARE AND PARTICIPATE IN THE CARE PLANNING PROCESS
USE THE HEALTH CARE PROFESSIONAL AND PHARMACIST OF RESIDENT'S CHOICE
IF RESIDENT IS ADJUDICATED INCOMPETENT, THESE RIGHTS TRANSFER ONTO THE RESIDENT'S GUARDIAN
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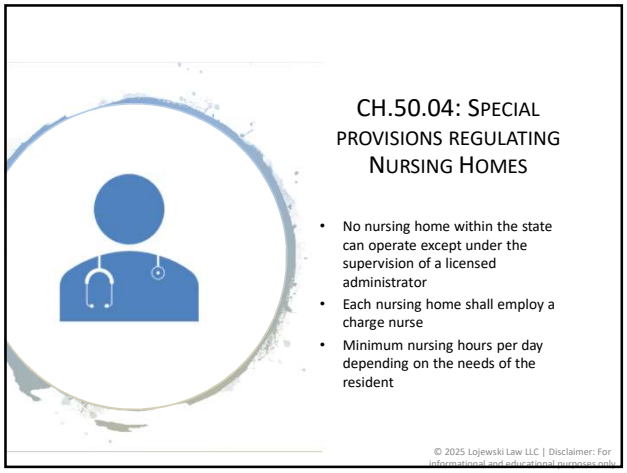
CH.50.04: SPECIAL PROVISIONS REGULATING NURSING HOMES
• No nursing home within the state can operate except under the supervision of a licensed administrator
• Each nursing home shall employ a charge nurse
• Minimum nursing hours per day depending on the needs of the resident
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CH.50.095: Resident's Right to Know. Nursing Home Reports

- Residents have a right to know certain information that will help aid them in assessing the quality of care provided
- Department of Health Services shall provide each nursing home and the office of the Long-term care Ombudsman with a report that includes the following:
  - The ratio of nursing staff available to residents per shift at each skill level for the previous year for the nursing home
  - The staff replacement rates for full-time and part-time nursing staff, nurse aides, and administrators for the previous year for the nursing home and for all similar nursing homes in the same geographical area
  - Violations of statutes or rules by the nursing home during the previous year for the nursing home and for all similar nursing homes in the same geographical area
  - This report will be created in a simplified one-sheet summary by the Department
- Nursing homes should make the report available to anyone requesting it and must provide a copy of the summary of the report to every resident, residents' guardians, prospective residents, and those accompanying prospective residents

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INDIVIDUALIZED DEMENTIA CARE

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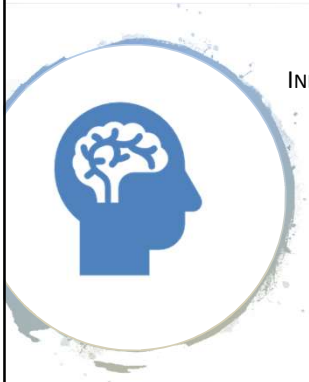

Importance of Individualized Dementia Care

- Dementia and Alzheimer's affects each person differently
- Dementia progresses at different rates individually and manifests in different ways
- Standardized care routines are not enough
- Residents with dementia are especially vulnerable to injury, neglect, abuse, and emotional trauma

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Individualized Care:

Improves Quality of Life

Reduces Preventable Harm

Lowers Facility Liability in Litigation

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Why Does Individualized Dementia Care Matter Legally and Clinically?

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Wisconsin DHS 132 (nursing homes) and DHS 83 (CBRFs/memory care) both require **individualized** care/service plans based on comprehensive assessments

Not providing customized care plans increases the risk of falls, elopement, pressure wounds, behavioral crises, and medication errors

- All of which can result in lawsuits and/or citations

Trauma-informed care is critical. Dementia can heighten fear and confusion. Impersonal care can feel threatening.

Since dementia can progress at different paces depending on the individual, reassessments and modifications to the care plan is critical too.

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DO's of Dementia Care

DO perform	DO perform a comprehensive assessment to understand the resident's preferences, fears, routines, and triggers
DO update	DO update the care plan regularly
DO provide	DO provide consistent staffing. Familiar caregivers reduce confusion and foster trust
DO create	DO create a calm, structured environment
DO use	DO use positive, gentle, non-confrontational communication, even when redirecting
DO incorporate	DO incorporate personal routines
DO train	DO train staff in dementia-specific behavior management and non-pharmacological interventions
DO provide	DO provide purposeful activities tailored to remaining abilities
DO watch	DO watch for non-verbal cues of pain, fear, or need
DO involve	DO involve the family in planning and reviews

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DON'Ts of Dementia Care

DON'T use	DON'T use a one-size-fits-all approach
DON'T rely on	DON'T rely on sedation or chemical restraints to manage behavior
DON'T isolate or ignore	DON'T isolate or ignore "difficult" residents
DON'T argue	DON'T argue with or correct a confused resident
DON'T rotate	DON'T rotate unfamiliar staff constantly without adequate training or handoffs
DON'T rush	DON'T rush care tasks
DON'T dismiss	DON'T dismiss new behaviors as "just dementia", instead assess for pain, infection, trauma, etc.

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Things to Consider:

- Some dementia residents cannot clearly verbalize what is happening
- Because of this, abuse and neglect can and does go undetected
- Both family and staff need to watch for non-verbal and situational red flags

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Possible Signs of Physical Abuse

- Unexplained injuries such as bruises, cuts, burns, or fractures
- Unexplained *severe* injuries
- Injuries in various stages of healing
- Repeated falls or injuries
- Withdrawal, anxiety, fearfulness or agitation that is abnormal to normal behaviors
- Restraint marks on wrists or ankles

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Possible Signs of Neglect

Bedsores	Repeated falls	Dehydration (dry mouth, increased confusion)
Significant weight loss	Wandering or elopement incidents	Poor hygiene, soiled clothing/bedding, strong odors of urine/feces

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Possible Signs of Emotional/Psychological Abuse

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Possible Signs of Sexual Abuse

- Bruising or bleeding in the genital area
- Torn clothing/underwear
- Unusual fear or behavior changes, especially when being bathed or dressed, or around certain staff/residents
- STIs or infections with no clear explanation

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What to Do if You're a **Family Member** and You Suspect Abuse or Neglect

Document	Ask	Take	Report
Document everything	Ask questions	Take photographs	Report to: • Law enforcement (if immediate danger or possible criminal matter involved) • Facility supervisor • Ombudsman • Disability Rights • Adult Protective Services • Division of Quality Assurance

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What to Do if You're a **Nursing Home or Memory Care Employee** and You Suspect Abuse or Neglect

Follow	Follow mandatory reporting laws
Report	Report internally
Make	Make an external report if needed to the Wisconsin DQA or regional Ombudsman
Document	Document with fact-based, specific details
Protect	Protect the resident
Do NOT try	Do NOT try to cover it up, even if pressured. It could potentially expose you to personal liability or loss of your license
Follow up	Follow up to make sure action was taken
Know	Know that you are legally protected against retaliation for reporting abuse in good faith

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Preventing Harm & Litigation: Changing the Culture of Care

Litigation often happens when there is a pattern of preventable harm, of neglect, of staff silence, or even of falsified records

If the goal (or hope) is to avoid litigation as a facility owner, it must be earned by making harm genuinely less likely

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1. Identify and Address Systemic Weak Points

- Many lawsuits arise not from isolated incidents, but from **predictable failures** in:
  - Staffing levels
  - Training
  - Communication
  - Documentation
  - Accountability

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EXAMPLE

One fall does not necessarily create liability that is needed to prove a negligence claim against a facility.

But, a 3rd fall after multiple missed rounds, no care plan update, short staffed, and inadequate interventions…that could be a lawsuit waiting to happen.

Your focus must be on prevention.

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2. Train for Dementia-Specific Realities

Dementia is more than just memory loss

It is a neurological conditions that affects judgment, mobility, communication, and behavior

Staff must be trained to:

- De-escalate without confrontation
- Identify behavioral triggers
- Detect pain in non-verbal residents
- Handle wandering/elopement risks
- Provide trauma-informed care

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One afternoon seminar on behavioral issues or general safety precautions is not enough.

Dementia-specific training should be mandatory, repeated, frequent, and hands-on.

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3. Prioritize Staffing

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Consistent Staffing lowers fall risk, reduces medication errors, and increases resident comfortability and satisfaction.

If staff ***know*** the resident, it is less likely a resident who is a x2 assist via hoyer is transferred by x1 with a sit-to-stand, falls, and fractures her hip. It is less likely a resident who is a pureed diet receives a breakfast sandwich for mealtime, chokes, and dies.

The possibility and more likelihood of litigation is when families begin to notice strangers caring for mom every day and nobody seems to know her name or her ***individualized needs***.

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4. Document for Accuracy, Not for Defense

- Proper documentation should:
  - Reflect care ***actually*** provided
  - Show responses to changes in condition
  - Note refused care, and what was done in response
  - Track trends over time

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Some facilities document to cover themselves *after* something goes wrong, and that is backwards

Unfortunately, false charting DOES happen.

Many nursing home lawyers know and understand EMR systems like PCC and can look at EMR logs, time stamps, discrepancies in records and know that something is not right.

The best way to avoid "chart disputes" is to document accurately, thoroughly, completely, and truthfully.

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5. Treat Complaints as Gifts, Not Threats

Families raising concerns are not necessarily trying to sue the facility

Often, they want someone to listen to their concerns, help them, and try to remedy the situation

Many family members contact a lawyer after multiple failed attempts of trying to work things out on their own

Documenting how you handle a concern with transparency can be used in litigation to potentially help shed light on the situation

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6. Build Internal Accountability Systems

- Care audits
- Random chart reviews
- Fall committee reviews
- Anonymous staff reporting lines
- It's more than just a root-cause analysis or retraining after an incident takes place.

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7. Collaborate with Families

- Families want to feel heard, be informed, and be respected
- Invite them to care plan meetings
- Answer and respond to their calls
- Share difficulties and limitations honestly

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8. Accountability is Not the Enemy

Taking responsibility, issuing a genuine apology, and implementing change after an incident occurs might prevent litigation

Cover ups, denial, and dismissing families is often when families feel that they have no choice

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LEGAL DOCUMENTS

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Power of Attorney

- A legal document that authorizes someone to act on another's behalf
- Relevant Types:
  - Healthcare
  - Durable/Financial
- Facilities should be checking if these documents exist and/or are activated upon/prior to admission

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Healthcare Power of Attorney

- A legal document in which a person (the principal) appoints someone they trust (the agent or healthcare proxy) to make medical decisions on their behalf if they become unable to make those decisions themselves
- Must be signed by 2 witnesses in Wisconsin
- NOT activated/effective unless and until the person becomes incapacitated, which requires a certification of incapacity by 2 physicians (or 1 physician and 1 licensed advanced practice clinician)

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Activated Healthcare POA

Once activated/effective, the HCPOA usually can make decisions about treatment options, surgeries, medications, long-term care placement, end-of-life care, and consent to or refusal of care

Since it is a legal document, the language in your specific HCPOA controls

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Durable/Financial Power of Attorney

- A legal document that gives a chosen agent the authority to manage the financial and legal affairs of the principal

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When is a DPOA Effective?

DPOA can be effective **immediately** or **only upon incapacity**, depending on how the document is written

The term "durable" means that it remains valid *even if* the principal becomes incapacitated

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What Can A DPOA Do?

- A DPOA typically can:
  - Manage bank accounts
  - Pay bills
  - Handle insurance matters
  - Apply for Medicaid
  - File taxes
  - Make financial decisions related to long-term care
  - Hire an attorney / Enter into litigation

Just like the HCPOA, since the DPOA is a legal document, the language in your specific DPOA controls

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When Should Someone Consider Creating These Documents?

Immediately after diagnosis of dementia, Alzheimer's disease, or any cognitive impairment

- While still mentally competent

Before any serious illness, surgery or aging-related decline

- Proactively plan

Routine estate planning for any adult

- Even if you're healthy

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Why Are These Documents Important?

- Dementia is progressive and unpredictable
- Without an activated HCPOA or financial POA, family members may need to go through a court guardianship proceeding
- Facilities often need clear documentation about who has the legal authority to consent to care and financial matters
- It ensures the resident's wishes are honored
- It helps protect the resident from financial exploitation if they lose the ability to manage money

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What Should Facilities Do if a Resident's Dementia Appears to be Progressing but These Documents Are Not Activated/Effective?

Review the POA documents

If the HCPOA has not yet been activated, the facility may need physician certification to certify the resident lacks capacity to make informed health care decisions

A DPOA may or may not require activation depending on what the document itself specifies

If the resident is showing signs of diminished capacity, request an evaluation by a physician and make sure providers understand it is for HCPOA activation

Proactively communicate with the family that the facility is seeking formal activation

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Why Is It Important for a Facility to Ensure These Documents Are Activated When Dementia Progresses?

- Without activated documents, staff may not *legally* be able to take certain actions, like change care plans or discharge residents, without involving the courts
- Continuing to treat the resident as though they can consent can create both legal and ethical risks for the facility
  - It leaves the facility in legal limbo if the HCPOA agent has no legal authority AND the resident also lacks capacity
  - Results in the facility's inability to obtain informed consent or make time-sensitive decisions
- Facilities should want to and need to know residents' legal status – who can consent, who can't, and who will be able to once the proper steps are taken
- Activating HCPOA but not activating DPOA means there is no legally capacitated authority to sign financial documents or assist with finances

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Key Differences between HCPOA and DPOA

	HCPOA	DPOA
Purpose	Medical decisions	Financial/legal decisions
Activation	Only when incapacitated	Can be immediate or upon incapacity
Examples of decisions	Surgery consent, medication choices, hospice care, placement decisions	Paying bills, managing bank accounts, applying for Medicaid, selling property, hiring a lawyer
Governing law	Wisconsin Ch. 155	Wisconsin Ch. 244
Document specifics	Often includes end-of-life directives	May grant broad or very limited financial powers

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Additional Key Points About These Documents

- Separate agents can be named for healthcare and finances
- Copies should be provided to healthcare providers, facilities, and necessary family members
- Revocation or updates should be made if family circumstances change
- Not having these documents can lead to unnecessary suffering, delays in care, and legal fights
- Best practice is to execute both HCPOA and DPOA at the same time. Alternatively, you want to execute DPOA *before* you become incapacitated.

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When to Call a Lawyer

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When Facilities Should Call a Lawyer

Consider consulting a lawyer when:

- A resident dies or suffers serious injury under questionable circumstances (fall, choking, elopement, assault, etc.)
- You receive a letter of representation from an attorney
- A staff member is accused of abuse, neglect, or misconduct
- You're unsure about how to legally activate POA
- A resident's capacity is in question and no legal representative has been identified
- There's a mandated report under investigation by the state
- You need to respond to a licensing complaint

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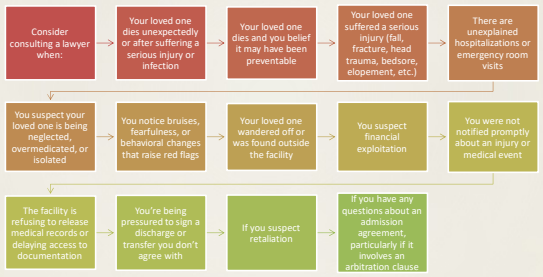
When Families Should Call a Lawyer



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Case Examples

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EXAMPLE - ELOPEMENT

- 84-year-old woman, moderate Alzheimer's disease, residing in a locked memory care unit
- Known to wander and documented risk of elopement
- WanderGuard deviced was issued but placed around her neck like a necklace, where she could easily remove it
- Observed fiddling with the device before
- Security cameras were not operational
- Memory care unit was locked
- Resident was able to bypass locked door after removing WanderGuard necklace and wander outside unnoticed
- It was January and snowing
- Found several hours later, deceased from hypothermia after exposure to severe winter weather

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Could the Facility Have Prevented Harm and, if so, How?

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- Proper placement of the WanderGuard
- Reassessment of elopement interventions once recognizing the fiddling with WanderGuard
- Supervision
- Room placement
- Reguarly testing security cameras and door alarms

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EXAMPLE - CHOKING

- 79-year-old man, Alzheimer's disease, and severe dysphagia
- Pureed diet order following speech therapy evaluation
- Dietary restrictions were documented in the care plan
- New employee served resident a turkey sandwich at lunch in resident's bedroom
- Resident began choking
- CPR was attempted but performed on the resident's low air loss mattress
- Resident died same day due to airway obstruction and anoxic brain injury

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Could the Facility Have Prevented Harm and, if so, How?

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- Double checking meal trays before delivery
- Staff education on dysphagia and diet order training
- Ensuring CNA Kardex is accurate and being used
- Accessible CPR boards and staff training to transfer residents to a firm surface
- Reinforcement audits – random meal audits to verify dietary restrictions are being honored

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EXAMPLE - FALL

- 86-year-old woman with Alzheimer's disease, high fall risk
- 3 prior falls, 2 out of bed while attempting to toilet herself
- Fall interventions on care plan were use of grippy socks, use of call light, and ensure room is free of clutter
- Fell during night shift while trying to independently transfer from bed to toilet
- Hip fracture, surgery, decreased mobility and accelerated cognitive deterioration

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Could the Facility Have Prevented Harm and, if so, How?

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- Escalated fall prevention – Reassessments and additional interventions after the prior falls, such as supervision, toileting schedule, low bed, or bed safety systems like fall mat, bilateral body pillows, etc.
- Conduct a root cause analysis
- Therapy referral
- Night shift staffing

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Lessons Learned: Reflection

Ask yourself and your team:

- *Are our current interventions enough?*
- *When was the last time we reassessed a resident's risks after a change in behavior or condition?*
- *Are we proactive – or do we wait for a bad outcome before we act?*
- *If a tragedy happened tomorrow, would we be able to show that we took every reasonable step to prevent it?*
- *Do we treat family concerns as opportunities to identify risks before they become emergencies?*
- *What would we want done if it was our own parent living here with dementia?*

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Facility Best Practices

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Facility Best Practices: Protecting Residents, Families, and the Facility

- Individualized Resident Care
  - Thorough initial assessments and update care plans
  - Tailor interventions
  - Proactively reevaluate cognition and mental capacity
- Family Collaboration
- Document accurately, thoroughly, and in real-time
- Maintain working alarm and security systems in locked memory care units
- Use root cause analysis, not just incident reports, after any fall, injury, elopement, etc.
- Foster a culture of accountability and transparency

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Dementia-Specific Best Practices

- Provide specialized dementia training to all staff
- Teach staff to recognize non-verbal signs of pain, distress or fear
- Create calm, structured environments to reduce agitation and wandering risk
- Use positive redirection rather than confrontation
- Design memory care units with safe wandering spaces, clear signage, and minimized overstimulation

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Take Action: Prevent Harm

1. Reassess each resident with a known risk
2. Test safety systems
3. Audit dietary compliance
4. Emergency response drills to make sure staff know what to do
5. Launch a "Family Feedback" Campaign
6. Train staff on dementia behavior
7. Empower internal reporting through an anonymous reporting system

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Recognize that preventing harm is smarter and cheaper than defending a lawsuit.

The goal is not perfection. The goal is vigilance.

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LOJEWSKI ABUSE & INJURY LAW

- Attorney Kristen Lojewski
- protectwi.com
- (414) 999-3771
- Kristen@lojewskilaw.com

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