CNA

We can show you more.®

Aging Services
2016 Claim Report

Using evidence to achieve excellence: engage, lead, succeed

INTRODUCTION

This, the ninth report on aging services claims produced by CNA, is focused on a small number of critical and timely risk topics. As resident falls continue to be the most frequent allegation, we have expanded the fall-related claim data and analysis to include such questions as whether the fall was witnessed, whether the resident had a history of previous falls and the outcome of the fall-related injury. Along with resident falls, we focus on pressure ulcers, another leading source of injury with potentially life-altering results for residents. We also discuss readmissions to acute care, using data derived from claims that closed in 2014 and 2015. Client success stories are presented with recommendations based upon real-life actions implemented by high-performing organizations. These success stories are distributed throughout the document.

Current data related to topics presented in previous CNA aging services claim reports can be found in Appendix A.

Executive Summary

- For-profit organizations comprise 62.1 percent of CNA aging services insured beds and 70.4 percent of the CNA closed claims in this report. (See Frequency of Closed Claims by Business Segment, Chart 1.)
- Assisted living closed claims incur an average total paid higher than the overall average total paid. (See Average Total Paid for Closed Claims by Bed Type, Chart 4.)
- Resident falls remain a significant challenge confronting aging services communities. The data demonstrate that resident falls account for 42.7 percent of the 2,617 claims at a cost of $208.4 million in total payments. (See Frequency of Closed Claims by Allegation, Chart 7.) The sheer volume of falls underscores the need to focus on preventing resident falls, mitigating fall-related injuries and managing the costs of claims.
- Resident fall is the most frequent allegation associated with closed claims involving readmissions to acute-care hospitals. (See Frequency of Readmission-related Closed Claims by Allegation, Table 38.)
- Pressure ulcer claims persist as one of the most critical challenges for skilled nursing facilities. The frequency of pressure ulcer claims for assisted living is low, however, their severity is higher than skilled nursing. Closed claims relating to pressure ulcers account for 18.6 percent of the 2,617 closed claims, at a total cost of $113.2 million. (See Frequency of Closed Claims by Allegation, Chart 7.)
- The one pressure ulcer claim that arose in an independent living setting had a total paid of $415,936. It is noteworthy that a major pressure ulcer claim can occur in an independent living community.
- The allegation with the highest severity is elopement, with an average total paid of $325,561.
- Four aging services organizations provided information on successfully decreasing resident falls and pressure ulcers. These high-performing organizations have leaders who demonstrate a devotion to providing safe care for residents, and to bolstering staff retention.
- Water damage is the most frequent cause of property loss for the CNA commercial aging services book of business. (See Frequency of Property Closed Claims by Cause of Loss, Chart 40 and the discussion of "Water Damage Closed Claims".)
- The major automobile-related concerns are distracted driving and driver selection.
- Theft/loss of data and unauthorized access are the two most common sources of cyber claims, comprising 38.3 percent of the 206 cyber claims. (See Frequency of Cyber-related closed Claims by Cause of Data Loss, Chart 44.)

Datasets and Methodology

The analysis in this report is based on 2,617 professional liability claims that closed between January 1, 2011 and December 31, 2015, with the exception of specific topics where a subset of the data is relevant, such as pressure ulcers and elopements. *Discussion of the topics included within the claim report for the first time including history of previous fall, witnessed and unwitnessed falls and readmissions to acute care are based upon data from a smaller and more recent subset of 1,387 claims that closed between January 1, 2014 and December 31, 2015.* Closed claims with an indemnity payment of less than $10,000, as well as claims from adult day care programs or home healthcare providers were excluded from both datasets. *Please note that percentages in charts or graphs may not equal exactly 100 percent due to rounding.*

This 2016 report differs from the 2014 version in a number of important areas. First, claims were included in the dataset only if they had a minimum indemnity payment of $10,000, rather than the $5,000 minimum in the last report. Another change is that "type of facility" has been changed to "bed type," in order to more accurately categorize resident populations in life plan communities. Finally, the format of the document has been modified. A significant portion of the data has been moved to Appendix A, in order to focus the industry's attention on resident falls, pressure ulcers and other current challenges. Because of changes in inclusion criteria and definitions, 2016 data and analysis should *not* be directly compared with equivalent sections in previously published CNA aging services claim reports.

The following inherent limitations to the data also should be noted:

- The data include only CNA-insured aging services organizations, rather than the total universe of aging services organizations.
- Indemnity and expense payments include only monies paid by CNA on behalf of its insureds. Deductibles and other possible sources of payment in response to a claim are not included.
- The CNA primary professional liability insurance indemnity limit is typically $1 million per claim.
- Resolving a claim may take many years. Claims that fulfill the inclusion criteria are included in the data based on when they closed, regardless of when the incident occurred.

Definitions*

The following terms are defined as follows within the context of this report:

- *Aging services community* is synonymous with aging services facility.
- *Average total paid* refers to indemnity plus expense costs paid by CNA, divided by the number of related closed claims included in the dataset.
- *Bed type* refers to the level of service (e.g., independent living, assisted living or skilled nursing) provided at the time of the incident based upon the resident contract, as well as the policies and procedures or protocols established by the aging services organization.
- *Book of business* is measured by the number of facility-based beds insured by CNA.
- *Business segment* refers to the not-for-profit or for-profit tax status of the organization.
- *Contributing medical condition* is a diagnosed illness that predated the injury related to the alleged adverse event. In this report, contributing conditions are limited to cardiac and pulmonary illnesses, dementia, diabetes, malnutrition, dehydration, obesity and osteoporosis.
- *Expenses* are monies paid by CNA for the investigation, management and/or defense of a claim or lawsuit.
- *Frequency and distribution* refer to the percentage of closed claims with a specified attribute, such as bed type, allegation or injury.
- *Improper care* refers to failure to follow an established nursing care/service plan, reasonable standard of care, or organizational policy and procedure.
- *Incurred claims* are those reported claims that result in an indemnity and/or expense payment.
- *Indemnity payments* are monies paid by CNA for the settlement, arbitration award or judgment of a claim.
- *Readmission to acute care* includes transfers of residents who were received from an acute care hospital and required return to an acute care hospital within 30 days of admission to the aging services community.
- *Reported claims* are all claims communicated to CNA, including those that do not result in a payment.
- *Resident abuse* includes allegations of physical, sexual, emotional and/or financial harm.
- *Severity* refers to monies paid by CNA on behalf of CNA-insured clients resulting from the settlement of a claim, arbitration award or a jury verdict. It is expressed as the average paid per claim for indemnity, expense or total paid (i.e., indemnity plus expense).
- *Sexual assault* is an injury classification encompassing rape and attempted rape.
- *Short-term stay* refers to admissions where the intent is rehabilitation or respite care and planned discharge, rather than extended care.

Abbreviations

Abbreviations used in this document include the following:

- AL/ALF: assisted living or assisted living facility
- FP: for-profit
- IL/ILF: independent living or independent living facility
- LPC: life plan community
- NFP: not-for-profit
- SN/SNF: skilled nursing or skilled nursing facility

* On April 13, 2016, the National Pressure Ulcer Advisory Panel issued a press release announcing a change in terminology from *pressure ulcer* to *pressure injury*. The decision was made to use the term "pressure ulcer" in this report based upon the prevalence of its use at the time of publication.

Reference Data

The following information is provided as an introduction to the five-year (2011-2015) data. As noted in the Datasets and Methodology section above, graphs and charts provided in this report reflect the five-year data, unless otherwise stated. The two-year data are utilized only in analysis of topics new to the 2016 report, which includes additional details regarding resident falls and readmissions to acute care.

Business Segment and Bed Type

Frequency of closed claims:

- For-profit organizations comprise 70.4 percent of the claims and 62.1 percent of insured beds.
- Skilled nursing beds have 80.7 percent of the closed claims while comprising only 45.1 percent of insured beds.
- The percentage of closed claims involving skilled nursing beds decreased between 2013 and 2015.
- The percentage of closed claims involving assisted living and independent living beds increased from 2013 through 2015.

Severity of closed claims:

- The average total paid for closed claims from for-profit organizations is $17,693 higher than the average total paid from not-for-profit organizations.
- At $221,496, the average total paid for assisted living beds is $9,787 greater than the overall average total paid of $211,709.

1 Frequency of Closed Claims by Business Segment

Business segment	Percentage of insured beds	Percentage of closed claims
For-profit	62.1%	70.4%
Not-for-profit	37.9%	29.6%
Total	100.0%	100.0%

2 Average Total Paid for Closed Claims by Business Segment

For-profit	$216,949
Not-for-profit	$199,256
Overall average total paid	$211,709

3 Frequency of Closed Claims by Bed Type

Bed type	Percentage of insured beds	Percentage of closed claims
SN	45.1%	80.7%
AL	29.9%	16.4%
IL	25.0%	2.8%
Unknown*	0.0%	0.1%
Total	100.0%	100.0%

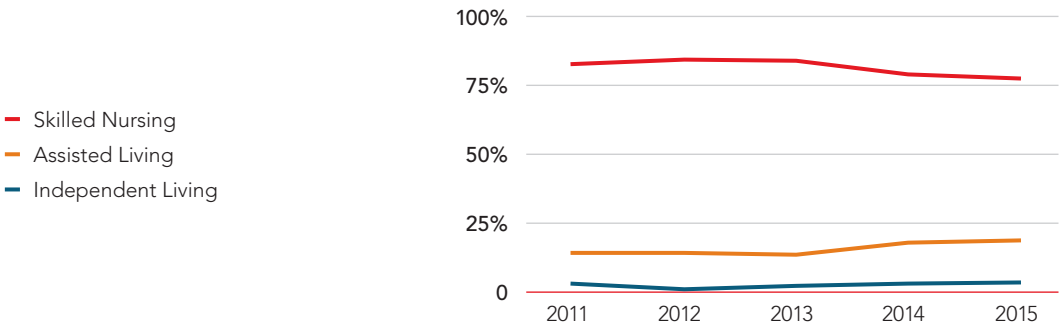
* There is no information about the level of care at CCRCs for two closed claims

4 Average Total Paid for Closed Claims by Bed Type

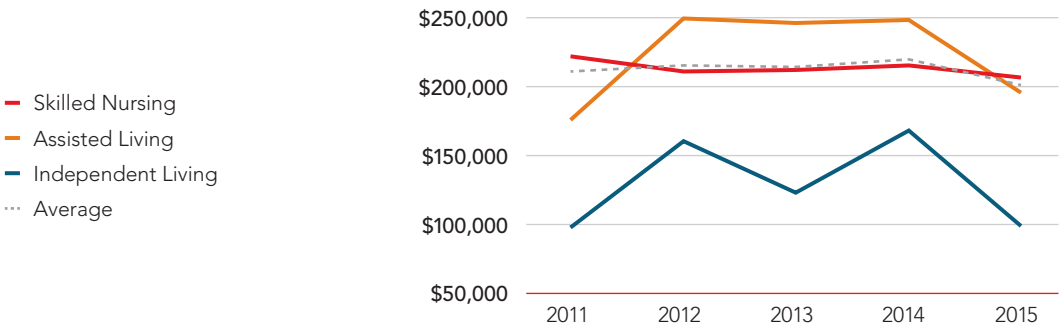
AL	$221,496
SN	$212,766
Unknown*	$206,470
IL	$123,825
Overall average total paid	$211,709

* There is no information about the level of care at CCRCs for two closed claims

5 Frequency of Closed Claims over Time by Bed Type, 2011-2015



6 Average Total Paid for Closed Claims over Time by Bed Type, 2011-2015



Allegations

- Resident falls and pressure ulcers continue to be the most common allegations.
- Elopement, failure to follow physician's order, delay in seeking medical treatment, pressure ulcers and failure to inform physician have the highest average total paid.
- While elopement and failure to follow physician order are the allegations with the highest average total paid, they are relatively infrequent.

7 Frequency of Closed Claims by Allegation

Resident fall	42.7%
Pressure ulcers	18.6%
Improper care (excluding falls)	14.7%
Failure to monitor (excluding falls)	6.1%
Resident abuse	4.2%
Delay in seeking medical treatment	3.2%
Medication error	1.9%
Failure to follow physician order	1.8%
Elopement	1.8%
Unsafe environment (excluding falls)	1.5%
Failure to inform physician	1.3%
Violation of resident rights	0.8%
Failure to move resident to higher level of care	0.7%
Failure to treat	0.3%
Improper placement for financial gain	0.1%
Failure to diagnose	0.1%
Lack of informed consent	0.1%
Total	100.0%

8 Average Total Paid for Closed Claims by Allegation

Elopement	$325,561
Failure to follow physician order	$323,325
Delay in seeking medical treatment	$245,783
Pressure ulcers	$232,398
Failure to inform physician	$231,321
Improper care (excluding falls)	$228,531
Failure to treat	$226,564
Resident abuse	$226,393
Failure to monitor (excluding falls)	$221,421
Resident fall	$186,589
Failure to move resident to higher level of care	$181,879
Violation of resident rights	$177,911
Medication error	$168,916
Unsafe environment (excluding falls)	$166,172
Improper placement for financial gain	$164,675
Failure to diagnose	$126,751
Lack of informed consent	$56,053
Overall average total paid	$211,709

Injuries

- Death, fracture(s) and pressure ulcer represent the three most frequent injuries in the aggregated data and for each type of community. Because of this consistency, data regarding frequency of injuries are not broken down by setting.
- Coma, amputation, death, sexual assault and back injury reflect the highest average total paid.

9 Frequency of Closed Claims by Injury

Death	52.7%
Fracture(s)	22.6%
Pressure ulcer	6.3%
Infection	2.9%
Contusion/bruise/swelling/edema	2.1%
Laceration	1.9%
Loss of limb/amputation	1.9%
Head injury	1.6%
Emotional distress	1.6%
Pain and suffering	1.5%
Muscle and ligaments	1.3%
Loss of organ/organ function	0.8%
Burn	0.8%
Dehydration/lack of nutrition	0.6%
Sexual assault	0.4%
Cerebral vascular accident (CVA)	0.3%
Skin tear	0.2%
Coma	0.2%
Back injury	0.2%
Teeth/dentures	0.2%
Sprain*	0.0%
Total	100.0%

* Sprain represents one claim which equals 0.04 percent.

10 Average Total Paid for Closed Claims by Injury

Coma	$264,499
Loss of limb/amputation	$261,693
Death	$253,304
Sexual assault	$246,785
Back injury	$235,752
Emotional distress	$218,358
Head injury	$197,814
Pressure ulcer	$187,696
Loss of organ/organ function	$187,060
Infection	$180,519
Burn	$174,549
Muscle and ligaments	$166,906
Fracture(s)	$159,918
Skin tear	$149,823
Pain and suffering	$137,839
Cerebral vascular accident (CVA)	$109,431
Dehydration/lack of nutrition	$103,871
Laceration	$87,673
Contusion/bruise/swelling/edema	$68,857
Teeth/dentures	$25,511
Sprain	$20,000
Overall average total paid	$211,709

Reports from the Field

As noted in the Introduction, our goal in this report is to focus the discussion on a small number of critical and timely risk topics. As part of that effort, success stories are presented from four CNA-insured organizations that have developed and implemented successful solutions for mitigating resident falls and pressure ulcers. Leaders of these organizations generously agreed to share their stories and methods with us. The organizations differ in demographics, but are similar in their devotion to providing high-quality care for residents.

REPORT FROM THE FIELD: A Multiple-site, For-profit Life Planning Community

By involving staff early in the process and inviting their feedback, the fall reduction program has not only been effective in meeting its safety goals, but also has promoted strong, inter-professional collaboration.

This for-profit organization offers short-stay and long-term skilled nursing care services, Alzheimer's care, orthopedic rehabilitation, ventilator care, dialysis care and assisted living services. It has been recognized as a 2015 recipient of the Silver Award – Achievement in Quality from the American Health Care Association and National Center for Assisted Living for dedication to improving the lives of patients and residents through quality care.

Payer mix

The payer mix is predominantly Medicare/Medicaid, with a low percentage of private pay.

Staffing

The organization aims for staffing levels that consistently meet national norms.

Resident falls

The fall reduction program began more than three years ago with the establishment of a Corporate Falls Steering Committee. The committee was tasked with developing standards to guide clinical care and to "hard-wire" the program so that its essential components became sustainable and immune to staff turnover and organizational change, while permitting some degree of tailoring from site to site. By involving staff early in the process and inviting their feedback, the fall reduction program has not only been effective in meeting its safety goals, but also has promoted strong inter-professional collaboration, including recognition, participation and approval of front-line staff.

The fall program includes a strong emphasis on prevention, as demonstrated by the following policies and practices:

- *Viewing resident falls as a syndrome with a constellation of causative factors.* Risk assessments are holistic, including a review of laboratory test findings, nutritional evaluations, medication reconciliation, and functional and cognitive testing.
- *Making clinical decisions collaboratively.* The fall team collectively analyzes the resident's risk profile and develops an individualized, integrated care plan for each resident.
- *Implementing "universal fall precautions."* All residents benefit from basic preventive interventions including, among other practices, actively clearing away of clutter and use of non-skid stockings.
- *Utilizing evidenced-based fall prevention standards.* These include implementing a version of the Otago Exercise Program, which involves a partnership between physical therapy and restorative nursing to provide a continuum of exercise. This exercise program addresses leg weakness and balance, two of the most modifiable fall risk factors.
- *Monitoring and analyzing the outcomes of specific interventions* designed to reduce falls.
- *Documenting and communicating expectations.* To this end, every resident receives a comprehensive fall risk assessment and is issued a detailed, specific problem statement.
- *Emphasizing proactive medication reconciliation.* This process helps prevent side effects and polypharmacy.

Pressure ulcers

The organization's skin integrity program has adopted an "interprofessional" model of care, by which all disciplines are actively involved in the risk assessment and care planning process for prevention of pressure ulcers. A corporate committee, the Skin Integrity Practice Council, is charged with keeping abreast of national guidelines, developing policy and educating staff, as well as monitoring quality improvement initiatives for all centers within the organization. The committee members represent physical therapy, medicine, nursing, risk management, nutrition and nursing leadership. In addition to developing policies for the organization, the Council collaborates with the Product Review Committee to ensure that the latest and most effective products for skin care and pressure ulcer prevention are being used.

The following additional activities have contributed to the success of this program:

- *A proactive risk assessment process.* Each category of risk is considered when interpreting the Braden Scale, as opposed to more traditional methods that focus on a total risk score. This methodology permits a more comprehensive approach to prevention and care planning.
- *A designated skin integrity nurse coordinator in each community.* The facility-based coordinator is responsible for ensuring that all pressure ulcer prevention measures are fully implemented.
- *An ongoing multidisciplinary staff education program.* Both registered nurses and licensed practical nurses receive skin care training, utilizing a workshop approach. Monthly skin and wound management webinar modules focusing on wound program basics are offered to all staff.
- *Advanced training for wound certification.* Registered nurses, nurse practitioners, physical therapists and physicians who have been identified as leaders and have a special interest in pressure ulcer prevention are strongly encouraged to participate on a complimentary basis in an Advanced Wound Workshop that includes a mix of live webinars and in-person workshop training. Both residents and the organization benefit from the higher number of certified wound specialists.
- *Formal communication guidelines.* These guidelines aid clinicians in managing expectations about non-healable wounds and unavoidable pressure ulcers. Clinicians are encouraged to communicate with residents and family about comorbidities and medical conditions as contributing factors to pressure ulcers and to realistically communicate probable outcomes and prognoses.
- *A resident turning program utilizing the SAGE® TAP model.* The SAGE TAP model was implemented in 26 centers for the highest-risk individuals, resulting in a significant reduction in facility-acquired sacral pressure ulcers. The success of this pilot program has resulted in a formal turning guideline with multiple turning assist options, based upon the resident's level of mobility.
- *Memory foam mattresses and other specialized equipment are used to reduce facility-acquired pressure ulcers.*
- *Utilization of this equipment in combination with the standardization of care delivery for pressure ulcer prevention* has helped the organization lower its rate of in-house acquired pressure ulcers to 2.3 percent, in contrast to national norms ranging from 2.5 to 25 percent.

Success factors – overall approach to resident care

- *The leadership team has adopted the Institute for Healthcare Improvement's "Triple Aim" initiative* as the driving force for all strategic planning. The Triple Aim framework is designed to optimize the resident experience and overall population health, while reducing the per capita cost of healthcare.
- *The organization created the position of "family support manager"* who is responsible for addressing care-related resident and family grievances. This program has helped avert professional liability claims through timely interventions following untoward incidents.
- *The leadership team displays its commitment to resident fall and pressure ulcer prevention by providing necessary resources to educate support staff* and to develop new, innovative and effective programs.

Risk management recommendations

Resident falls

- *Sustain leadership involvement and support* in planning and maintaining a fall-reduction program.
- *Utilize concepts from the Otago or other evidence-based exercise programs*, including progressive strength and balance exercises in restorative nursing programs.
- *View resident falls as a syndrome with a constellation of causative factors.* Risk assessments should be holistic, including a review of laboratory findings, nutritional evaluations, medication reconciliation, and functional and cognitive testing.
- *Make clinical decisions collaboratively.* The fall team should collectively analyze the resident's risk profile and develop an individualized, integrated care plan for each resident.
- *Implement "universal fall precautions"* for the benefit of all residents.
- *Analyze the outcomes of specific interventions.* The effectiveness of fall-reduction measures should be continuously monitored and analyzed.
- *Document expectations.* Every resident should receive a written, comprehensive problem statement, an all-inclusive fall risk assessment and a care/service plan that addresses identified risks for falls.
- *Emphasize proactive medication reconciliation*, in order to prevent side effects and polypharmacy.

Skin integrity

- *Sustain leadership involvement and support* in planning and maintaining a skin integrity program.
- *Emphasize a holistic process for determining risks for pressure ulcers,* including a review of data from laboratory testing, nutritional evaluations, medication reconciliation, and functional and cognitive assessments.
- *Establish interpretive guidelines for the Braden scale that incorporate each category of risk*, and consider these risk factors when formulating care plans.
- *Develop ongoing educational programs for staff and clinicians,* including advanced training for wound certification.
- *Provide guidance in conveying expectations* and prognoses to residents and families.
- *Consider purchasing turning and repositioning equipment* that both minimizes staff injuries and helps prevent pressure ulcers.

PART ONE: REVIEW AND ANALYSIS OF RESIDENT FALLS AND PRESSURE ULCERS

Preventing the occurrence and minimizing the severity of resident falls and pressure ulcers remain priorities for the aging services industry, residents, their families, the Centers for Medicare & Medicaid Services (CMS), and professional associations. Both falls and pressure ulcers often have life-changing or even fatal consequences for residents, as well as financial and reputational costs for organizations.

Some healthcare organizations have successfully decreased resident falls and pressure ulcers by adopting the "Six Sigma" approach to quality improvement. The central focus of Six Sigma is to reduce errors by *increasing consistency and decreasing variance* in provision of care, as well as use of equipment, products and supplies. Decreasing variance does not imply eliminating creative approaches to quality improvement. Rather, it means that new ideas, once they are fully developed, are implemented consistently by all staff members, with outcomes measured and analyzed.

Another innovation in healthcare is application of the "Lean" approach. This philosophy is designed to create more value for the customer/resident without expanding resources by focusing on processes that provide value, while eliminating steps and processes that do not enhance quality resident care (other than legally mandated activities). By evaluating current protocols, policies and procedures in relation to the Six Sigma and Lean methodologies, leaders can gain new insights regarding fall and pressure ulcer reduction.

For information on utilization of Six Sigma and Lean concepts within the healthcare field, see "Lean Six Sigma: Some Basic Concepts" from the National Health Services Improving Quality (previously known as the NHS Institute for Innovation and Improvement), and Bandyopadhyay, J. and Coppens, K., "The Use of Six Sigma in Healthcare," in *International Journal of Quality & Productivity Management*, volume 5:1, December 15, 2005.

Resident Falls

The need to increase efforts in mitigating resident falls is corroborated once again by CNA claim data, as demonstrated by the following fall-related findings:

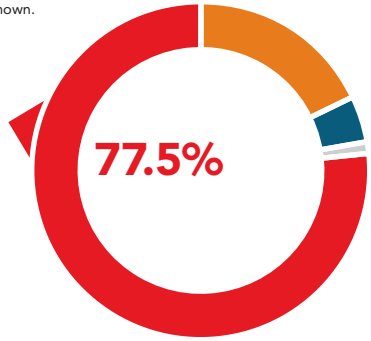
- Falls represent 1,117 (42.7 percent) of the 2,617 closed claims. (See Frequency of Closed Claims by Allegation, Chart 7.)
- Of these 1,117 fall-related closed claims, 88.5 percent involve failure to monitor and improper care.
- Typically, failure to monitor claims involve inadequate staff interaction with and/or observation of the resident, resulting in the resident attempting to ambulate independently and being found on the floor. In many cases, the resident either did not call for assistance or staff were called and failed to respond in what was perceived by the resident as a timely manner.
- Many improper care allegations involve care plans that may not have adequately addressed the resident's risk for falling or were not carefully followed, especially in terms of resident transfer (e.g., from a wheelchair to the bed). In many instances, the incident involved transfers performed by one employee, although the care plan specified the need for a two-person assist.
- The most frequent location for claims related to falls is the resident's bed, where residents were not given adequate assistance transferring into or out of bed.
- More than two-thirds (68.0 percent) of fall-related claims include a fall at the bedside, bathroom or other area in the resident's room.
- Almost half (48.4 percent) of the falls in the two-year claim data subset ultimately resulted in death.
- The average total paid for fall-related claims is $186,589. (See Average Total Paid for Closed Claims by Allegation, Chart 8.)
- The highest average total paid allegations for fall-related claims are associated with improper care and failure to monitor.
- The highest severity fall-related claims at independent living communities involve one resident who experienced multiple falls and another who fell and was not found for over 36 hours.
- More than half (56.9 percent) of the 601 fall-related claims that closed in 2014-2015 involve residents with a history of previous falls within the preceding 12 months. This finding indicates the need to take decisive measures to prevent multiple, serious falls.
- Almost two-thirds (61.1 percent) of these 601 falls were not witnessed by staff.

The following charts are based upon the five-year dataset, which includes 1,117 fall-related closed claims.

11 Frequency of Resident Fall-related Closed Claims by Bed Type

Percentage of 1,117 closed claims
* One fall-related closed claim occurred at a CCRC, but the level of care at the time of the incident is unknown.

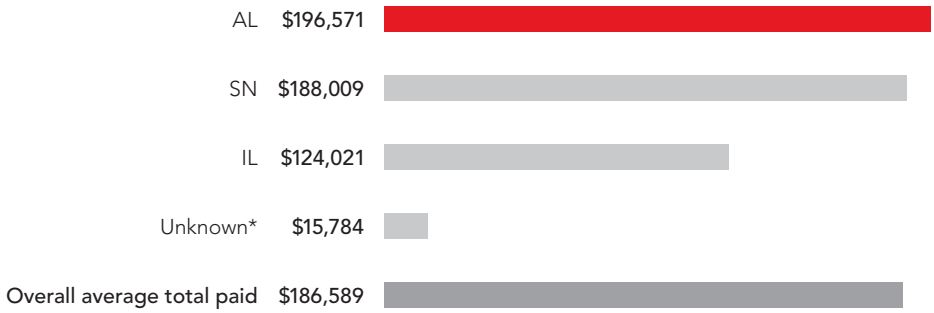
Most **fall-related claims** involve **skilled nursing**.



77.5% SN
18.0% AL
4.4% IL
0.1% Unknown*

12 Average Total Paid for Resident Fall-related Closed Claims by Bed Type

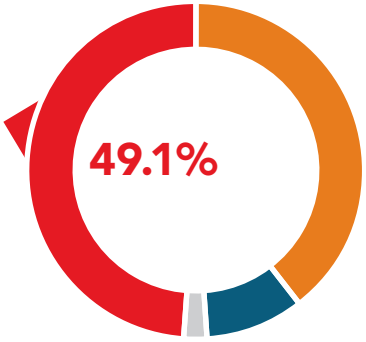
* One fall-related closed claim occurred at a CCRC, but the level of care at the time of the incident is unknown.



13 Frequency of Resident Fall-related Closed Claims by Allegation

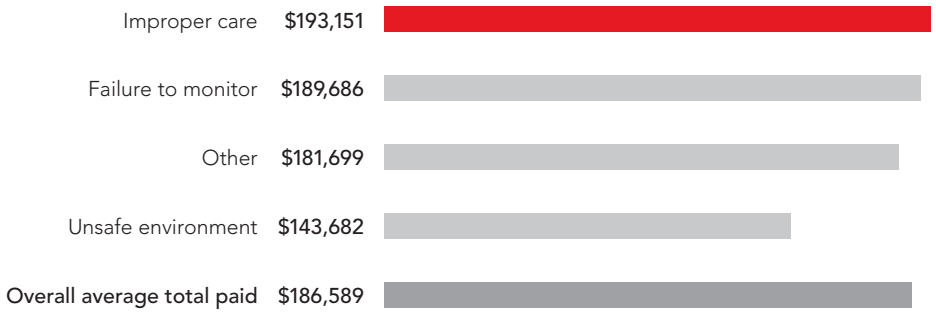
Percentage of 1,117 closed claims

Failure to monitor is the **most common** fall-related **allegation**, accounting for almost **half the claims**.



49.1% Failure to monitor
39.4% Improper care
9.3% Unsafe environment
2.2% Other

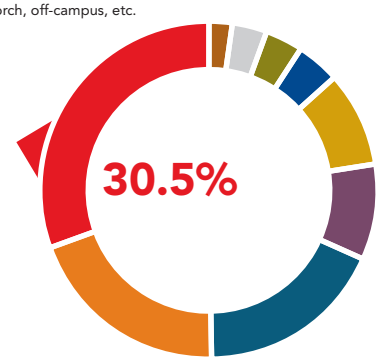
14 Average Total Paid for Resident Fall-related Closed Claims by Allegation



15 Frequency of Resident Fall-related Allegations by Location

Percentage of 1,117 closed claims
* "Other outdoors" locations include patio, porch, off-campus, etc.

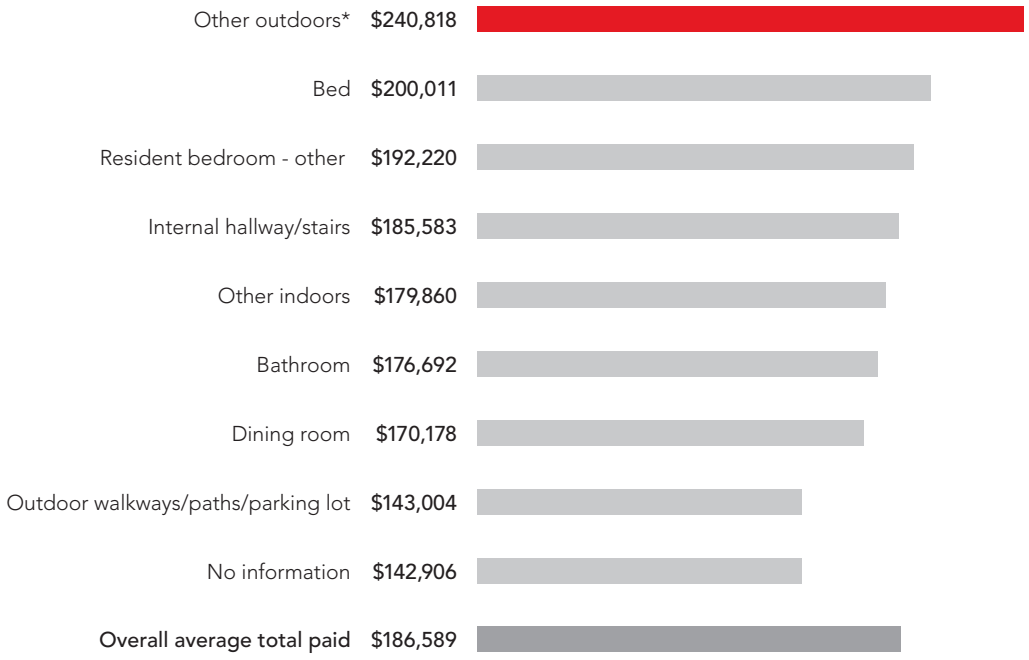
Almost **one-third of the falls** involve the **resident's bed**.



30.5% Bed
19.6% Other bedroom
17.9% Bathroom
9.2% Internal hallway/stairs
9.0% Other indoors
4.2% Dining room
3.4% Outdoor walkway/paths/parking lot
3.4% No information
2.1% Other outdoors*

16 Average Total Paid for Resident Falls by Location

* "Other outdoors" locations include patio, porch, off-campus, etc.

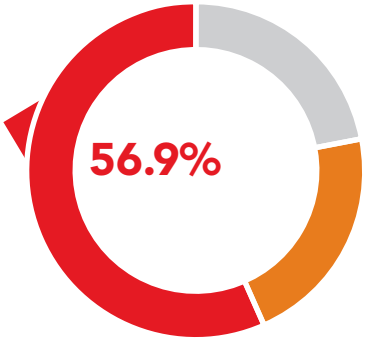


The following charts are based upon the two-year dataset, which includes 601 fall-related closed claims.

17 History of Previous Fall: Frequency of Closed Claims

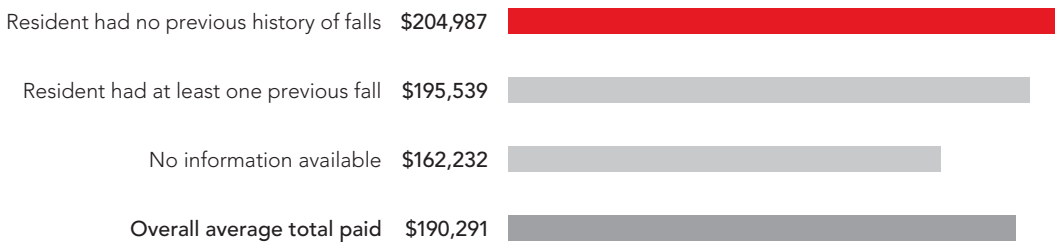
Percentage of 601 closed claims

More than half of **fall-related claims** involve residents with **a history of previous falls**.



56.9% Resident had at least one previous fall
21.8% No information available
21.3% Resident had no previous history of falls

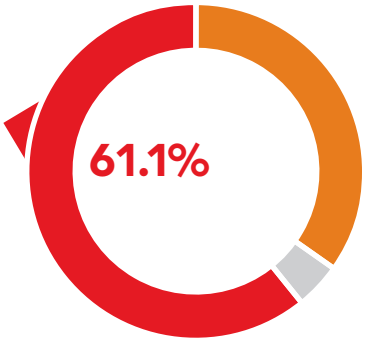
18 History of Previous Fall: Average Total Paid for Closed Claims



19 Witnessed and Unwitnessed Falls: Frequency of Closed Claims

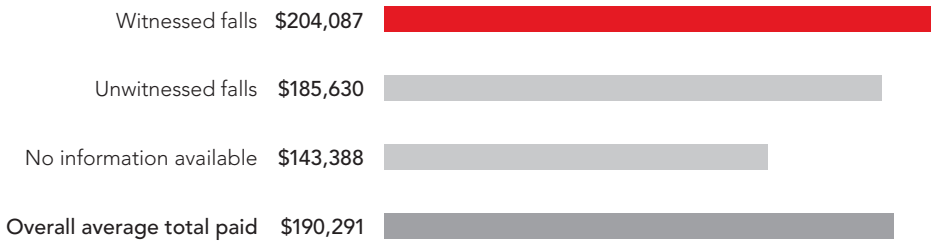
Percentage of 601 closed claims

Most falls were **not witnessed** by staff.



61.1% Falls unwitnessed by staff
34.8% Falls witnessed by staff
4.2% No information available

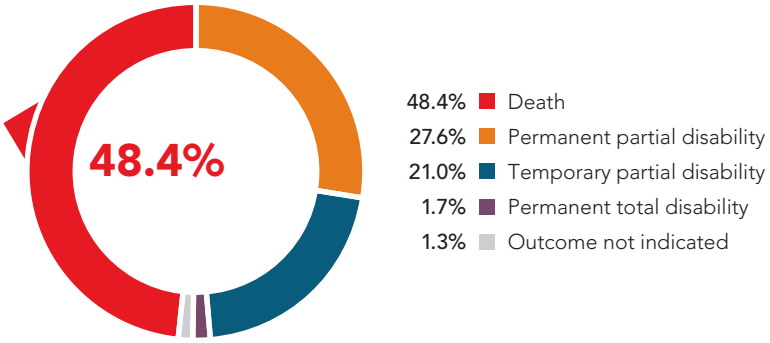
20 Witnessed and Unwitnessed Falls: Average Total Paid for Closed Claims



21 Resident Falls by Outcome of Injury: Frequency of Closed Claims

Percentage of 601 closed claims

Death is the **most common outcome** for **fall-related claims**.



Risk management recommendations regarding resident falls are included in Reports from the Field, as well as the following two Case Scenarios.

CASE SCENARIO: Resident Fall and Failure to Follow Resident's Care Plan

Summary of Facts

The resident was an 84-year-old man admitted to the insured's facility for rehabilitation following a right tibia/fibula fracture requiring surgery which occurred during his stay at an unaffiliated assisted living facility. The resident had a history of hypertensive heart disease and congestive heart failure. After surgery, the resident became more confused and frequently refused rehabilitation sessions. He was noted to be at risk for falls, and his care plan included staff checks every 15 minutes, full assistance with bathing and dressing, as well as a two-person assist for ambulation and transfers. In addition, the resident was being maintained on anticoagulant therapy. Although his care plan was never changed, he often ambulated with his walker unassisted and without using a call bell to summon assistance. Staff members were observed transferring and ambulating the resident by one individual.

Approximately one month after the client's admission to the insured's facility, a certified nursing assistant (CNA) bathed and clothed the resident prior to transferring him to his bedside chair. During transfer, the resident moved suddenly, and the CNA was unable to prevent the resident from falling to the floor. The CNA immediately called a nurse, who noted an area of ecchymosis on the resident's left forehead and assisted the CNA in returning the resident to bed using a mechanical lift. The resident complained of pain in his left ankle and exhibited mild shortness of breath. The physician was called and ordered nasal oxygen at two liters per minute, additional pain medicine, neurological checks every 30 minutes for 12 hours and ankle X-rays. The physician later visited the resident, noted no significant injuries but did observe an elevated INR and reduced the Coumadin dose in response. The physician also reviewed the X-rays and determined they were normal. The neurological checks revealed that the resident was able to follow verbal commands, but sometimes used inappropriate words when conversing.

The following day, the resident's INR reached critical levels. The physician placed the Coumadin on hold for three days with daily INR testing. On the third day, the INR was again in the critical range and vitamin K was ordered and administered. The resident's oxygen level was normal and the nasal oxygen was discontinued. On the fourth day, the INR was normal and Coumadin was reordered. The resident continued to experience left ankle discomfort but it was resolved with pain medication. On the fifth day, the resident became increasingly confused, had complaints of worsening pain and was transferred to the emergency department. He was accompanied by his daughter, a plaintiff attorney specializing in professional liability litigation.

The family notified the insured facility that the resident would not be returning and retrieved his belongings. The insured subsequently learned that the resident had suffered a large subdural hematoma. He was discharged from the hospital to hospice care, where he died five days later. The family was highly critical of their father's care at the insured's facility and initiated a lawsuit.

Allegations

- Failure to follow the resident's plan of care, which required two people for transfers and ambulation.
- Failure to follow the resident's plan of care, which called for monitoring the resident every 15 minutes.
- Failure to provide properly trained staff in adequate numbers to safely care for the resident.
- Delay in obtaining medical treatment for the resident's injuries, resulting ultimately in his death.
- Violation of the resident's rights and ongoing disregard for his well-being.

Liability Assessment

It was undisputed that the resident's care plan required two people to assist the resident in transfers and ambulation. Although the resident often ambulated independently or required only a minimal assist with transfers, the care plan had not been modified. The diagnosis of a subdural bleed was not made for five days notwithstanding documentation of confusion and increased difficulty with verbal expression. The increased risk for intracranial bleeding with head injury and anticoagulant therapy was not specifically addressed.

Resolution

The decision was made to proceed to mediation with intent to settle. Negotiations were heated as the family was angry. The claim settled at policy limits with no admission of liability.

Risk management recommendations

- *Ensure that resident care plans are reviewed frequently* and accurately reflect the level of care needed to meet the resident's physical, mental and social needs.
- *Adhere strictly to resident care plans*, especially in regard to transfer and ambulation safety requirements.
- *Perform and document all resident safety checks as ordered.* The presence of family or visitors with the resident does not alter the need for staff to perform safety checks consistent with documented orders.
- *Consider all aspects of the resident's treatment, including medications*, when evaluating fall-related risks and interventions.

CASE SCENARIO: Multiple Resident Falls

Summary of Facts

The resident, an 80-year-old, non-English speaking man, was admitted to the insured's skilled nursing facility with a diagnosis of unstable angina which made it impossible to safely live alone. The initial nursing assessment noted that the resident was self-reliant in activities of daily living and was able to transfer by himself and ambulate independently with a walker. The resident experienced no difficulties except for a single fall without injury in his second year at the facility. At that time, the resident was identified to be at risk for falls. Fall precautions were ordered, including a low bed and both bed and chair alarms.

During the resident's fourth year at the insured facility, he had a series of falls over a six-week period, all of which occurred in his bedroom, and did not result in injuries. No specific actions were taken until after the fourth fall, when the physician ordered a wheelchair for the resident to replace use of the walker. The wheelchair was left at the resident's bedside for his use. However, the walker was not removed, and the resident continued to ambulate using the walker. Two weeks later, the resident fell again and suffered severe pain and deformity of his right leg. He was admitted to the hospital and underwent surgery for repair of a fracture of the right femoral head. The resident never returned to the insured's facility.

The insured later learned that the resident had a very difficult postoperative course with multiple medical complications. He subsequently suffered two dislocations of the repaired femoral head, underwent a second surgical repair and, when that failed, had a total right hip replacement. He also developed wounds on his heels, a deep vein thrombosis, a bowel obstruction and a right hip abscess with marked destruction of the right femoral head. He never fully recovered from the fracture. The family alleged the resident's severe and rapid decline was due to the falls that occurred at the insured's facility, including the fall resulting in a fracture.

Allegations

- Failure to properly assess resident's fall risk.
- Failure to implement appropriate fall precautions.
- Failure to properly supervise resident.
- Failure to provide a safe environment.
- Failure to provide adequate staffing for the resident's care and safety needs.

Liability Assessment

Defense counsel initially believed the claim could be defended. However, in consideration of poor documentation and staff interviews revealing that the ordered fall precautions were never implemented, the decision was made to attempt to settle the claim.

Resolution

The claim settled at policy limits.

Risk management recommendations

- *Regularly review and update the resident's care plan* to reflect treatment ordered and care provided.
- *Obtain and utilize resident care and safety equipment as ordered.* Immediately report the lack of any such safety equipment through the chain of command until the needed items are provided.
- *Accurately document the resident's condition,* including potentially unsafe behaviors and compliance or noncompliance with the established care plan.
- *Address resident and family noncompliance* with the resident's care and safety plans.

Pressure Ulcers

Pressure ulcers rank with resident falls as a leading source of injury and associated liability. Moreover, defending pressure ulcer claims may be complicated by emotionally evocative photographs used in court, even if the photos were taken to document excellent clinical care rendered to the resident.

The rates of facility-acquired pressure ulcers are problematic. For at-risk populations, the incidence of pressure ulcers at stage 2 or higher is at least 15 percent. (See Balzer, K. and Kottner, J. "Evidence-based Practices in Pressure Ulcer Prevention: Lost in Implementation?" *International Journal of Nursing Studies*, November 2015, volume 52:11, pages 1655-1658.)

There has been considerable debate on whether pressure ulcers should be viewed as avoidable injuries. A significant amount of information on the prevention and healing of pressure ulcers is available on the Internet, including a number of CNA publications and evidence-based prevention and treatment programs offered by the Agency for Healthcare Research and Quality (AHRQ) website. The AHRQ notes that the agency is developing tools to "improve clinical decision-making by helping clinical staff identify residents at risk for adverse events, including pressure ulcers, falls, and avoidable hospitalizations." Relevant resources are available here.

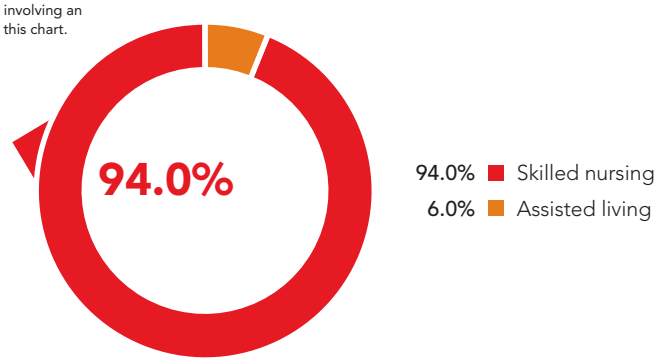
A review of CNA closed claims reveals the following findings:

- Of the 2,617 closed claims in the dataset, pressure ulcer is the primary allegation in 487 (18.6 percent) of claims. (See Frequency of Closed claims by Allegations, Chart 7.) One pressure ulcer claim with a total paid of $415,936 involves a resident aging-in-place with the assistance of home health care services at an independent living community. It is not included in the charts below because it may draw the reader to the misleading conclusion that independent living settings have the highest average payment for pressure ulcer-related claims. Therefore, the findings below are based on 486 closed claims with pressure ulcer as the primary allegation. Nevertheless, it is noteworthy that a major pressure ulcer claim can occur in an independent living community.
- Death is the most common injury associated with pressure ulcer claims, while amputation is the most expensive.
- The average total paid for the 487 pressure ulcer claims is $232,398, compared with an overall average total paid of $211,709. (See Average Total Paid for Closed Claims by Allegations, Chart 8.)

22 Frequency of Pressure Ulcer-related Allegations by Bed Type*

Percentage of 486 closed claims
* As noted above, the one pressure ulcer claim involving an independent living resident is not included in this chart.

Almost all pressure ulcer-related **allegations involved skilled nursing**.



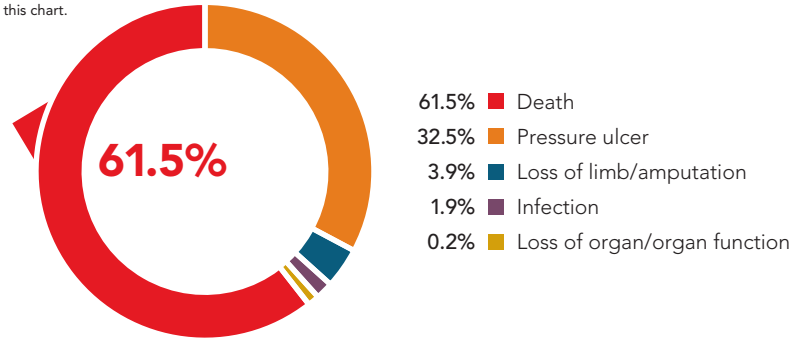
23 Average Total Paid for Pressure Ulcer-related Allegations by Bed Type*

* As noted above, the one pressure ulcer claim involving an independent living resident is not included in the average total paid.

24 Frequency of Pressure Ulcer-related Allegations by Injury*

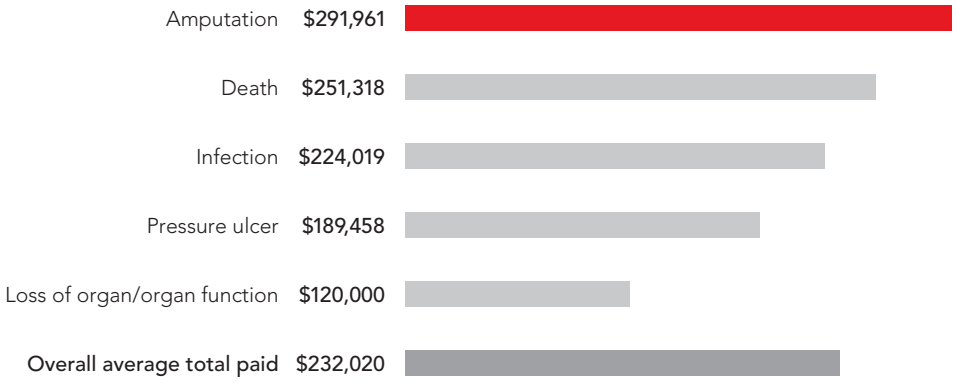
Percentage of 486 closed claims
* As noted above, the one pressure ulcer claim involving an independent living resident is not included in this chart.

Death is the **most common injury** among **pressure ulcer-related claims**.



25 Average Total Paid for Pressure Ulcer-related Allegations by Injury*

* As noted above, the one pressure ulcer claim involving an independent living resident is not included in the average total paid.



Risk management recommendations regarding pressure ulcers can be found in Reports from the Field as well as the following two Case Scenarios.

CASE SCENARIO: Facility-acquired Pressure Ulcer

Summary of Facts

The resident, a 74-year-old woman who had undergone a recent left hip replacement complicated by postoperative pneumonia, was admitted to the insured's skilled nursing facility for rehabilitation. She suffered from several chronic conditions, including diabetes, neurologic neuropathy, peripheral vascular disease, chronic obstructive pulmonary disease, renal insufficiency and hypertension. Despite this woman's poor medical history, her admission assessment identified her as at "low risk" for skin problems. The resident's care plan included elevating her heels, monitoring laboratory results, performing visual skin checks, evaluating nutrition, monitoring intake and applying skin moisturizers.

One month after admission, the resident was observed to have a large sore on her left heel. She told her physician and her family that two days prior she had hit her heel on a metal post attached to her footboard, but had not reported it to the staff. Photos of the resident's bed revealed an uncapped metal post with an open metal edge. Antibiotics, nutritional supplements, frequent dressing changes, a pressure relief mattress and protective booties were prescribed. All were implemented, as well as a bed change, but the resident refused to wear the booties. The rehabilitation staff documentation indicated the resident was uncooperative with care. Despite staff counseling of the risks, the resident frequently moved her legs across the sheets resulting in shearing and disruption of dressings.

The wound persisted despite treatment, and the resident was subsequently transferred to a hospital for specialized wound treatment. She did not return to the insured's facility. It was later learned that she had developed osteomyelitis, and that her wound had progressed to the point of exposed bone and gangrene. She was admitted to a different hospital, where she underwent a left above-the-knee amputation. The gangrene also caused exacerbation of her chronic renal failure, resulting in the need for hemodialysis for approximately one year.

Allegations

- The facility failed to identify the resident as at high risk for skin breakdown and failed to provide protective booties upon admission.
- The resident suffered a traumatic heel injury arising from an uncapped steel post attached to the bed footboard, subsequently resulting in an above-the-knee amputation.

Liability Assessment

It was undisputed that the wound occurred while under the care of our insured. The photographs of the wound, even in its early stages, were graphic and would be disturbing to a jury. Additional photographs of the resident's bed at the time of the injury revealed an uncapped metal post with unprotected metal edges. Defense experts provided widely conflicting opinions regarding the necessity for protective booties, which complicated the defense of the nursing care. Significant gaps in documentation of the resident's skin and wound assessments, daily skin care and wound care complicated the defense of the medical care provided. Defense experts questioned the competence of the wound care nurse, who left the facility shortly after the resident's wound was first identified. The facility's wound care was then assumed by the director of nursing, who had no specific expertise in wound care. The resident's noncompliance with recommended care and treatment was noted, but no alternative treatments or approaches were attempted or documented.

Resolution

Given these facts, the decision was made to attempt to settle the claim. The final settlement was in the high six-figure range.

Risk management recommendations

- *Ensure that the facility employs/contracts with credentialed professionals* who can properly assess and medically manage resident wounds.
- *Avoid gaps in documentation* as gaps create the appearance there may have been lapses in communication and continuity of care, as well as severely hampering legal defense in the event of litigation.
- *Actively address resident noncompliance* by offering alternative treatment and care plans.
- *Document all alternative treatment initiatives instituted* to overcome resident noncompliance.
- *Include family members and significant others in attempts to enhance resident compliance* and document all such efforts.
- *Obtain behavioral health consultation regarding resident noncompliance*, if appropriate.

CASE SCENARIO: Facility-acquired Pressure Ulcer with Incomplete Documentation

Summary of Facts

The resident was an 82-year-old man who was originally admitted to the insured's skilled nursing facility with a diagnosis of dementia. Approximately five years following his admission, the facility was purchased by a new owner. Approximately six weeks after the new ownership began operating the facility, staff observed that the resident had developed a left heel ulcer. Five days after the report of the heel ulcer, the resident was noted to have an infected sore on his right leg. There was no evidence in the resident's record that either wound was assessed, measured or staged. The resident's daughter noted that her father seemed dehydrated and complained of being hungry, so she brought him food and beverages. His daughter regularly complained to staff about her father's continued decline, but no additional steps were taken to improve his care.

Three months later, he developed a fever and was received in the hospital emergency department in cardiopulmonary arrest. He was resuscitated and diagnosed with a urinary tract infection, septic shock and multiple pressure ulcers of the legs, sacrum, buttocks and arm. Ten days after his admission to the hospital he was transferred to hospice care where he died five days later. The cause of death was reported as septicemia from the urinary tract infection.

Allegations

- Failure to turn and reposition the resident as prescribed.
- Failure to develop and follow an appropriate care plan for skin assessment and pressure ulcer prevention and management.
- Failure to provide proper care and treatment resulting in infection.
- Failure to provide proper nutrition and hydration.

Liability

The resident's daughter linked her father's decline to the change in facility ownership and the resulting lack of properly trained and experienced staff. Documentation in the resident's records was inadequate, and care plans were neither reviewed nor updated. His wounds were not assessed, measured or staged, and the insured facility had no formal wound care program in place. The resident's nutritional status and intake were not noted. Staff depositions were negative and were deemed to decrease the chances of a defense verdict. Experts deemed the resident's treatment and resulting injuries as difficult to successfully defend, and the decision was made to avoid litigation and pursue settlement.

Resolution

The claim was settled in the high six-figure range.

Risk management recommendations

- *Include resident acuity in determining appropriate staffing levels* to ensure that adequate numbers of properly trained staff are available to meet resident care and safety needs.
- *Develop, review and revise resident care* plans to include all aspects of resident care needs and safety.
- *Adopt, follow and document a rigorous wound prevention and management program*, which includes assessment of all residents for wounds on a regular basis.
- *Turn and reposition residents as ordered* and document these activities.
- *Evaluate and monitor resident intake* to ensure adequate hydration and nutrition. Provide supplemental nutrition, as needed.

REPORT FROM THE FIELD: A Faith-based, Skilled Nursing Community

The leadership team believes that providing a safe and homelike environment is an attainable goal, which does not require an elaborate set of policies and procedures or above-average revenues.

This organization is a 101-bed, faith-based, not-for-profit community offering long-term care and short-term rehabilitation, as well as a self-contained, secure memory care unit. It has consistently received a Five Star CMS rating in all categories, as well as several awards for high-quality care. The Chief Executive Officer has also received several industry awards. In 2015, the facility was recognized by the American Health Care Association for customer satisfaction, low hospital readmission rates and reduced usage of antipsychotic medications.

Payer mix

The payer mix is predominantly Medicare/Medicaid, with a low percentage of private pay. Fundraising activities are used to pay for projects so that operational revenues can be spent solely on areas essential to maintaining high levels of employee satisfaction and excellent resident care.

Staffing

On average, the community provides 3.8 CNA hours per resident per day, with one CNA for every seven residents during the day shift. This staffing level is higher than the national average of 2.47 (2 hours, 28 minutes) CNA hours per resident per day. (See Nursing Home Compare.)

Resident falls

The director of nursing noted that elders fall more in nursing homes than at home, attributing these falls to residents' overall frail physical condition, multiple comorbidities and memory impairment. Fall rates are difficult to compare across organizations due to variations in the definition of a fall. Using the most all-encompassing definition, the community averages 0.33 falls per resident day. Their fall program includes several components that differentiate it from other fall programs, contributing to sustained success:

- *In-depth investigations following every resident fall.* Utilizing a simple, non-burdensome form, the nursing supervisor reviews medications and blood pressures, interviews the resident as soon as possible following a fall, and assesses such factors as presence of or need for equipment, clothing and footwear. The information is used to modify the resident's care plan and environment, as well as to initiate physical therapy or occupational therapy interventions. *The medical director signs every fall investigation form and the pharmacy reviews completed investigations, as requested, in addition to performing a monthly review of every resident.*
- *Judicious use of personal alarms.* Based upon the community's experience that alarms frighten and distract residents, personal alarms are approved only for compelling reasons.
- *CNA hall monitors.* CNA hall monitors are utilized to provide resident care as needed during especially busy times, such as at the change of shift.
- The following policies and procedures are in force:
  - The facility is restraint-free.
  - Every department undergoes continuing education regarding fall prevention.
  - Residents are checked during rounds every two hours, including an offer to toilet and meet other resident needs.
  - Use of psychotropic medications is very low relative to state and national norms, and no hypnotic medications are administered to residents.
  - Monthly falls meetings occur on all shifts. At these meetings, staff from rehabilitation services and activities, as well as at least one CNA, determine root causes and exchange ideas regarding additional opportunities to enhance protocols and/or care plans.

Pressure ulcers

This facility has experienced zero facility-acquired pressure ulcers over several years. They attribute this achievement to the following practices:

- *Creating and adhering to an organizational culture where pressure ulcers are not acceptable.* Employees are fully engaged in this commitment, which is instilled during the initial orientation process and continually reinforced by experienced CNAs.
- *Providing excellent nursing care* that focuses on such basics as consistent turning of residents, attention to nutrition and hydration, and good incontinence care.
- *Assigning CNAs to the same residents* so they can more effectively monitor changes in the residents' skin condition.
- *Providing early intervention by CNAs*, who are instructed to immediately report changes in skin condition to nursing staff.
- *Encouraging open communication* among staff, the medical director and other physicians/practitioners.

Success factors – overall approach to resident care

At this facility, the leadership team believes that providing a safe and homelike environment is an attainable goal which does not require an elaborate set of policies and procedures or above-average revenues. The secret to success is sticking to the basics:

- *Value staff and focus on retaining nurses and CNAs.* The CEO of this organization shared, "We value our staff and focus on retaining nurses and CNAs. Our employees are treated like family. We believe that doing nice things for employees equals good care for the residents." Investing in employee satisfaction is seen as the key to organizational success.
- *Complimentary soft drinks, coffee and snacks are made available to staff* throughout the day, and there is no charge for lunch and dinner. In addition, emergency loans are made on occasion.
- *Adequate staffing, especially of front-line caregivers, is viewed as a cardinal rule* to achieve high-quality care.
- *Staff members are consistently assigned to the same residents,* enabling nurses and CNAs to identify clinical changes in a more timely manner and prevent injuries from occurring.
- *The goals of the "Advancing Excellence in America's Nursing Homes" national campaign have been adopted.* This model utilizes such quality improvement benchmarks as falls, infections, staff turnover and timely clinical interventions.
- *The medical director serves as the primary care provider for all residents.* This approach helps bolster resident satisfaction and has lowered hospital readmission rates.

Risk management recommendations

- *Develop a culture of safety* that includes the following components:
  - *Ensure that senior leaders consistently demonstrate their dedication to high-quality care and resident safety*, as well as staff satisfaction and retention.
  - *Maintain an organizational commitment to providing appropriate staffing*, especially of front-line caregivers.
  - *Maintain a blame-free environment*, analyzing problems in an objective, systematic manner.
  - *Review and regularly adjust, as needed, fall and skin care programs* to evaluate their effectiveness and to eliminate actions that do not significantly add value. (See the self-assessment on pages 63-69 for additional suggestions on evaluating these programs.)
  - *Invite front-line staff to quality meetings* in order to discuss specific situations and share ideas about how to improve resident safety and well-being.
  - *Establish commitment at all staff levels to achieve specified performance goals* and high-quality care.
  - *Encourage open communication among nurses, CNAs and practitioners* regarding early signs of changes in residents' conditions.
- *Develop a fall prevention program* that includes:
  - *Consistent, purposeful rounding* to proactively identify resident needs.
  - *Timely, comprehensive investigation* of every fall.
  - *Use of hall monitors* to supervise residents during change of shift, mealtimes and other busy periods.
  - *Judicious use of personal chair, wheelchair or bed alarms.*
  - *Minimal use of psychotropic medications*, reviewing each prescription for possible alternative interventions.
  - *A restraint-free environment* to the greatest extent possible.
- *Develop a skin care program that includes:*
  - *Staff education on identifying pressure ulcer risk factors*, utilizing a holistic approach.
  - *Consistent staff assignments* to provide continuity of resident care and expeditious identification of early changes in skin condition.

PART TWO: ONGOING CHALLENGES AND EMERGING RISKS

This section of the report discusses several significant current and emerging risks confronting aging services organizations, including elopement, workplace violence and resident abuse. Coupled with these challenges are the risk exposures associated with Medicare/Medicaid programs relating to hospital readmissions and class action litigation focused on understaffing issues.

Elopement

Elopement involves the unauthorized departure from a building of a resident who, due to medical or psychosocial conditions, has been clinically deemed unsafe to leave the building unaccompanied. Analysis of elopement claims reveals the following common risk factors:

- *A lack of vigilance* in maintaining a secure environment.
- *A biased initial risk assessment* as a result of the resident's limited mobility, lack of prior elopement attempts and/or inaccurate history of the resident's cognitive status given by family members.
- *Inadequate staff training* for working with cognitively impaired residents.
- *Failure to manage family and resident expectations* regarding level of supervision.

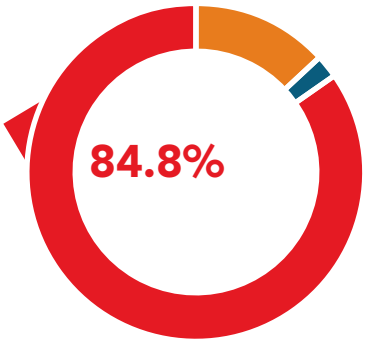
CNA data indicate that resident elopement is a low-frequency occurrence, encompassing 46 of 2,617 claims. However, elopement continues to have the highest average total paid at $325,561, as compared to the overall average total paid of $211,709.

- Most residents (84.8 percent) who eloped had cognitive impairment.
- Death occurred in 45.7 percent of the elopement claims.
- Assisted living communities experience the highest number of elopements, which may reflect the rising acuity of residents in this level of care.
- Contrary to common belief, the risk of elopement does not end after the first year. Half (50.0 percent) of the claims involve residents who eloped a year or more after admission.

26 Frequency of Resident Elopement Closed Claims by Associated Factors

Percentage of 46 closed claims

Most **elopement claims** involve **cognitively impaired** residents.

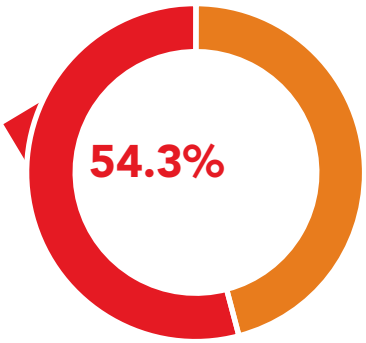


84.8% Cognitive impairment
13.0% Psychiatric issues
2.2% Anger

27 Frequency of Resident Elopement Closed Claims by Bed Type

Percentage of 46 closed claims

More than half of **elopement claims** are associated with **assisted living**.



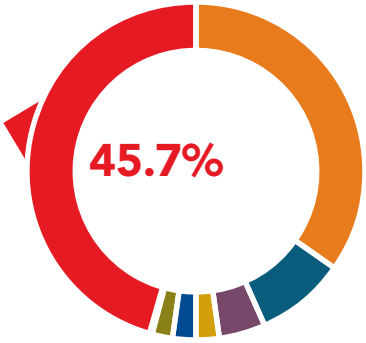
54.3% Assisted living
45.7% Skilled nursing

28 Average Total Paid for Resident Elopement Closed Claims by Bed Type

29 Frequency of Resident Elopement Closed Claims by Injury

Percentage of 46 closed claims

Death is the **most frequent injury** associated with **elopement claims**, followed by fracture(s).

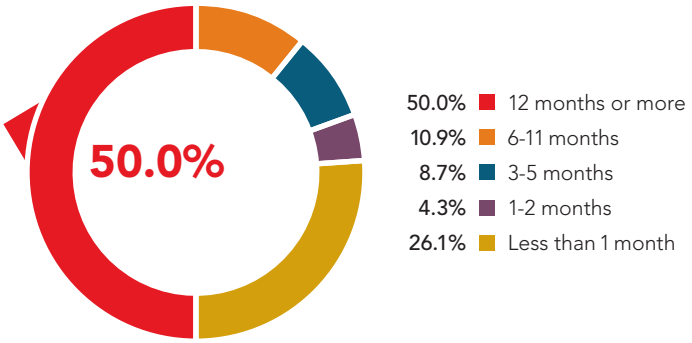


45.7% Death
34.8% Fracture(s)
8.7% Contusion/bruise/swelling/edema
4.3% Head injury
2.2% Dehydration/lack of nutrition
2.2% Muscle and ligaments
2.2% Laceration

30 Length of Time from Admission to Elopement (All Bed Types)

Percentage of 46 closed claims

Exactly half the **elopement claims** involve residents who had **been at the facility** for at **least 12 months**.



Risk management recommendations

- *Ensure that staffing levels are sufficient and reflect resident acuity.*
- *Reassess the elopement prevention program especially at assisted living facilities* as the rate of elopement claims in that setting is increasing.
- *Provide ongoing education regarding care for the cognitively impaired resident* and document these efforts.
- *Perform comprehensive elopement risk assessments*, which include evaluation of cognitive impairment, psychiatric conditions, medications that cause confusion, a history of prior elopement attempts, wandering behaviors and statements about wanting to leave the facility.
- *Perform initial elopement risk assessments immediately upon admission* and reassess elopement risk on an ongoing basis.
- *Place new residents in rooms closer to nursing stations and away from exits*, in order to help staff monitor at-risk residents and reduce elopement attempts.
- *Conduct routine environmental safety rounds*, paying special attention to areas that are not within view of staff. The rounds should include visual inspection of door locks, alarm systems, soft-closing elevators, and after-hours facility entry alarm and tracking systems, as well as camera surveillance of identified high-risk areas.
- *Conduct routine elopement drills*, and educate all staff about emergency response when a resident is reported missing.

CASE SCENARIO: Elopement from a Secured Unit

Summary of Facts

The resident was a 77-year-old woman with dementia who was ambulatory and generally healthy. She had been living in the assisted living facility for more than two years. As her dementia progressed, she began wandering, became increasingly restless and was identified as being at risk for elopement. The resident was transferred to the insured's secured memory care unit (MCU) where she continued to wander and walk the halls at all hours. She was known to enter other residents' rooms, try to open locked doors and attempt to leave the unit with visitors. She had been successful in leaving the MCU on two occasions and had been found in the facility's adjacent assisted living unit. Her wandering and confusion continued despite the introduction of anti-psychotic medication.

One evening, the resident received her evening dose of anti-psychotic medication and was settled into bed just before 8:00 pm. When staff made rounds at 8:30 pm, the resident could not be located. The staff searched the unit, including other resident rooms and common areas. They then searched the grounds without success. Approximately two hours after the resident was last seen by staff, the nurse called the administrator, who notified the police and requested assistance from 911 emergency services. EMS and police joined the search and at 11:00 pm, they found the resident at the far end of the insured's property. She was laying face-down in a pond at the bottom of a steep embankment located just 100 yards from the facility's exit. The cause of death was accidental drowning.

State Regulatory Agency Involvement

The incident was immediately reported to and investigated by a state regulatory agency which cited the facility for an unsafe environment both inside and outside the MCU. The insured was also cited for failing to provide adequate elopement prevention training to MCU staff.

Allegations

Allegations were asserted against the corporation, the insured facility, the facility's management group and the administrator. Some of the major allegations included:

- Failure to maintain a safe environment.
- Failure to provide perimeter fencing for the pond, despite the insured's awareness of the steep embankment and consequent safety risk.
- Failure to properly assess the resident.
- Failure to prevent the resident from eloping, which resulted in her death.
- Failure to properly train employees in working with residents at risk for elopement.

Liability Assessment

It was undisputed that the resident eloped from a unit designated as secure for residents with dementia and died while under the care of the insured. The door to the MCU was known to have previously malfunctioned – it did not always alarm when opened or automatically relock when closed. The insured was aware of the steep embankment surrounding the pond but had not installed a protective fence. There was a significant delay in notifying the administrator and in obtaining the assistance of 911 and police following the elopement. And finally, staff provided contradictory statements that would create defense difficulties.

Resolution

Given the death of the resident, the findings of the state regulatory agency, adverse media attention and the perceived weakness of witnesses, concerted efforts were made to settle the case. The case was settled at the policy limits.

Risk management recommendations

- *Evaluate the physical environment for appropriateness of high-risk units,* i.e., those advertised and marketed as safe and designed for residents at higher risk for elopement.
- *Ensure a safe environment for residents,* including those at increased risk for elopement.
- *Provide residents with facility-supported elopement prevention monitoring devices.*
- *Regularly inspect and maintain all doors and locks, as well as elopement prevention equipment.*
- *Educate staff about elopement risks,* risk assessment procedures and proactive interventions.
- *Maintain facility grounds in a safe manner,* with special attention to bodies of water.
- *Build secure fences around the facility in urban areas and if there is a nearby body of water* that could be a danger to residents.

Violence in the Workplace

For years, violence has been a major source of concern for hospitals and other healthcare entities, and the problem has spread into aging services communities. Maintaining a "safe environment" now includes not only preventing resident abuse, but also protecting employees, administrators and visitors from violent crimes. The following incidents illustrate the types of risks that every aging services community must be aware of:

- *An independent living facility resident allegedly set fire to a nursing home over a dispute with staff.* (See here for more information.)
- *A kitchen worker at an assisted living facility shot and killed two housekeepers and shot and injured himself* in a domestic dispute that spilled over into the workplace. (See here for more information.)
- *A nurse was killed in the parking lot of the skilled nursing facility where she worked.* Her ex-husband was arrested. (See here for more information.) *McKnight's*, December 09, 2015 via Pendulum Legal Risk Network.
- *An employed certified nursing assistant murdered a resident in his room,* after being suspected of forging checks belonging to the resident. (See CASE SCENARIO: Violent Death in Assisted Living Community, page 38.)
- *A white supremacist gunman entered a Jewish Community Center and its affiliated aging services facility in Kansas with an assortment of guns and began shooting.* (See here for more information.)

The Occupational Safety and Health Administration's webpage provides background information on violence in the healthcare workplace, as well as a "Road Map" that highlights real-world violence prevention programs and the efforts of aging services communities.

Some states have responded to rising levels of violence and resident abuse by permitting families to place video cameras in resident rooms. Legislation expressly permitting electronic monitoring devices to be installed in resident rooms has been enacted in at least five states (including Illinois, New Mexico, Oklahoma, Texas and Washington) as of the date of this publication.

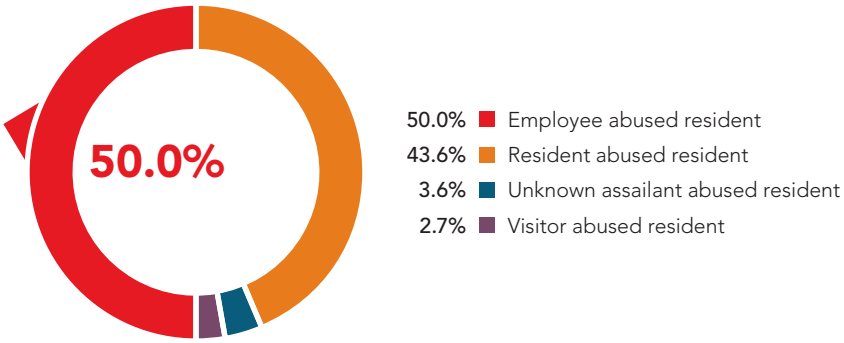
Analysis of CNA closed claim data demonstrates that:

- Abuse claims are low-frequency, high-severity occurrences, encompassing 4.2 percent of 2,617 closed claims with an average total paid of $226,393.
- One-half (50.0 percent) of abuse-related claims involve an employee, while resident-on-resident abuse comprises 43.6 percent of the claims.
- The most frequent injury associated with abuse is emotional distress.

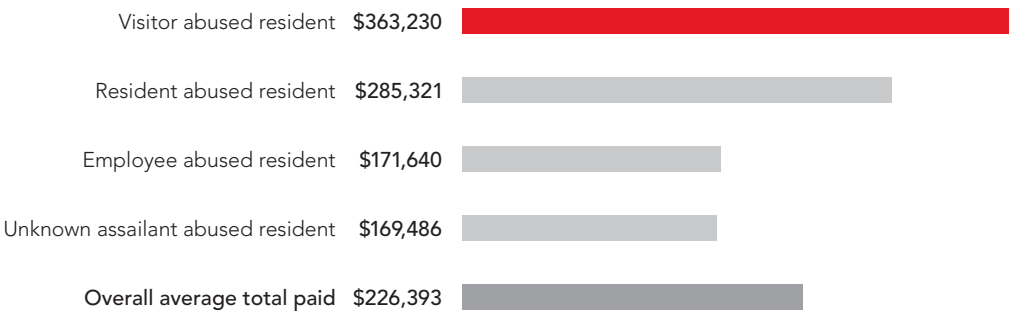
31 Frequency of Resident Abuse-related Closed Claims by Type of Abuse

Percentage of 110 closed claims

Employee abuse of residents **occurs more** often than **resident-on-resident abuse**.



32 Average Total Paid for Resident Abuse-related Closed Claims by Type of Abuse



33 Highest Frequency for Resident Abuse-related Closed Claims by Injury

Percentage of 110 closed claims

Emotional distress	23.6%
Death	18.2%
Contusion/bruise/swelling/edema	15.5%
Fracture(s)	15.5%
Sexual assault	9.1%

Risk management recommendations

- *Establish policies and procedures for staff to follow in the event of a breach in facility security,* the presence of an armed or unarmed intruder, or an individual threatening violence.
- *Meet with members of the local police department to discuss options for responding to an intruder,* up to and including an "active shooter" scenario.
- *Implement a violence prevention program*, which includes but is not limited to:
  - Promulgating a zero-tolerance policy for bullying and other forms of sexual, physical, emotional, verbal and financial abuse.
  - Teaching staff what constitutes bullying and abuse in all of its forms.
  - Training staff during orientation and annually on effective methods for interacting with persons with dementia and/or behavioral problems. Training should include assessing and de-escalating agitated, inappropriate or potentially violent behavior.
  - Assessing residents prior to and upon admission for potentially abusive, inappropriate and/or violent behavior.
  - Ensuring that care plans address risks for residents who act in an inappropriate or abusive manner, or who may evoke abusive responses from others.
  - Documenting in resident care plans interventions for mitigating inappropriate, abusive and/or violent behavior.
  - Instructing staff how to respond to an active shooter and other security breaches.
  - Performing drills to ensure that staff are prepared for a violent incident on the premises.
  - Enforcing compliance with reporting requirements relative to suspected resident abuse.
  - Implementing protocols for communicating with residents, families, staff members and media immediately following violence on the campus.
  - Establishing support programs for staff, residents and families following violent incidents in the community.
  - Prohibiting retaliation against residents, families or employees who report incidents of abuse, neglect or violence.
  - Conducting multistate criminal and sexual offender background checks for prospective employees prior to employment, for contractors prior to unsupervised presence in the community and for residents prior to admission.

For more information on establishing an effective violence prevention program, consult the extensive materials available through the Occupational Safety and Health Administration and relevant professional associations.

CASE SCENARIO: Violent Death at Assisted Living Community

Summary of Facts

The 84-year-old resident had been living at the insured's assisted living facility for five years. He was alert and oriented and required assistance only with his medications. During a visit with his son, he indicated that several of his personal checks had been stolen and cashed by someone whose name he did not recognize. The son reported the theft to the director of resident nursing (DRN), who notified the resident's bank, assisted in initiating restoration of his funds and notified the police.

The DRN recognized the name on the checks as that of a part-time CNA, who had undergone a background check upon hire several years earlier with no negative findings. The police officer assigned to the case suggested that the insured not take any disciplinary action against the suspected employee since he was not scheduled to work for a week and there was a danger of "tipping him off" to the ongoing police investigation. The DRN and administrator followed the officer's advice and a detective arrived at the insured facility within 48 hours for further investigation.

Soon afterward, the resident discussed the matter with other residents. Staffing for that night was limited to one CNA, but additional security had been provided for the resident's apartment, including alarms installed in the hallway. Both staffing and security measures met state requirements. The night-shift CNA was extremely busy and was unable to check the resident after assisting him with medications at 9:15 pm. While several alarms occurred that evening, they were not investigated due to recent experience with false alarms. At 6:45 the following morning, the CNA found the resident on the floor next to his bed with his feet twisted in the linens. He appeared blue, was cold to the touch, had no pulse, had multiple head and facial wounds, and was surrounded by significant amounts of drying blood. Upon arrival, emergency medical services declared him dead.

The resident's family members were notified. Investigators determined that the death was due to suspicious circumstances, rather than a fall or other natural causes. The police investigated the suspect employee's cellphone records, which revealed that the suspect had received a call from another employee on the day of the event. When questioned, the employee admitted to calling the suspect after hearing the resident complain about his stolen checks but did not report this to the facility or to the police.

A review of the facility's security data showed that the suspect had entered the facility at 10:00 p.m. on the night of the incident. When questioned, the suspect denied any involvement with the resident's death. He was arrested and held for questioning while a full investigation continued. Following additional questioning by police, the suspect confessed to stealing the resident's checks. He stated that he went to talk to the resident to apologize and make amends but after he identified himself as the check thief, the resident struck him with his cane. The suspect claimed that he defended himself against the resident, who fell and hit his head, at which point the suspect fled without having injured the resident in any way. However, the Medical Examiner reported that the resident had suffered multiple severe blows to the face and head, and classified the death as a homicide.

The suspect was charged with first-degree murder, forgery, burglary and abuse of a vulnerable person. Police performed a full forensic investigation, and the evidence supported the charges. The suspect subsequently confessed to all charges and was sentenced to life imprisonment without the possibility of parole. The resident's family initiated a wrongful death lawsuit, naming the insured corporation, insured facility, director of resident nursing and the employee who notified the suspect of the police investigation.

Allegations

- Failure to provide adequate security measures.
- Failure to protect resident from foreseeable criminal acts.
- Failure to prohibit CNA from gaining access to the facility.
- Failure to promptly confront CNA with criminal allegations to prohibit him from gaining entry into resident room.
- Failure to provide adequate staffing.

Liability Assessment

The resident was murdered while under the care of the insured in its assisted living facility. The facility had committed a number of lapses, including failing to properly repair the building's security system, leading to unanswered alarms; neglecting to deactivate the employee's facility access card; and not instructing the resident to refrain from discussing the theft of his checks and the suspect's name.

Resolution

Given the resident's tragic death and investigative and judicial findings, CNA resolved this claim at the policy limits.

Risk management recommendations

- *Include both current and prior residency state background checks* when screening potential employees who have recently relocated to the area.
- *Investigate all known or suspected crimes against residents* in an aggressive and timely manner.
- *Take appropriate steps to ensure the resident's continued safety* during investigations.
- *Implement enhanced safety precautions,* such as hiring additional security personnel 24 hours a day until the investigation has been completed.
- *If an employee is suspected of a workplace crime, relieve the employee of work duties, and disable the employee's security badge and access card* until the police investigation can be completed and the matter is resolved.
- *Warn possible crime victims to avoid discussing the matter* pending investigation and resolution.
- *If a resident or employee is known to be in danger, alert staff on a need-to-know basis of the situation* prior to the apprehension of the criminal suspect.
- *Immediately contact legal counsel regarding actions to take pending resolution of a criminal investigation,* especially in terms of notification and suspension of access to the facility.

Readmissions

Resident readmissions to acute care settings are a significant concern for aging services organizations. By decreasing readmissions, organizations may demonstrate their quality of care, strengthen their ability to compete in the marketplace and enhance their likelihood of gaining entry into accountable care organizations. This section offers guidance in reducing hospital readmission rates.

According to one study, "almost one-fourth (23.5 percent) of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination." (Mor, V. et al., "The Revolving Door of Rehospitalization From Skilled Nursing Facilities," *Health Affairs*, January 2010, vol. 29:1, pages 57-64.)

The Centers for Medicare & Medicaid Services (CMS) has launched multiple initiatives to reduce avoidable readmissions from nursing homes enrolled in the Medicare and Medicaid programs. On August 27, 2015, CMS announced a new effort to reduce potentially avoidable re-hospitalizations by funding higher-intensity treatment services in nursing facilities for residents who may otherwise be hospitalized upon an acute change in condition. This value-based reimbursement incentive program has potentially significant consequences for aging services providers.

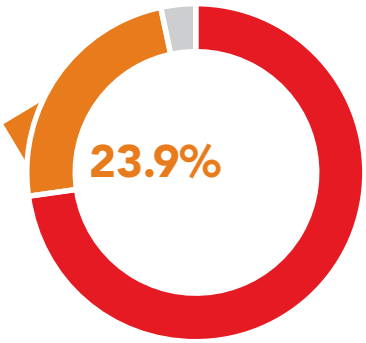
CNA data demonstrate that 23.9 percent of the 1,387claims that closed between 2014 and 2015 involve a hospital readmission – a rate that closely parallels the findings of the Mor study cited above.

- Resident fall is the most frequent *allegation* in claims involving readmission to a hospital within 30 days. This finding underscores the importance of minimizing resident falls in any program designed to reduce readmissions.
- Cardiac and/or pulmonary illnesses are the most frequent *contributing medical conditions* among readmission-related closed claims. Please note that each closed claim could be coded with up to three contributing medical conditions, therefore, the total in chart 39 is greater than 331 claims and the data is number of claims, not percentage of claims.

34 Frequency of Closed Claims by Readmission Status

Percentage of 1,387 closed claims
* No information to determine readmission status

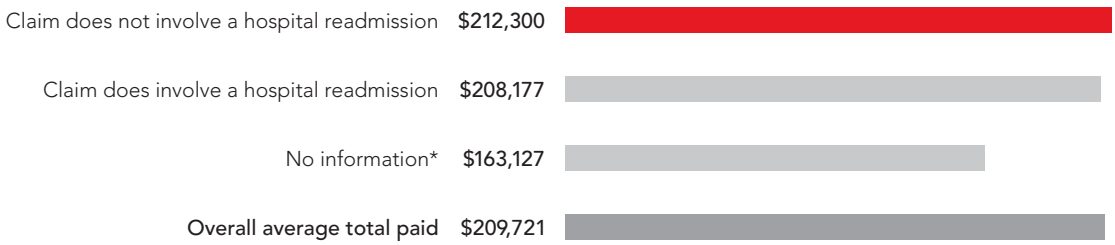
Almost a quarter (23.9 percent) of the **closed claims** in the 2014-2015 dataset **involve** a **hospital readmission**.



72.9% Claim does not involve a hospital readmission
23.9% Claim does involve a hospital readmission
3.2% No information*

35 Average Total Paid for Closed Claims by Readmission Status

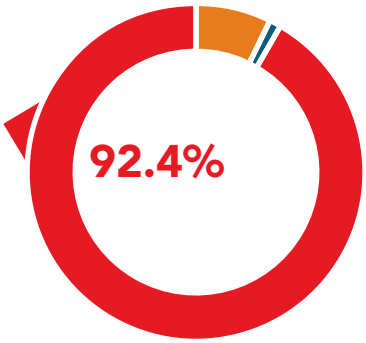
* No information to determine readmission status



36 Frequency of Readmission-related Closed Claims by Bed Type

Percentage of 331 closed claims
* One claim with "No information" involves a CCRC and bed type at time of incident is unknown.

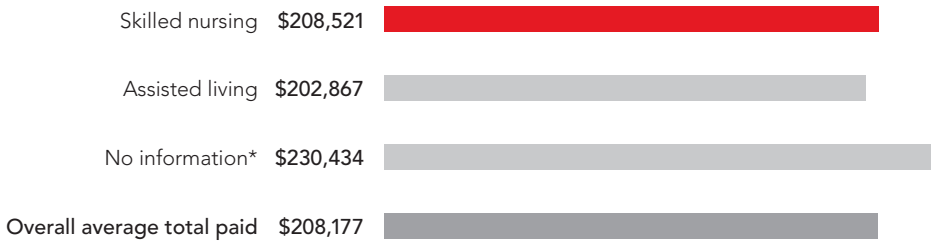
Most **readmission-related claims** involved **skilled nursing**.



92.4% Skilled nursing
7.3% Assisted living
0.3% No information*

37 Average Total Paid for Readmission-related Closed Claims by Bed Type

* One claim with "No information" involves a CCRC and bed type at time of incident is unknown.



38 Frequency of Readmission-related Closed Claims by Allegation

Percentage of 331 closed claims	
Resident fall	38.4%
Improper care (excluding falls)	19.3%
Pressure ulcers	16.3%
Failure to monitor (excluding falls)	7.3%
Delay in seeking medical treatment	6.9%
Failure to follow physician order	3.9%
Medication error	2.4%
Abuse	1.8%
Failure to inform physician	1.2%
Unsafe environment (excluding falls)	0.9%
Violation of resident rights	0.6%
Elopement	0.3%
Failure to treat	0.3%
Lack of informed consent	0.3%
Total	100.0%

39 Number of Contributing Medical Conditions

Cardiac and pulmonary	234
Dementia	144
Diabetes	116
Osteoporosis	39
Dehydration	39
Obesity	36
Malnutrition	28
No contributing factors	26

Risk management recommendations

- *Consider family and resident expectations related to treating in place and re-hospitalizations* when creating resident care plans.
- *Establish a model for "treating in place"* or adopt an evidence-based program such as the Interventions to Reduce Acute Care Transfers (INTERACT) program presented by the American Medical Directors Association.
- *Consider utilizing telemedicine services* to implement a "treat in place" program.
- *Maintain appropriate staffing levels* that reflect changing resident acuity patterns.
- *Train staff to recognize and identify early symptoms of changes in residents' medical conditions*, and to respond appropriately.
- *Perform diagnostic testing in a timely manner* and report results promptly to the ordering physician/practitioner.
- *Develop strategies to manage cardiac, pulmonary and other chronic conditions* in collaboration with the hospital and the resident's personal physician.
- *Employ or contract with transition coordinators and utilize approved transfer protocols* and standardized medication reconciliation tools to enhance communication among caregivers during resident transitions.
- *Ensure that higher-acuity residents have appropriate access to physicians/practitioners* to facilitate prompt provision of care at the facility when a resident experiences a change in condition.
- *Track 30-day readmissions* and monitor the effectiveness of processes designed to minimize re-hospitalizations, such as timely identification of and response to clinical changes in a resident's condition.
- *Evaluate readmission patterns*, examining such factors as day of the week, providers making admission decisions and underlying causes for readmissions, such as exacerbation of chronic conditions and infections.

Class Action Claims in Aging Services

A class action is a lawsuit in which one or several persons sue on behalf of a larger group. Once a class action has met the legal requirements of ascertainability, numerosity, commonality, typicality, adequacy and predominance, it can be "certified" by the court system. Class action lawsuits can be prohibitively expensive due to the potential for aggregation of otherwise minimal damages and legal costs associated with burdensome discovery. Insurance coverage may be at issue, as the litigation can involve damages that may be excluded, such as criminal fines, penalties, punitive awards or injunctive relief.

While class actions are certainly not new to the aging services industry, over the past few years class action lawsuits have increased based upon the same general allegation: chronic understaffing. Class action litigation based upon understaffing have these common characteristics:

1. The defendant facilities share ownership, operators and/or management company, with one class action lawsuit including residents of multiple facilities.
2. The suits occur in states with a mandated minimum number of nursing hours per resident day.
3. The facilities are required to self-report staffing levels and/or acuity levels monthly.

In 2014, for example, the Supreme Court of Arkansas certified a class action lawsuit against 12 nursing homes operated by one organization in which the plaintiffs alleged inadequate staffing and violations of the Arkansas Long-Term Care Residents' Rights Act and Deceptive Trade Practices Act.

Federal Law and Regulations

Federal law and regulations relating to staffing also affect the defensibility of class action cases. The Affordable Care Act requires facilities to electronically submit direct care staffing information based upon payroll. These data will be used to publicly report on staffing levels and turnover rates at facilities. The data collection, which began on a voluntary basis in 2015, became mandatory as of July 1, 2016.

Frequent Allegations

Class action complaints include alleged violations of state-specific safety codes related to resident's rights (e.g., California Health & Safety Code 1430(b)), as well as violations of state deceptive trade practices laws. Specifically, plaintiffs may allege that the facilities claim to comply with adequate staffing levels in the admission agreement/resident's bill of rights (i.e., meeting minimum or increased requirements based upon resident acuity), and the facility failed to meet these requirements. Moreover, plaintiffs may allege that the facilities misrepresented their staffing levels in marketing and admission documents, and that residents were misled into entering into the agreements based upon material misrepresentations. Therefore, marketing materials and websites should not include potentially misleading statements such as "Our facility provides 24-hour nursing supervision." Statements about staffing levels may be misinterpreted by prospective residents and families whose experience is based on acute care hospital-level nursing staffing. The statement "24-hour nursing supervision" may become the basis for a deceptive practices action if the facility employs only one nurse on-site.

Action Plan

Upon notification of a pending class action lawsuit, the organization should immediately seek legal counsel with expertise in both class action and aging services litigation. The organization's insurer also may have expertise in this type of class action litigation and may be able to facilitate prompt determination as to whether there are any legal arguments that may result in either removal to federal court or dismissal. Thereafter, legal counsel should work closely with the organization to assess the merits and course of action for the claim.

Risk management recommendations

- *Maintain appropriate staffing levels* that are aligned with resident census and acuity, are consistent with state and national norms, and fulfill regulatory requirements.
- *Ensure that staffing data are accurately reported to CMS* and reconcile reports with internal data.
- *Manage resident and family expectations* by communicating what resident services are and are not provided in a clear, accurate and straightforward manner, both in discussions and in marketing materials.
- *Immediately address any verbal or written complaints regarding understaffing* initiated by residents or families.
- *Prohibit superlatives or promises regarding resident outcomes* in marketing brochures, websites, advertisements and social media.
- *Document care provided in a consistent, accurate, timely and complete manner*, so that records can serve as objective, tangible evidence in the event of litigation.
- *Document daily staffing levels* and maintain these records for a length of time consistent with state requirements.

REPORT FROM THE FIELD: A For-profit, Assisted Living/Memory Care Community

Resident care includes special emphasis on continued mobility and involvement in meaningful activities, notwithstanding cognitive impairment.

Silverado, a for-profit organization specializing in memory care, has 32 assisted living community locations across eight states. In addition to assisted living, Silverado has one skilled nursing facility, nine hospice offices and seven At Home offices. It considers the compassion and dedication of its staff and the leadership team as fundamental to its success.

According to its website, Silverado's mission is to offer innovative programs that improve the quality of life for residents with memory impairment. It has been awarded the 2016 Alzheimer's Association Corporate Award for its "dedication to enriching lives, honoring the human spirit and redefining memory care." A 2016 documentary depicts Silverado as an innovative organization that embraces a core operating philosophy of "love and recognizing the value of the human spirit." Resident care includes special emphasis on continued mobility and involvement in meaningful activities, notwithstanding cognitive impairment. This approach improves the quality of life for residents, while also reinforcing Silverado's fall and pressure ulcer prevention programs.

Payer mix

While assisted living and At Home are predominantly private pay, hospice and the skilled nursing facility do include Medicare and Medicaid reimbursement. Overall, the organization is approximately 90 percent private pay.

Staffing

Assisted living communities are staffed at approximately one full-time equivalent per resident day, including all associates (i.e.,employees).

Resident falls/pressure ulcers

The following strategies are integral to the organization's falls and pressure ulcer prevention programs:

- *Instituting vigilant medication reconciliation upon admission and with any change in resident condition*, which decreases the incidence of falls and pressure ulcers by reducing polypharmacy and medication side effects, as well as increasing exercise endurance.
- *Educating staff about pressure ulcer prevention protocols,* including identification of risk factors, proper transfer techniques and effective skin care treatments.
- *Actively encouraging mobility and weight-bearing movement* in various ways.
- *Making snacks and other food available to residents at all hours* in order to maintain proper nutrition and weight, a key factor in pressure ulcer prevention.

Success factors – overall approach to resident care

- *Ensuring that licensed nurses are on site 24/7,* as are social work staff.
- *Treating residents and staff with kindness and respect*, knowing that this will enhance the quality of life for all.
- *Accompanying residents to the emergency department* if no family member is available.
- *Permitting pets to reside with residents* to combat loneliness.
- *Adopting an intergenerational program* and encouraging the involvement of family members with consideration for customary health and safety precautions.
- *Facilitating an aging-in-place process* when appropriate.
- *Offering an evidenced-based cognitive program,* which includes physical and cognitive exercise, stress reduction therapies, purposeful social activities and support groups.

Risk management recommendations

- *Encourage staff to view each resident as an individual* capable of contributing to the community.
- *Develop fun, interesting and innovative programs* that offer cognitive and psychosocial stimulation for residents.
- *Implement an intergenerational program* that includes family members of residents and fosters ongoing resident engagement in community activities.
- *Encourage cognitively impaired residents to participate in purposeful activities* that relate to their career, social and educational interests.
- *Develop a comprehensive medication reconciliation policy.*
- *Track utilization of psychotropic medications* against improvement in resident alertness and participation in activities.
- *Permit pet visits* (for pets approved by a veterinarian) and initiate a pet therapy program.
- *Encourage regular, purposeful movement for all residents* including those who utilize wheelchairs.

PART THREE: ENTERPRISE RISK MANAGEMENT

Our ongoing goal is to encourage and assist healthcare leaders in adopting a strategic, enterprise-wide perspective on assessing and managing risks, including the broad range of property and casualty exposures. Water damage and auto accidents currently are major risk exposures for aging services organizations requiring the attention of leadership in order to reduce losses and safeguard both residents and staff.

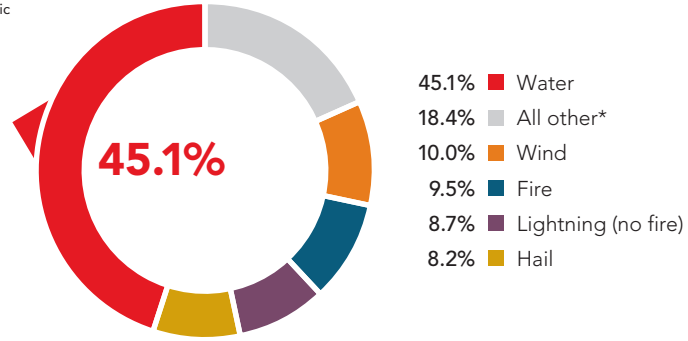
Commercial Risk Exposures

The following analysis is based upon 2,827 claims involving commercial risk exposures that closed between January 1, 2011 and December 31, 2015. All relevant claims are included in the dataset, with no minimum indemnity payment by CNA. These losses were covered by one or more of CNA's aging services insurance policies, including combined/package (i.e., professional, general, property, auto/fleet, crime and inland marine liability coverages), auto/fleet and/or cyber liability coverage. The losses resulted in a total payment of $116,854,893 by CNA on behalf of our clients.

40 Frequency of Property Closed Claims by Cause of Loss

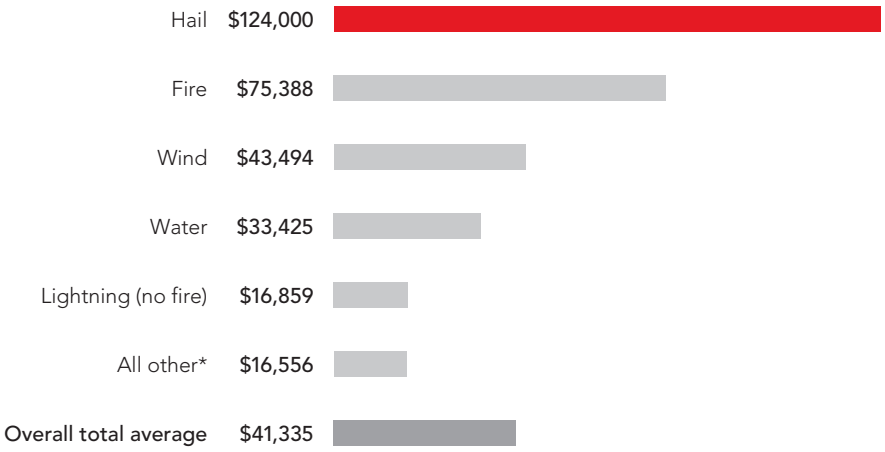
Percentage of 2,827 closed claims
* "All other" includes incidents representing less than 5 percent of the claims, such as electronic disruption, theft, vandalism, explosion, etc.

Water damage is the **most common** property **loss**.



41 Average Paid for Property Claims by Cause of Loss

* "All other" includes incidents representing less than 6 percent of the claims, such as disruption, theft, vandalism, explosion, etc.



Water Damage Closed Claims

Given the potential impact of water damage on the continuity and quality of resident care, as well as the expense associated with business interruption, a more in-depth analysis of water-related losses was undertaken in 2015. The analysis revealed that 65 percent of water damage claims involved bursting of water supply and sprinkler pipes during cold weather. Such freeze-ups and ruptures can cause major damage very quickly, especially from a one-inch pipe, which has almost four times the flow of a half-inch pipe.

Most of the claims were the result of failure to properly prepare for cold weather. Many were further complicated by a poor initial emergency response, including failure to shut off water control valves in a timely manner. Several large losses were directly attributed to:

- *Failure to drain low point valves on dry pipe sprinkler systems* that run in unheated areas, such as attics.
- *Inadequate or disturbed attic insulation*, creating cold spots in areas not typically at high risk for freezing.
- *Louvered openings in mechanical spaces that do not fully close*, exposing these areas to freezing temperatures.

Risk management recommendations

- *Implement a written emergency action plan* that includes the following measures:
  - Ensure that water control valves are clearly labeled and readily accessible.
  - Train supervisors and managers on all shifts, to ensure there is an individual on site 24/7 who is prepared to respond to an emergency water leak.
  - List local emergency plumbing service providers with 24/7 response capability.
- *Include cold weather preparation on the preventive maintenance schedule*, inspecting exterior walls, window louvers and mechanical spaces before the onset of freezing weather.
- *Check sprinklers* on a quarterly basis.
- *Drain low point valves on dry pipe systems* before the first freeze.
- *Restore attic insulation* after performing any work in an attic space.

Automobile Exposures

CNA-insured aging services organizations experienced 865 covered automobile liability claims that closed between January 1, 2011 and December 31, 2015, resulting in a CNA payment of at least $5,000. Many of these claims involve either suboptimal driver selection or distracted driving.

Driver selection includes not only determining who is qualified to drive a van, bus or other vehicle, but also who has the knowledge and skills to safely assist residents on and off the vehicle and correctly restrain passengers. In addition, criminal background checks should be performed for every driver, even if the employee's customary duties do not typically involve resident interaction. Leaders can ensure that only reliable, properly licensed employees with unblemished driving records and acceptable criminal background checks (in compliance with organizational policy), are permitted to drive on behalf of the facility by implementing an effective motor vehicle records (MVR) program.

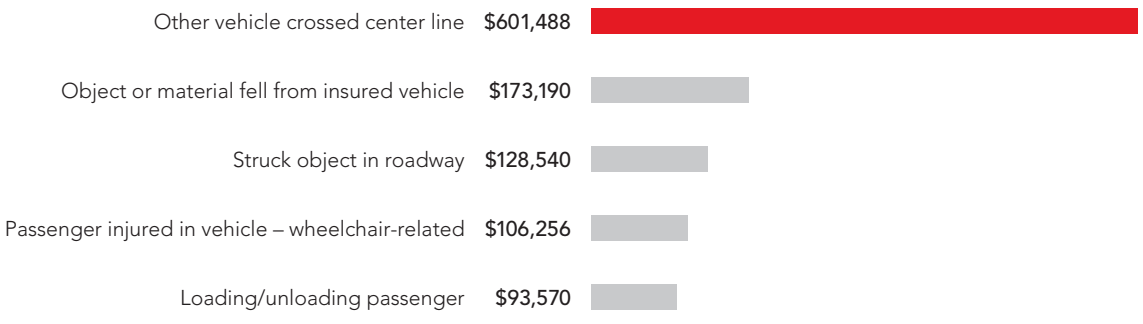
Distracted driving poses a significant risk exposure to organizations that permit employees to drive company-owned or personal vehicles for work-related reasons. Common activities that divert attention from the road include texting, mobile phone use, eating/drinking, reaching for an object, talking with a passenger and reading navigation systems. According to the National Safety Council, 26 percent of all vehicle crashes involved mobile phone use, including hands-free operation. (See "Understanding the Distracted Brain, Why Driving While Using Hands-free Cell Phones Is Risky Behavior," A National Safety Council white paper, April 2012.)

Improving driver selection and eliminating driver distraction is critical to protecting residents and employees, as well as organizational assets and reputation.

42 Highest Frequency of Automobile Closed Claims by Type of Accident

	Percentage of 865 closed claims
Insured vehicle rear-ended other vehicle	16.1%
Insured failed to observe clearance	10.1%
Other vehicle rear-ended insured	6.2%
Insured failed to yield	6.1%
Insured vehicle struck parked car	5.2%

43 Highest Average Paid for Automobile Closed Claims by Type of Accident



Risk management recommendations

Driver selection

- *Require drivers to complete resident intra-vehicular safety and transfer procedure training,* ensuring that drivers have the knowledge and skills to safely assist residents on and off the vehicle and correctly restrain passengers.
- *Provide adequate numbers of trained staff in the vehicle* to complete two-person transfers as needed.
- *Identify who is* permitted *to drive and who* actually *drives for your organization.* This listing may include non-employees operating the organization's vehicles, drivers of vehicles owned or leased by the organization, drivers of commercial vehicles owned by the organization, drivers with a commercial driver's license and/or employees driving their own vehicle on organizational business.
- *Verify that all drivers have a current driver's license*, which is valid for the type of vehicle they operate.
- *Check all drivers' MVRs prior to their driving for the organization* and annually thereafter. Request a five-year MVR review, if possible.
- *Perform a criminal background check for every driver* who may have contact with residents, families or other staff.
- *Specify the type and number of driving violations that disqualify a prospective driver* from operating a vehicle for the organization.

For additional information and guidance, see CNA's "Driver Selection Risk Control Guide."

Distracted driving

- *Issue a written policy on avoiding distractions while driving*, such as prohibiting eating, drinking and reading navigation systems. Navigation systems should be permitted and utilized only if directions are given verbally.
- *Limit the use of cell phones when operating any vehicle on organizational business, in compliance with all relevant statutes and regulations.* At a minimum, require drivers to be legally parked if they wish to make a non-urgent cell phone call from their vehicle.
- *Instruct drivers to use voicemail to notify callers that they are not available to answer calls* when they are driving.
- *Implement a disciplinary program* for violations of driving-related policies, including unsafe use of cell phones.

For additional information regarding driver and fleet management, please see www.cna.com/driverperformance.

Cyber Liability Risk Exposures

Cyber liability exposures have been significantly affected by two major pieces of federal legislation. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 was designed to improve patient care through the use of electronic health records that can be shared among institutions. By encouraging implementation of electronic health record systems, the law has significantly increased the volume of patient data compiled by healthcare institutions – data that must be secured against unauthorized access, use or release. Aging services organizations must also be compliant with the Health Insurance Portability and Accountability Act (HIPAA) Final Omnibus Rule, issued in 2013, which broadens the privacy and confidentiality requirements for independent contractors and business associates serving healthcare organizations.

Due to the broad range of requirements and sanctions in HIPAA and HITECH, the repercussions of an unauthorized release of sensitive data can be burdensome, including notification of all affected parties. However, it should be noted that such laws usually include a safe harbor provision whereby data breaches involving encrypted data do not require notification of potentially affected parties.

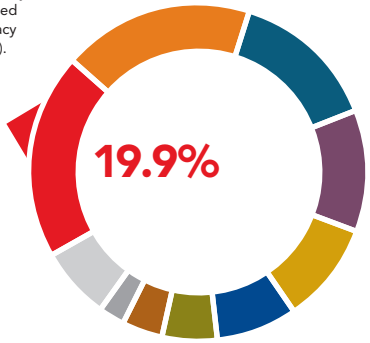
The data regarding cyber-related closed claims include CNA excess policies. The predominant risks associated with cyber liability are the potentially high costs rather than frequency of claims. The following comments are based upon CNA analysis of all healthcare-related cyber liability claims that closed between January 1, 2011 and December 31, 2015. The analysis reveals that:

- Theft/loss and unauthorized access to data continue to be the most common cyber liability claims.
- Hacking includes 20 claims; one of these claims incurred a payment of $10,000,000.

44 Frequency of Cyber-related Closed Claims by Cause of Data Loss

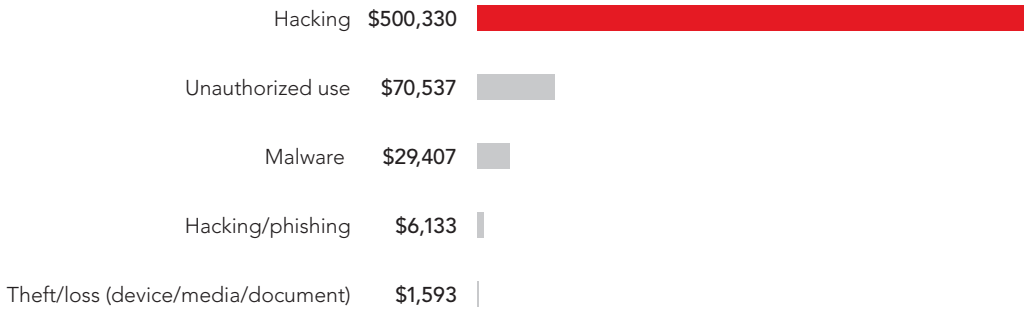
Percentage of 206 closed claims
* "All other" includes causes of loss that individually account for less than 2 percent of the 206 closed cyber claims (i.e., identity theft, malware, privacy regulation, social media and unauthorized use).

Data theft/loss is the **most frequent** source of **cyber liability**.



19.9%	Theft/loss (device/media/document)
18.4%	Unauthorized access
14.1%	Accidental (data loss)
11.7%	Accidental (document loss)
9.7%	Hacking
7.8%	Unauthorized disclosure
5.3%	Phishing
3.9%	Fraud
2.4%	Crypto-ransomware
6.8%	All other*

45 Highest Average Total Paid Cyber-related Closed Claims by Cause of Data Loss



Risk management recommendations

- *Implement a cyber security awareness educational program* and require that all employees complete the course annually.
- *Conduct a thorough needs and vendor risk assessment* when planning to acquire new or expanded IT capabilities.
- *Select reputable, dependable IT systems*, as well as vendors.
- *Require full-disk encryption* to mitigate the consequences of a data breach and nullify third-party notification requirements.
- *Adopt security measures that counter the threat of "ransomware,"* which block access to computer systems until a sum of money is paid.
- *Minimize the risk of accidental disclosure* through ongoing training and up-to-date policies governing the transmittal of sensitive information.

For additional discussion and recommendations regarding cyber security, see CNA's *Healthcare Perspective*, Issue 9–2016, "Cyber Liability: Minimizing the Risk of a Data Breach."

Fall prevention interventions include a "walk and dine" activity and an exercise program designed to improve residents' strength and balance.

The William Breman Jewish Home is a five-star rated, 96-bed facility, specializing in long term skilled nursing care, Alzheimer's/dementia care and short-term rehabilitative care. It has received My InnerView's Excellence in Action award, a national honor recognizing commitment to superior customer and staff member satisfaction for five years. Organizational data demonstrate a sustained reduction in pressure ulcers and resident falls with injuries.

Payer mix

The payer mix includes 40 percent Medicaid, 25 percent Medicare and 35 percent private pay.

Staffing

CNA staffing ratios are 1 to 6 day shift; 1 to 8 evening shift and 1 to 12 night shift. These staffing levels permit more individualized care.

Resident falls/pressure ulcers

The facility proactively addresses risks associated with both falls and pressure ulcers early in the admission process, utilizing the following strategies:

- *Upon admission, residents and their families are given a community handbook, which states straightforwardly that there are no guarantees that the resident will not fall.* Families and residents are informed that many factors influence fall risk, including underlying comorbidities.
- *This information is reinforced at a "welcome home" luncheon*, where staff can talk with families about quality measures and safety, including mitigation of falls and pressure ulcers.
- *Fall prevention interventions include a "walk and dine" activity* and an exercise program designed to improve residents' strength and balance.
- *The pressure ulcer prevention program includes use of pressure-relieving mattresses* and high-quality skin care products for all residents. Medical-grade honey products are being used to successfully heal pressure ulcers.
- *A wound physician performs rounds weekly* and nurse practitioners examine wounds three times per week, to ensure that residents in the wound care program are routinely assessed by clinicians.
- *All residents participate in a skin-cleansing program*, receiving baths and/or showers at least three times per week.

Success factors – overall approach to resident care

- *Commitment to maintaining favorable staffing ratios*, enabling staff to provide individualized care.
- *Use of ongoing "huddles" throughout the day*, not solely during shift change reports, to enhance communication about resident concerns and/or changes in condition. All staff members – including CNAs and ancillary services – are encouraged to participate in the huddle.
- *Recognition programs* to reward high-performing staff for successful outcomes.

Risk management recommendations

- *Consider using a formal tool for communicating expectations and risks* related to pressure ulcers and falls to residents and families upon admission.
- *Include creative techniques to incorporate exercise into the activities of daily living*, such as a "walk and dine" program.
- *Maintain staffing levels* sufficient to enable individualized, resident-centered care.
- *Utilize "huddles" or brief communication sessions throughout each shift* to ensure that all staff are aware of each resident's current needs.

CONCLUSION

CNA and our aging services insureds perform at an optimal level when we collaborate to promote resident safety. We offer this resource as a roadmap to help our clients improve resident services, efficiently allocate human and financial resources, and mitigate major sources of risk. The following questions may help focus these ongoing risk control efforts:

1. Is your organization committed to providing a compassionate, resident-focused culture of safety?
2. Does your organization monitor updates in evidenced-based practices that could further help staff prevent and mitigate resident falls and pressure ulcers?
3. Has the organization allocated sufficient human and technical resources towards the goal of enhancing safety and quality?
4. Is there a program in place to ensure that all caregivers have the necessary knowledge, skills and attitude to provide high-quality care?
5. Is your organization committed to addressing not only professional liability exposures, but also property, auto and cyber risks?
6. Are you measuring progress toward achieving these goals? And if not now … when?

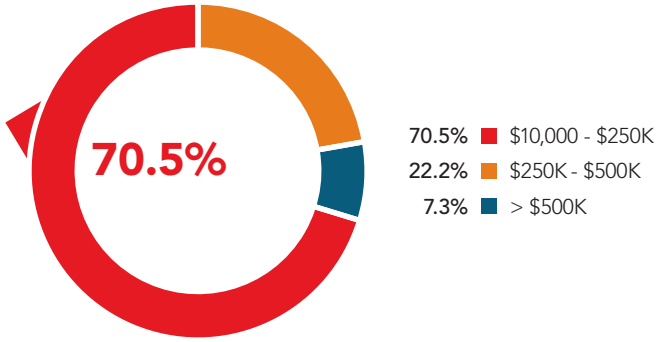
APPENDIX A:
UPDATED PREVIOUSLY REPORTED DATA

Distribution and Severity of Closed Claims by Total Paid

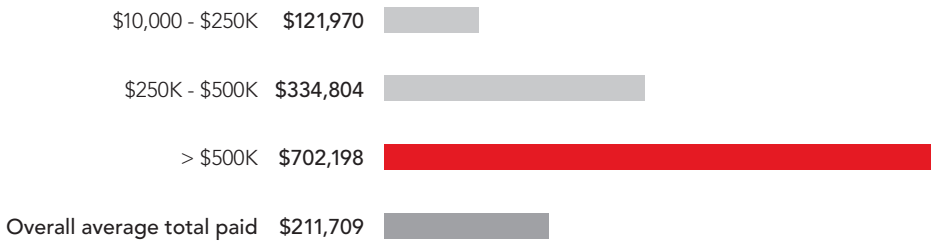
The following charts update topics explored in CNA aging services claim reports from past years. As noted in the Datasets and Methodology section, the significant changes in inclusion criteria and definitions in this edition mean that the current data should not be directly compared with equivalent sections in previously published claim reports. However, these data do provide a useful and interesting snapshot of liability patterns in today's aging services industry.

46 Frequency of Closed Claims by Total Paid Groups

The **majority of claims** have a **total paid** between **$10,000 and $250,000**.



47 Average Total Paid for Closed Claims by Total Paid Groups



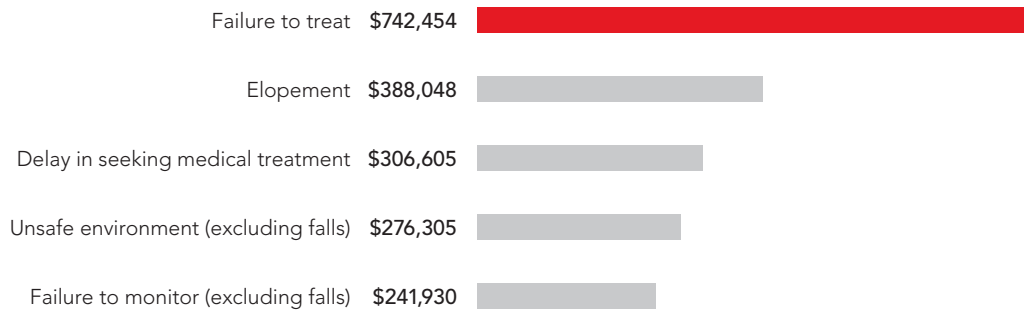
Data by Bed Type

Assisted Living Closed Claims

48 Highest Frequency Assisted Living Allegations

Percentage of 429 closed claims	
Resident fall	46.9%
Improper care (excluding falls)	10.7%
Resident abuse	7.9%
Pressure ulcers	6.8%
Elopement	5.8%

49 Highest Average Total Paid for Assisted Living Allegations

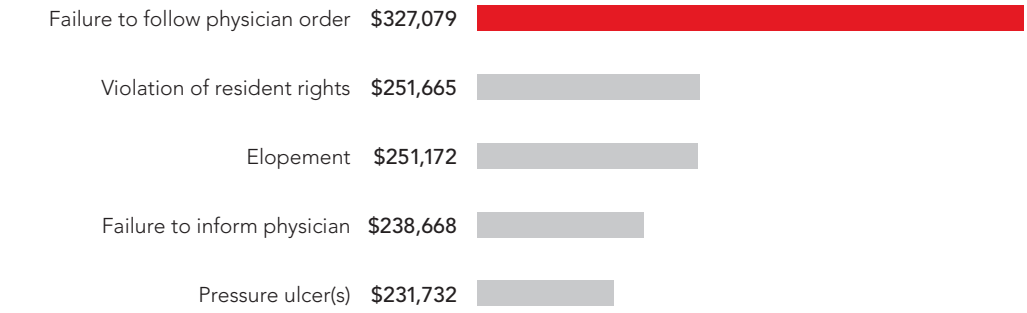


Skilled Nursing Closed Claims

50 Highest Frequency Skilled Nursing Allegations

Percentage of 2,112 closed claims	
Resident fall	41.0%
Pressure ulcers	21.6%
Improper care (excluding falls)	15.9%
Failure to monitor (excluding falls)	6.3%
Resident abuse	3.5%

51 Highest Average Total Paid for Skilled Nursing Allegations

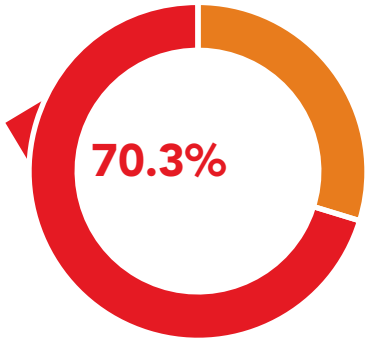


Short-term-stay Closed Claims

52 Frequency of Short-term-stay Closed Claims by Business Segment

Percentage of 391 closed claims

Most **short-term-stay claims** occurred at a **for-profit facility**.



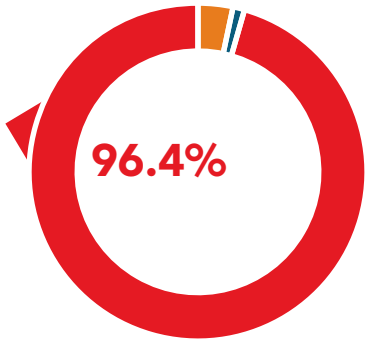
70.3% For-profit
29.7% Not-for-profit

53 Average Total Paid for Short-term-stay Closed Claims by Business Segment

54 Frequency of Short-term-stay Closed Claims by Bed Type

Percentage of 391 closed claims
* One claim with "No information" involves a CCRC and bed type at time of incident is unknown.

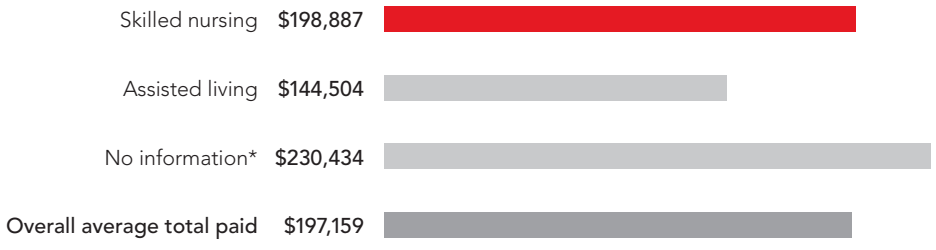
Almost all **short-term-stay claims** involved **skilled nursing**.



96.4% Skilled nursing
3.3% Assisted living
0.3% No information*

55 Average Total Paid for Short-term-stay Closed Claims by Bed Type

* One claim with 'No information' involves a CCRC and bed type at time of incident is unknown.

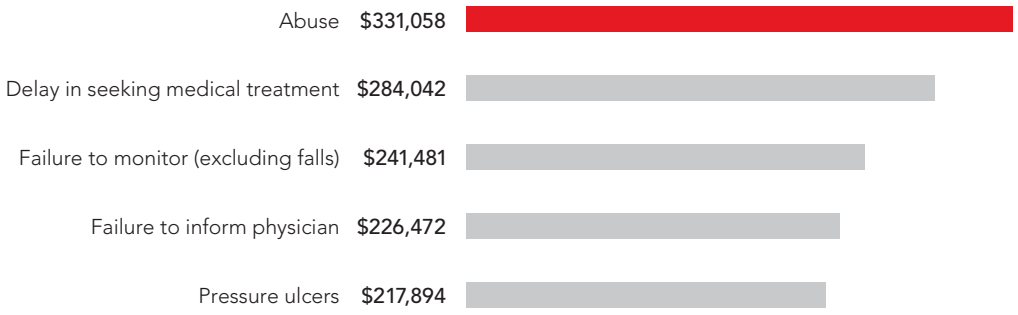


56 Highest Frequency of Short-term-stay Closed Claims by Allegation*

Resident fall	47.1%
Improper care (excluding falls)	15.9%
Pressure ulcers	15.3%
Delay in seeking medical treatment	6.1%
Failure to monitor (excluding falls)	5.4%

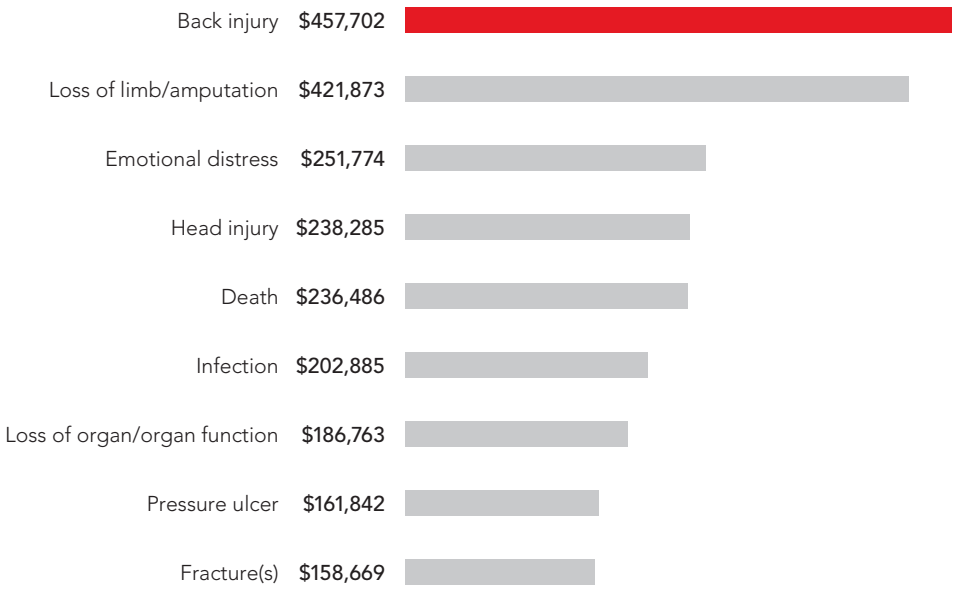
Percentage of 391 closed claims
* Only allegations comprising 5 percent or more of the 391 closed claims are included.

57 Highest Average Total Paid for Short-term-stay Closed Claims by Allegation



58 Highest Average Total Paid for Short-term-stay Closed Claims by Injuries*

* The most frequent short-term-stay injuries are death, fractures and pressure ulcers.



Analysis of Closed Claims with a Minimum Indemnity Payment of $1 Million

Thirteen claims in the dataset resolved with an indemnity payment of $1 million or more, as described in Chart #59, below. Some of the allegations in the chart are more specific than in Chart #7, Frequency of Closed Claims by Allegation.

Analysis of these claims reveals the following:

- Eleven of the 13 closed claims (84.6 percent) involve for-profit insureds.
- Eight of these claims (61.5 percent) involved skilled nursing level of care, while the remaining five (38.5 percent) involved assisted living.
- Four of the 13 closed claims (30.8 percent), involve allegations of improper care.
- Nine of the 13 closed claims (69.2 percent) involve the death of the resident.
- Claims with the highest paid indemnity often involve failure to comply with facility policies and procedures, missing or altered documentation, and/or suspected staff improprieties.

59 Summary of Closed Claims with $1 Million Paid Indemnity

Summary	Allegation	Injury	Bed-type
1. Diuretics were prescribed for a short-term rehabilitation resident who subsequently fell and experienced increased confusion. No changes were implemented in the care plan. He fell again while attempting to get out of bed as a result of staff failing to respond to his needs for toileting in a timely manner. The second fall resulted in a subdural hematoma requiring surgical intervention and rendering the resident totally disabled.	Resident falls – failure to monitor	Head injury	SN/for-profit
2. A resident eloped from an assisted living secured dementia unit through a malfunctioning door and subsequently drowned in a retention pond on the premises. Key factors complicating the defense were failure of the facility to install perimeter fencing despite a previous resident drowning incident; failure to repair a malfunctioning lock; failure to prevent the elopement; and delays in notifying the administrator, family and police.	Elopement	Death	AL/for-profit
3. A resident with a psychiatric history was admitted to skilled nursing for physical rehabilitation. He was discharged to an unlicensed boarding house (allegedly for financial reasons) and eloped. Medical record documentation indicates the resident did not have the capacity to make his own decisions, yet staff failed to notify the family regarding the discharge. The boarding house administrator testified that the SNF denied readmission for the resident.	Violation of resident rights	Emotional distress	SN/for-profit
4. A home health agency sitter, hired to stay with a resident diagnosed with Alzheimer's disease, abandoned her post on two occasions. During those occasions, the resident was attacked by another resident and sustained multiple rib fractures and a head injury. The resident expired three weeks later. Defense issues included lack of documentation of the incidents, failure to notify the family and damaging text messages on staff personal phones.	Failure to monitor	Death	AL/for-profit
5. A resident fell during a transfer while assisted by one staff member from the bed to a chair. The resident expired 17 days later due to an intracranial hemorrhage. The primary allegation was failure to follow the care plan, which required two-person transfers. The physician's failure to address an elevated INR and delay in seeking a hospital evaluation contributed to the legal defense challenges in this case.	Resident falls – improper care	Death	SN/for-profit

Summary	Allegation	Injury	Bed-type
6. A resident allegedly experienced three instances of abuse and negligence. The first incident involved a CNA who bullied and "wrestled" with the resident to remove her call pendant. The CNA was terminated. The second occurrence involved use of a wheelchair without footrests, resulting in a femur fracture. Delay in treatment led to an above-the-knee amputation. In the third incident, the resident sustained rib fractures during a transfer and expired several days later.	Improper care (excluding falls)	Death	AL/not-for-profit
7. A resident sustained five unwitnessed falls within a six-week period. The last fall resulted in a hip fracture requiring surgical fixation, which was subsequently complicated by infection, pressure ulcers and hip dislocations. Further complicating the case was the failure of staff to follow the physician's order to replace the resident's walker with a wheelchair after the fourth fall.	Fall – improper care	Fracture(s)	SN/for-profit
8. A resident's checkbook was stolen by an employed CNA. The CNA was to be suspended when he presented for his next shift. Another staff member alerted the suspect, who then returned to the facility and murdered the resident. Criminal background checks had been performed, but they failed to discover previous arrests in another state of the involved employee. The primary allegations were related to inadequate security and failure to deactivate the employee's security badge.	Unsafe environment of care	Death	AL/for-profit
9. Overall care of the resident was alleged to be substandard. Issues included delay in treatment of a fracture; failure to notify physician and family of change in condition; and failure to diagnose and treat urinary sepsis, which led to the resident's death. Inadequate nursing documentation further complicated the claim.	Improper care (excluding falls)	Death	SN/not-for-profit
10. A morbidly obese resident was admitted with community-acquired pressure ulcers which subsequently became infected, leading to sepsis and death. Allegations included failure to complete and document a wound assessment upon admission and failure to inform the physician of abnormal test results which in turn caused a delay in transferring the resident to the hospital. Missing resident records pertaining to wound care contributed to the defense challenges in this case.	Failure to inform MD of change in condition	Death	SN/for-profit
11. A resident eloped from a memory care unit and fell in the parking lot. He sustained a head injury, resulting in his death. The staff failed to follow the policy requiring visual checks every two hours and assumed that the resident was in the bathroom when he was not seen in bed. Subsequent analysis determined that the door alarm system failed to activate and was defective at the time of the incident.	Elopement	Death	AL/for-profit
12. Failure to treat constipation and malnutrition resulted in a bowel impaction which was left untreated for several days. Due to his cardiac history and other comorbidities, the resident expired. Defense challenges included not only issues with care provided, but also alteration and forgery of the resident medical record.	Improper care (excluding falls)	Death	SN/for-profit
13. Inadequate care of venous stasis wounds led to gangrene, ultimately requiring below-the-knee amputation. Further complicating the case was the presence of maggots in a wound. Allegations also included inadequate staffing levels and altered documentation.	Improper care (excluding falls)	Amputation	SN/for-profit

APPENDIX B: SELF-ASSESSMENT FOR AGING SERVICES COMMUNITIES

This checklist is designed to help aging services organizations identify and address risk exposures by evaluating and enhancing current policies and procedures.

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Culture of Safety			
Ensure that senior leaders consistently demonstrate their dedication to high-quality care and resident safety, as well as staff satisfaction and retention.			
Maintain a blame-free environment, analyzing problems in an objective, systematic manner.			
Invite front-line staff to quality meetings in order to discuss specific situations and brainstorm about opportunities to improve care.			
Establish performance goals for staff and motivate employees to provide high-quality care.			
Instruct certified nursing assistants (CNAs) to engage in ongoing communication with nurses and practitioners regarding changes in residents' condition.			
Maintain adequate staffing levels that reflect changing resident acuity in order to provide individualized, resident-centered care.			
Foster realistic expectations about pressure ulcers and falls among residents and families upon admission, using written forms and educational tools, as necessary.			
Involve leadership in planning safety programs aimed at enhancing skin integrity and reducing falls.			
Train staff to view each resident as an individual capable of contributing to the community.			
Develop fun, interesting and innovative programs that offer cognitive and psychosocial stimulation for residents.			
Encourage cognitively impaired residents to participate in purposeful activities that relate to career, social and educational interests.			
Implement an intergenerational activity program that includes residents and family members.			
Consider permitting pet visits and implementing a pet therapy program. (Pets should have approval from a veterinarian regarding their health and temperament.)			
Create an organizational culture in which the target is to reach and maintain zero facility-acquired pressure ulcers, and inculcate this idea during orientation and on an ongoing basis thereafter.			
Have experienced CNAs serve as role models for newly hired staff, disseminating organizational expectations, methods and values.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Culture of Safety (continued)			
Focus on nursing fundamentals, such as consistently turning residents, providing adequate nutrition and hydration, and managing incontinence issues.			
Consistently assign CNAs to the same residents so they can swiftly identify clinical changes in condition, including changes in skin integrity.			
Address staff satisfaction through visible encouragement and acts of kindness, such as providing complimentary soft drinks, coffee, snacks and meals throughout the day.			
Encourage ongoing "huddles" throughout the day for all staff, as well as traditional shift change reports, to enhance communication among caregivers about resident concerns and/or changes in condition.			
Include families in activities, encourage shared mealtimes and provide meals for families.			
Resident Falls			
Perform consistent, purposeful rounding to proactively identify resident needs.			
Investigate every fall in a timely, comprehensive manner.			
Collectively analyze each resident's fall risk profile, in order to develop an individualized, integrated care plan.			
Utilize hall monitors to supervise residents during shift changes, mealtimes and other busy periods.			
Minimize use of psychotropic medications and review each prescription for possible alternative interventions.			
Include at least one CNA when performing root cause analyses and developing protocols and resident care plans.			
Monitor effectiveness of fall-reduction interventions and make improvements as indicated.			
Develop a comprehensive medication reconciliation policy that includes medication review upon admission and on an ongoing basis.			
Creatively incorporate weight-bearing exercise and movement into the residents' activities of daily living, such as a "walk and dine" program.			
Utilize concepts from the "Otago" or other evidence-based exercise programs, including integration of strength and balancing exercises into restorative nursing programs.			
Encourage wheelchair-bound residents to exercise and engage in purposeful movement.			
Use personal alarms judiciously, bearing in mind that alarms often frighten and distract residents and may not be effective in fall prevention.			
Encourage clinicians to discuss falls and fall prevention with residents and families, including the potential impact of comorbidities and other risk factors.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Pressure Ulcers			
Employ a holistic process for determining skin risks, including review of data from laboratory testing, nutritional evaluations, medication reconciliation, and functional and cognitive assessments.			
Educate staff about pressure ulcers, including major risk factors and basic preventive measures.			
Assign staff to care for the same residents over time, in order to provide continuity of care and swifter identification of early changes in skin condition.			
Instruct CNAs to immediately report symptoms of a pressure ulcer to their nursing supervisor.			
Utilize pressure-relieving mattresses and high-quality skin care products for all residents at risk for acquiring a pressure ulcer.			
Institute a skin-cleansing program in which residents receive baths and/or showers at least three times per week.			
Offer all residents a comprehensive problem statement, an all-inclusive pressure ulcer risk assessment and care/service plan.			
Establish interpretive guidelines for the Braden scale that consider each category of risk factors when formulating care plans.			
Encourage clinicians to talk to residents about non-healable wounds and unavoidable pressure ulcers, including the impact of comorbidities on probable outcomes.			
Develop ongoing educational programs for staff and clinicians, including advanced training for wound certification and guidance in conveying expectations and prognoses to residents and families.			
Consider purchasing turning and repositioning equipment that both minimizes injuries to staff and helps prevent pressure ulcers among residents.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Readmissions			
Establish a model for "treating in place" or adopt an evidence-based program, such as the Interventions to Reduce Acute Care Transfers (INTERACT) program from the American Medical Directors Association.			
Consider family and resident expectations about "treating in place" and rehospitalizations when creating resident care plans.			
Ensure that higher-acuity residents have prompt access to facility-based practitioners following a change in condition.			
Consider using telemedicine to enhance the organization's treating in place program.			
Track 30-day readmissions and monitor the effectiveness of processes designed to minimize rehospitalizations.			
Evaluate readmission patterns, examining such factors as day of the week, providers making admission decisions and underlying causes for readmissions, such as exacerbation of chronic conditions and infections.			
Employ transition coordinators, institute transfer protocols and utilize standardized medication reconciliation tools to enhance communication among caregivers during resident transitions to or from acute-care facilities.			
Perform diagnostic testing in a timely manner and report results promptly to the ordering physician/practitioner.			
Develop strategies to manage cardiac, pulmonary and other chronic conditions in collaboration with the hospital and the resident's personal physician.			
Train staff to recognize and identify early symptoms of changes in residents' medical condition, and to respond promptly and appropriately.			
Commercial Risks – Flooding			
Implement a written emergency action plan that includes the following measures:			
- Ensure that water control valves are clearly labeled and readily accessible.			
- Train supervisors and managers on all shifts on how to respond to an emergency water leak.			
- List local emergency plumbing service providers with "24/7" response capability.			
Incorporate cold-weather preparation into the preventive maintenance schedule, making sure to inspect exterior walls, window louvers and mechanical spaces before the onset of freezing temperatures.			
Check sprinklers on a quarterly basis.			
Drain low point valves on dry pipe systems before the first freeze.			
Restore insulation after performing any work in an attic space.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Commercial Risks – Auto			
Driver selection:			
Identify who can and does drive for the organization, including all employees and non-employees who operate commercial and passenger vehicles owned or leased by the facility, as well as employees who drive their own vehicle on organizational business.			
Verify that all drivers have a current driver's license, that is valid for the type of vehicle they operate.			
Check all drivers' motor vehicle records prior to their driving for the organization and annually thereafter. When possible, request a five-year motor vehicle record review.			
Create and enforce clear criteria for drivers, specifying the type and number of driving violations that disqualify a prospective driver.			
Distracted driving:			
Issue a written policy on avoiding distractions while driving, such as eating, drinking, use of cell phones and programming navigation systems.			
Limit the use of cell phones when operating any vehicle on organizational business, in compliance with all relevant statutes and regulations. At a minimum, require drivers to be legally parked if they wish to make a non-urgent cell phone call from their vehicle.			
Implement a disciplinary program for violation of cell phone policies and other driving-related rules.			
Commercial Risks – Cyber Liability			
Implement a cyber security awareness educational program, and require that all employees complete the course annually.			
Select reputable, dependable IT systems and vendors, after conducting a thorough needs and vendor assessment process.			
Require full disk encryption, as data breaches involving encrypted data do not typically require notification of affected parties under the vast majority of state laws and regulations.			
Protect against "ransomware," a type of malware that blocks access to computer systems until a sum of money is paid.			
Minimize the risk of accidental disclosure through ongoing training and up-to-date policies governing the management of sensitive information.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Violence Prevention/Response			
Establish policies and procedures for staff to follow in the event of a breach in facility security or the presence of an armed or unarmed intruder or person threatening violence.			
Meet with members of the local police department to discuss options for responding to an intruder, up to and including an "active shooter" scenario.			
Implement a violence-prevention program, which includes, but is not limited to:			
- Establishing a zero-tolerance policy for bullying and other forms of verbal and physical abuse.			
- Training staff on how to respond to an active shooter and other security breaches.			
- Complying with reporting requirements in regard to suspected resident abuse.			
- Implementing protocols for communicating with residents, families, staff members and media immediately following a violent incident.			
- Initiating support programs for staff, residents and families following a violent incident.			
- Prohibiting retaliation against residents, families or employees who report incidents of abuse, neglect or violence.			
- Performing multistate criminal and sexual offender background checks for prospective employees and residents prior to their employment/admission.			
- Training all staff on how to work with persons with dementia and/or behavioral problems, especially in terms of detecting and de-escalating agitated, inappropriate or potentially violent behavior.			
- Ensuring that care plans address appropriate interventions for residents who are at risk of either acting in an abusive manner or evoking abusive responses from other residents or staff.			

Current Status of Risk Control Measures	Acceptable	Needs Attention	Not Applicable
Elopement			
Reevaluate staffing requirements as acuity levels rise and residents require new levels of service.			
Regularly reassess the elopement-prevention program, especially at assisted living facilities.			
Include a wide range of risk factors when assessing current or prospective residents for elopement risk, including cognitive impairment, psychiatric conditions, medications that cause confusion, a history of prior elopement attempts, wandering behaviors and statements about wanting to leave the facility.			
Perform initial elopement risk assessments immediately upon admission, and reassess elopement risk on an ongoing basis.			
Place new residents in rooms away from exits and closer to nursing stations, in order to help staff monitor at-risk residents and reduce elopement attempts.			
Conduct regular elopement drills, and educate all staff about responding to an elopement.			
Class Action Claims in Aging Services Organizations			
Mitigate potential class action claims by maintaining appropriate staffing levels in terms of both resident census and acuity levels.			
Ensure that staffing data are accurately reported to the Centers for Medicare and Medicaid Services, and reconcile reports with internal data.			
Manage resident and family expectations by communicating in a clear, accurate and straightforward manner, both in person and in print.			
Do not use superlatives, make promises regarding outcomes or exaggerate organizational capabilities in marketing brochures or websites. For example, the statement "Our facility provides 24-hour nursing supervision" may be an overstatement if the facility employs only one nurse on-site.			

333 South Wabash, Chicago, IL 60604
1-866-262-0540 www.cna.com