Senior Care

A Coded Case Analysis

JANUARY 2022

MedPro Group

Resident at high risk for skin breakdown was admitted with a detailed care plan providing for pressure ulcer prevention strategies. She developed a sacral ulcer which was not staged by staff for over a month, by which time it had progressed to Stage IV. Wound care charting was substandard, delays in notifying family and physician of her deteriorating condition were frequent, and staff failed to adhere to policies for turning/repositioning.

A woman has a stroke, taking away her ability to walk independently. During her time in a skilled nursing facility, she suffers at least eight falls; she dies following the last fall.

A man with a previous history of elopement is admitted with no risk assessment. Agitated and confused, the resident exits through an unlocked staff break door. The next morning, he is found deceased outside of the facility.

The stories are heartbreaking.

The emotional toll these events have on residents, families and staff is incalculable. And the impact they can have on a facility's reputation can have long-term consequences.

Key Points

Over 1100 senior care cases were referenced for this report…

The Big Picture

Cases arising in skilled nursing facilities account for 71% of case volume, and 69% of total dollars paid*.

- On average, skilled nursing cases are slightly less expensive to defend than assisted living cases, although assisted living cases close more often with indemnity paid.
- Although overall case volume is low, the highest percentage of cases closing with indemnity paid is found among the independent living cases.

Resident safety allegations, including failures to mitigate the risk of falls, incidents occurring during transport, and assaults, are the most common allegations.

As expected, nursing staff account for the largest proportion of responsible services in both skilled and assisted facility settings. In independent settings, non-clinical staff were most commonly identified as responsible.

More than half of all resident injuries in skilled and assisted facility settings were classified as high severity, up to and including death.

Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the resident's outcome, and/or to the initiation of the case, are markedly similar across all settings.

- Real risk mitigation opportunities exist, and encompass all aspects of resident care; these include inadequate assessments and identification of residents needing a higher level of care, improperly managed care plans, failures to ensure general safety on facility grounds and during transport, failures to follow policies/procedures, and suboptimal communication amongst staff and between staff/residents/families.

MedPro Group senior care cases opened between 2016-2020. Because all claims/suits related to an individual resident event are rolled into one case for coding purposes, and because the overall focus of the report is not to provide actuarial insights but rather to enhance clinical risk management efforts, specific case volumes for every aspect of this report are not included.*Total paid = expense + any indemnity dollars paid; financial valuation as of 6/30/2021

General Data Analysis

Looking Into the Data

While this section details stories and data by facility type and explores the clinical severity of outcomes, residents and their caregivers know that no injury is minor in the individual's experience. Even though well-meaning staff act on behalf of facility residents, mistakes do occur that lead to emotional and physical injury.

We trust you'll read our data and associated case stories with an eye toward how these events might have been prevented: for the benefit of the resident, their family as well as the staff member.

Throughout this report, we'll answer the following questions, supported with data:

- Where (in which facility type) do most of the events occur?
- Which allegation types are most common?
- Who is most likely to be responsible for the resident's injury, and how serious are the injuries?
- How do failed processes of care, known as contributing factors, impact resident outcomes?

Distribution of Case Volume by State

9 states noted account for:

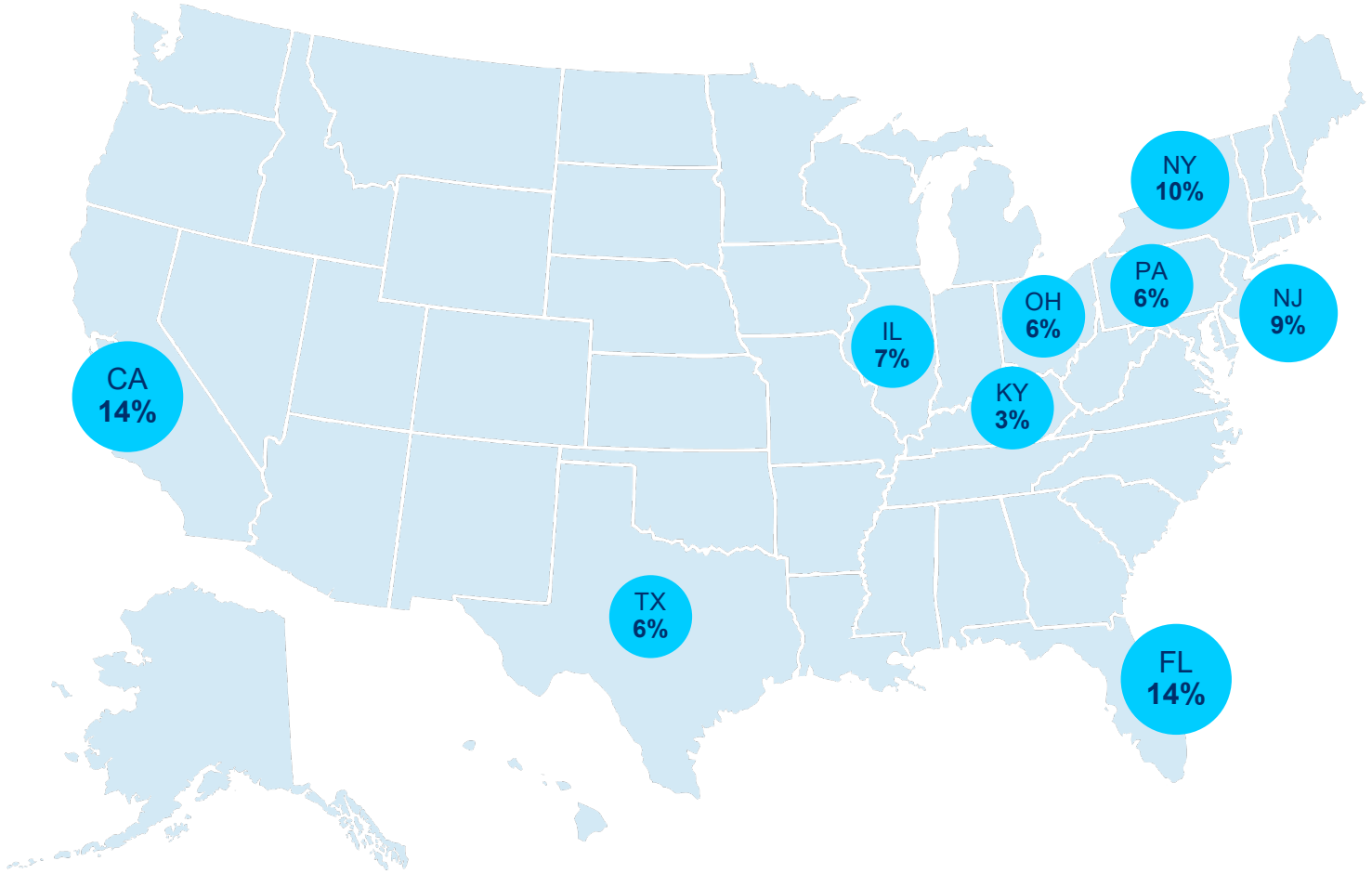
- 74% of all case volume
- 74% of total dollars paid* on closed cases

All other states account for </= 2% of case volume each.

Average total dollars paid per closed case across all states & facility types = $165,000

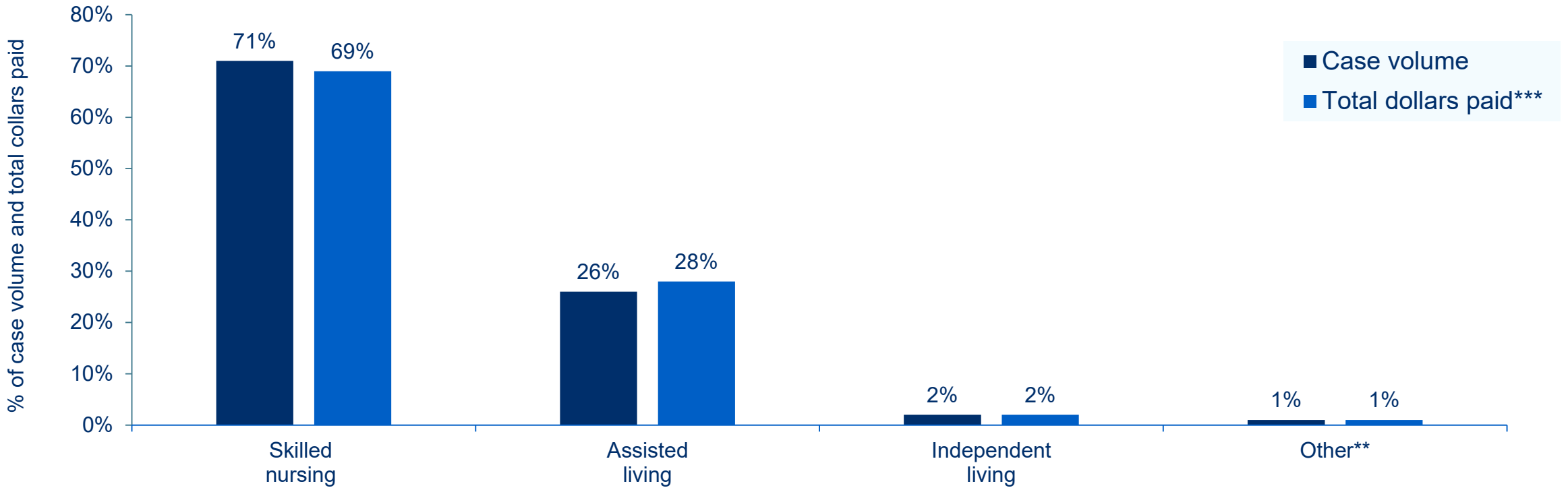
Average total dollars paid per closed case for each of the 9 states noted:

CA	$286,000	NY	$121,000
FL	$137,000	OH	$110,000
IL	$190,000	PA	$116,000
KY	$209,000	TX	$111,000
NJ	$104,000		



MedPro Group senior care cases opened between 2016-2020. *Total paid = expense + any indemnity dollars paid; financial valuation as of 6/30/2021

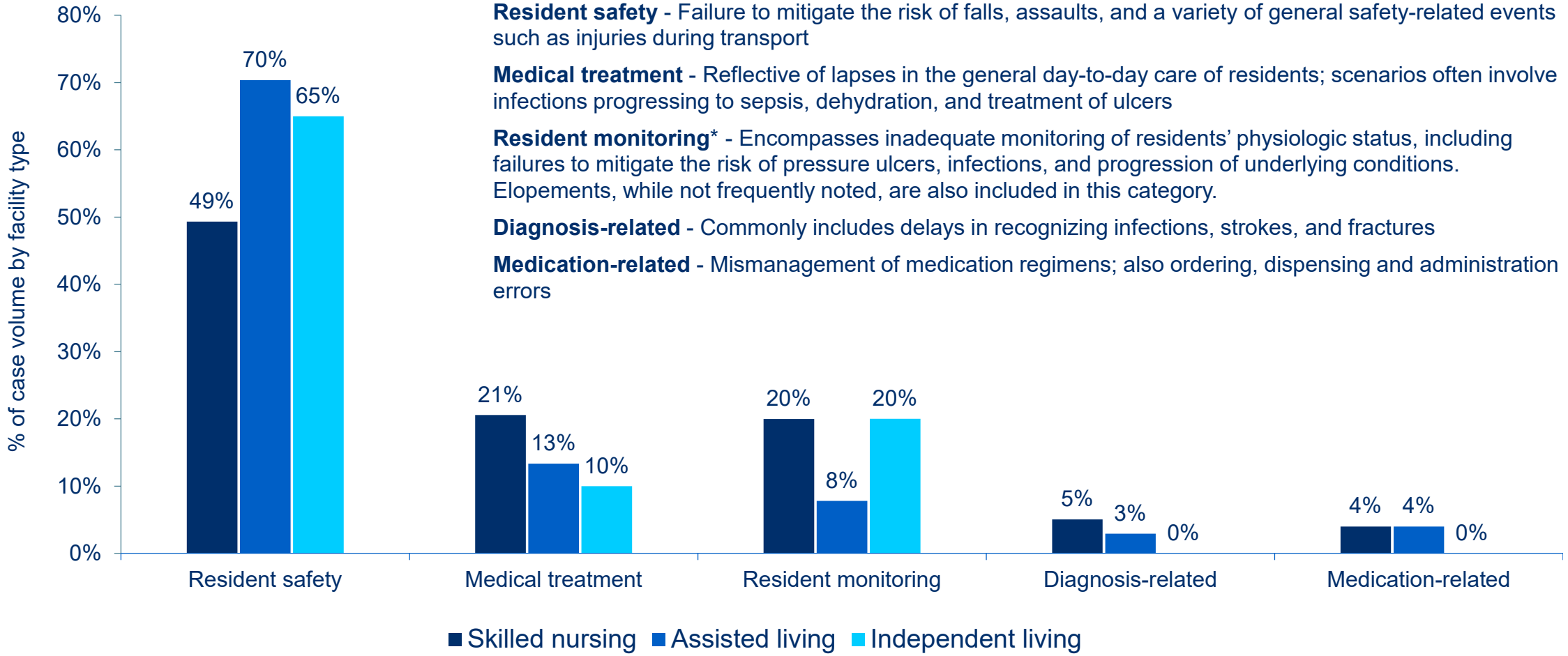
Distribution of Case Volume* & Financial Severity by Facility Type



Average total dollars paid per case by facility type			
$160,000	$177,000	$166,000	$91,000

MedPro Group senior care cases opened between 2016-2020; *Case distribution by facility type does not necessarily reflect the distribution of MedPro Group insured facility types;
**Other = mix of home health, group home, behavioral health, geri-psych; ***Total paid = expense + any indemnity dollars paid; financial valuation as of 6/30/2021

Most Common Primary Allegation Categories by Facility Type



Allegations characterize the essence of the case.

Resident safety - Failure to mitigate the risk of falls, assaults, and a variety of general safety-related events such as injuries during transport

Medical treatment - Reflective of lapses in the general day-to-day care of residents; scenarios often involve infections progressing to sepsis, dehydration, and treatment of ulcers

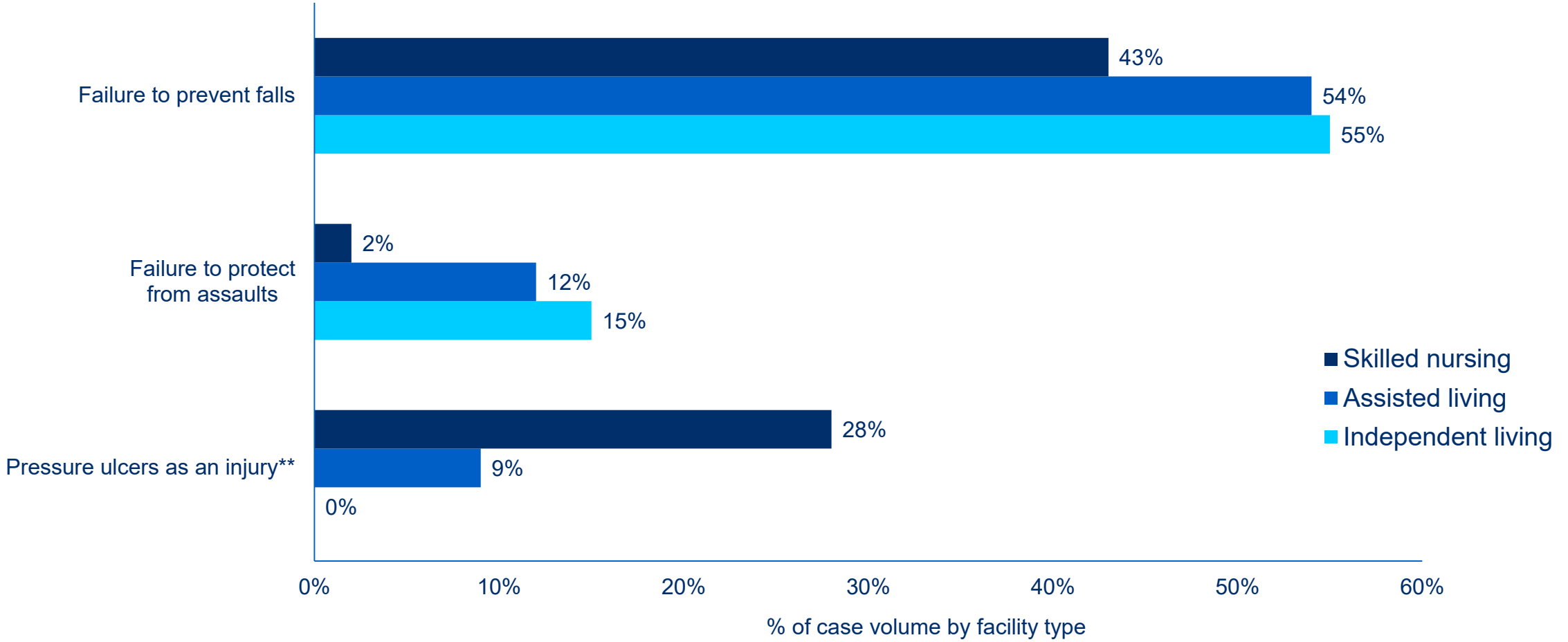
Resident monitoring* - Encompasses inadequate monitoring of residents' physiologic status, including failures to mitigate the risk of pressure ulcers, infections, and progression of underlying conditions. Elopements, while not frequently noted, are also included in this category.

Diagnosis-related - Commonly includes delays in recognizing infections, strokes, and fractures

Medication-related - Mismanagement of medication regimens; also ordering, dispensing and administration errors

MedPro Group senior care cases opened between 2016-2020; *Resident monitoring cases on average are 48% more expensive to defend and resolve than the average of all other cases. The very few independent living cases attributed to this category reflect inadequate monitoring of residents with known medical issues (includes the issue of whether emergency pendants/call lights in resident apartments are functioning/monitored).

Focus: Common Resident Safety Allegation Details* by Facility Type



MedPro Group senior care cases opened between 2016-2020; *Reflective of combined primary & contributory case allegations. There is always one primary allegation, but cases can reflect more than one contributory allegation. Combining the two provides greater insight into the true volume of cases per allegation. **Pressure ulcer-involved cases are captured with an injury code, not as an allegation; they are noted primarily in allegations of inadequate monitoring & improper management of medical treatment.

Common Allegation Details* by Facility Type: Financial Severity

Average total dollars paid*** per allegation by facility type

	Skilled	Assisted	Independent
Failure to prevent falls	$100,000	$102,600	$134,000
Failure to protect from assaults	$44,400	$150,600	$329,300
Pressure ulcers** as an injury	$133,100	$99,000	N/A
Elopements	$185,000	$213,900	N/A

While infrequent, elopements are noted in 6% of assisted living cases, and in just 1% of skilled cases. These cases are financially severe and can result in critical resident injuries or death.

MedPro Group senior care cases opened between 2016-2020; *Reflective of combined primary & contributory case allegations. There is always one primary allegation, but cases can reflect more than one contributory allegation. Combining the two provides greater insight into the true volume of cases per allegation. **Pressure ulcer-involved cases are captured with an injury code, not as an allegation; they are noted primarily in allegations of inadequate monitoring & improper management of medical treatment. ***Total paid = expense + any indemnity dollars paid; financial valuation as of 6/30/2021

Locations and Responsible Services

Where

do most of the events occur?

By far the most common location is in a **resident's room or apartment**.

Who

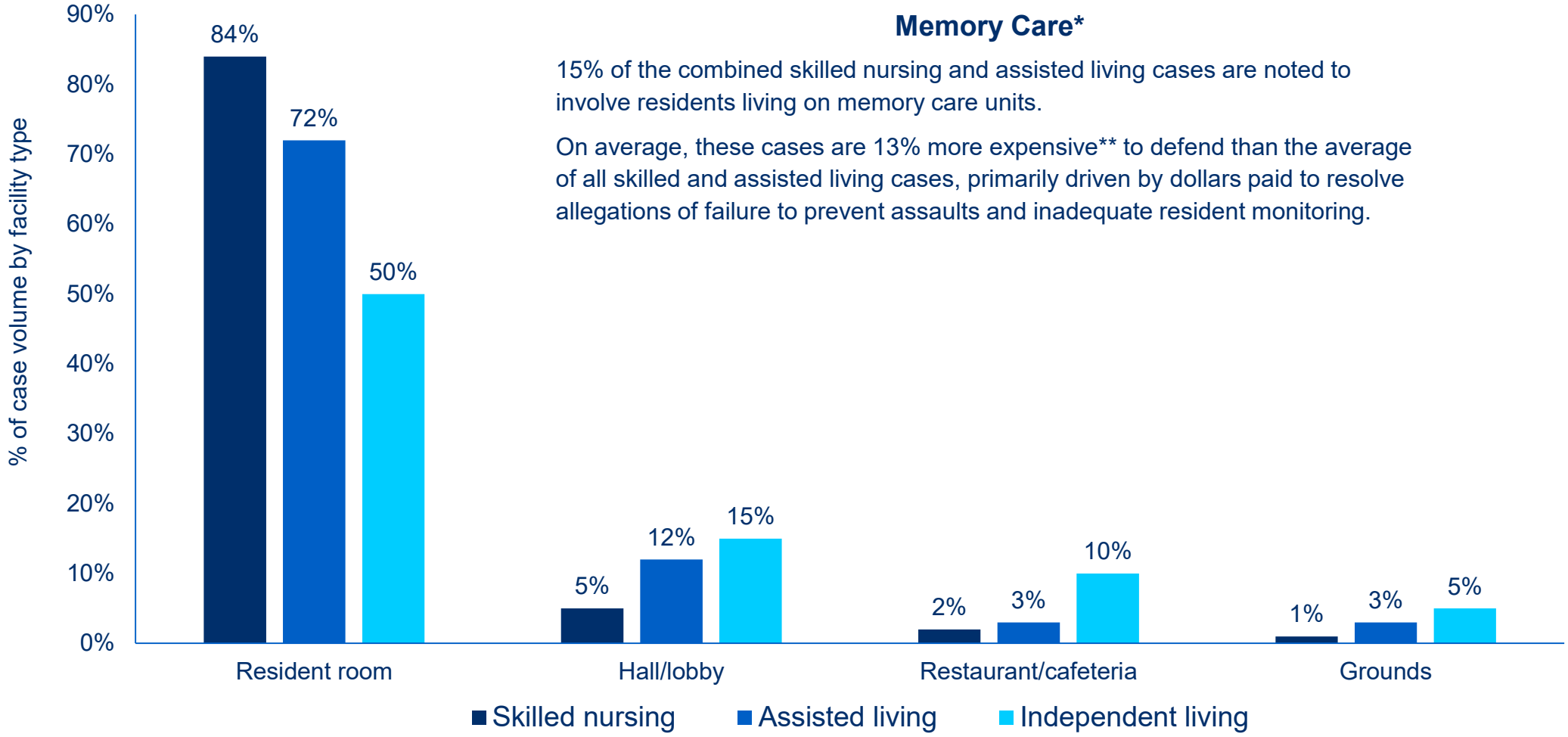
is most likely to be involved in an event?

Nursing staff
in skilled and assisted living facilities

Non-clinical staff
in independent residential settings

MedPro Group senior care cases opened between 2016-2020

Most Common Location of Events by Facility Type



Memory Care*

15% of the combined skilled nursing and assisted living cases are noted to involve residents living on memory care units.

On average, these cases are 13% more expensive** to defend than the average of all skilled and assisted living cases, primarily driven by dollars paid to resolve allegations of failure to prevent assaults and inadequate resident monitoring.

MedPro Group senior care cases opened between 2016 & 2020; *Memory care units are documented in the case coding only if verified in the associated case file documentation. Within the coding taxonomy, memory care is not a specific location, but rather a unit of the facility; **Total paid = expense + any indemnity dollars paid; financial valuation as of 6/30/2021

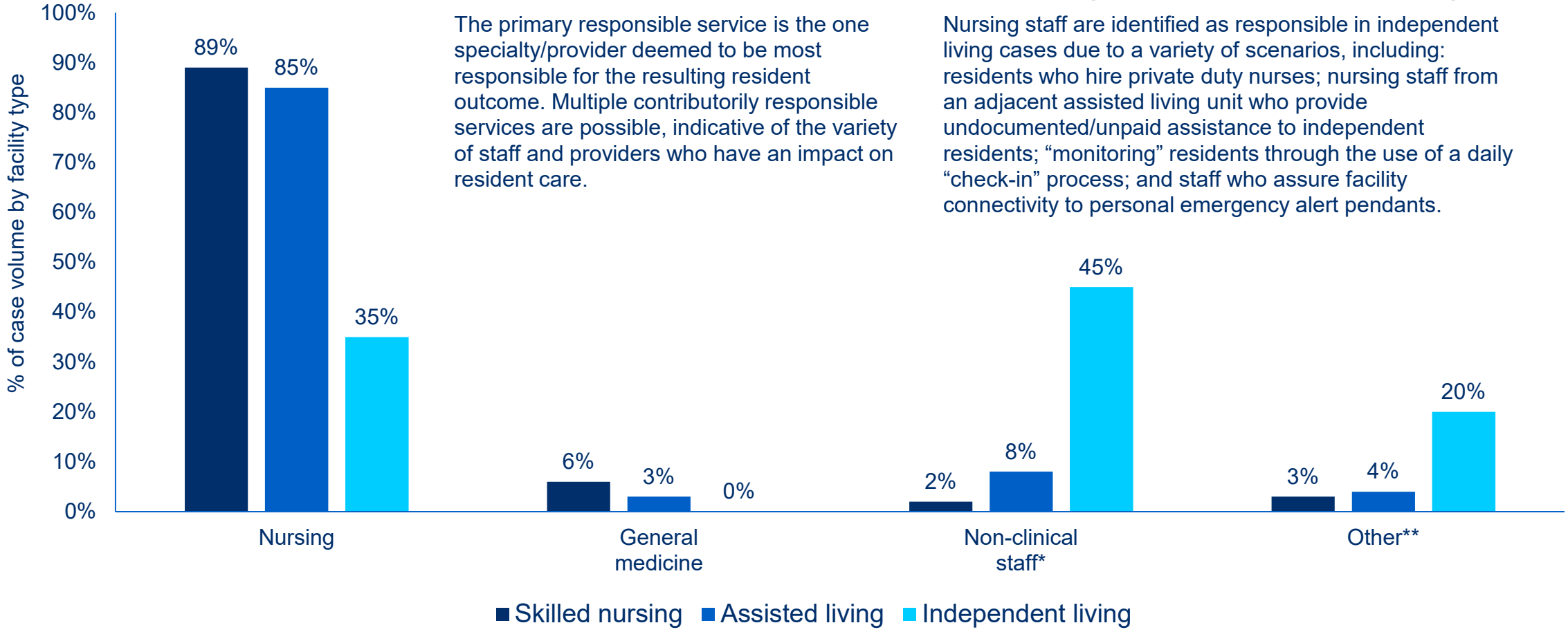
Responsible Services by Facility Type

Responsible Services

The primary responsible service is the one specialty/provider deemed to be most responsible for the resulting resident outcome. Multiple contributorily responsible services are possible, indicative of the variety of staff and providers who have an impact on resident care.

Nursing Staff and Independent Living

Nursing staff are identified as responsible in independent living cases due to a variety of scenarios, including: residents who hire private duty nurses; nursing staff from an adjacent assisted living unit who provide undocumented/unpaid assistance to independent residents; “monitoring” residents through the use of a daily “check-in” process; and staff who assure facility connectivity to personal emergency alert pendants.



MedPro Group senior care cases opened between 2016 & 2020; Of note, general medicine providers are noted as contributorily responsible in another 13% of skilled nursing facility cases, and in 9% of assisted living cases, as would be expected in their role as medical directors of facilities.*Non-clinical staff = aides, transport staff, sitters, office staff, etc.; **Other = facility medical directors, physicians, pharmacists

Clinical Severity

% of case volume by facility type

Clinical Severity Categories	Sub-categories	Skilled	Assisted	Independent	Definitions
LOW	Emotional Injury Only	5%	9%	30%	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury				Lacerations, contusions, minor scars or rash, where no delay in recovery occurs
MEDIUM	Temporary Minor	37%	36%	25%	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major				Burns, drug side effect; recovery delayed
	Permanent Minor				Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	58%	55%	45%	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury				Paraplegia, blindness, loss of two limbs or brain damage
	Grave				Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death				Death
		41%	39%	20%	% of each facility type's case volume resulting in resident death

MedPro Group senior care cases opened between 2016-2020; *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Case Examples by Clinical Severity

The following stories are categorized by clinical severity (high, medium, low) and facility type.

- **Skilled Nursing**
- **Assisted Living**
- **Independent Living**

CLINICAL SEVERITY
LOW

CLINICAL SEVERITY
MEDIUM

CLINICAL SEVERITY
HIGH

We're relaying these true stories as lessons to build understanding of the challenges that both senior care providers and residents face. Learning from these events, we trust that you will take the necessary steps to implement best practices in your facility, as outlined in the section focused on risk mitigation strategies.

Skilled Nursing

CLINICAL SEVERITY

LOW

SETTLED

$10,000

STORYLINE

A short-term rehab resident was found sitting on the floor with no complaint of injury. The resident's wife alleged that staff failed to notify the facility's physician of episodes of pulse oximetry decreases, implying that these resulted in the non-witnessed fall.

SETTLED

$35,000

STORYLINE

Although initially there were no findings to substantiate the resident's complaints of inappropriate conduct by a facility nurse, six months later the same nurse was accused of assaulting a resident at a different facility. This led to criminal charges, one of which involved the first resident. The first facility's process for background checks of staff, vendors and volunteers was insufficient.

MedPro Group senior care cases opened between 2016-2020

Skilled Nursing

CLINICAL SEVERITY

MEDIUM

SETTLED

$45,000

STORYLINE

A woman was found on the floor having slipped out of her wheelchair. While initially there was no evidence of injury, she began to complain to her family of leg/hip pain. No complaints were documented in her chart, nor were concerns elevated to a physician. Two weeks later, she was later found to have broken her femur, and required surgery.

SETTLED

$215,000

STORYLINE

An insulin-dependent diabetic man was diagnosed with diabetic ketoacidosis. He did recover, but investigation revealed late and/or missing medication administration entries in the chart, failures to document blood sugar levels, and repeated failures to notify the physician when the levels fell out of range.

MedPro Group senior care cases opened between 2016-2020

Skilled Nursing

CLINICAL SEVERITY
HIGH

SETTLED
$300,000

STORYLINE

A woman at high risk for skin breakdown was admitted with a detailed care plan providing for pressure ulcer prevention strategies. This plan was not followed. She developed a sacral ulcer which was not staged by staff for over a month, by which time it had progressed to Stage IV. Wound care charting was substandard, delays in notifying family and physician of her deteriorating condition were frequent, and staff failed to adhere to policies for turning/repositioning.

SETTLED
$360,000

STORYLINE

A man with a previous history of elopement was admitted, however, no risk assessment for elopement was done, and in fact, the chart was documented as “no risk.” He was noted to be agitated, confused, and continually tried to get out of bed. During the morning check of all residents, he was discovered to be missing, and was subsequently found deceased outside of the facility, having exited overnight through an unlocked staff break door. Failures to monitor residents every two hours as per facility policy were evident.

MedPro Group senior care cases opened between 2016-2020

Assisted Living

CLINICAL SEVERITY

LOW

SETTLED

$25,000

STORYLINE

A man was discovered unattended in a dayroom with the foot of his recliner propped up by a wheelchair (intended by the aide to prevent him from getting up unassisted). Bruising, swelling and lacerations were also noted on his elbow. An investigation revealed a previously undocumented fall. In large part due to these two instances, the resident's wife removed him from the facility.

SETTLED

$60,000

STORYLINE

A female resident fell in her room and injured her leg, while fending off a possible assault by a male resident who was known to wander in and out of other residents' rooms. There was a delay in notifying the family, and a subsequent police investigation.

MedPro Group senior care cases opened between 2016-2020

Assisted Living

CLINICAL SEVERITY

MEDIUM

SETTLED

$100,000

STORYLINE

A woman receiving hospice care had a signed DNR order in effect. When she was found unresponsive in a common area, a med-tech called 911 and began CPR. When informed by an aide about the DNR, the tech continued CPR, stating that “best practice” was to perform CPR until emergency personnel arrived. The resident was revived and sustained rib fractures. The facility was found to have no express policies/training related to CPR, and the med-tech was found to have committed abuse.

SETTLED

$212,000

STORYLINE

A woman fell in her shower and couldn’t reach the emergency call cord. Thirty-six hours later, her neighbor notified staff that she hadn’t seen the resident. The woman was found on the floor suffering from dehydration and speaking incoherently. She was admitted to a skilled nursing unit for acute rehabilitation. She ultimately returned to her apartment, although accelerated cognitive decline was observed. The facility was cited for failing to perform any of the variety of daily checks intended to ensure resident safety.

MedPro Group senior care cases opened between 2016-2020

Assisted Living

CLINICAL SEVERITY

HIGH

SETTLED

$332,500

STORYLINE

A private care aide was the only staff member on duty overnight. A resident eloped; he was found the next morning outside, suffering from hypothermia, and required transfer to a skilled facility to manage a subsequent decline in health. His aide did not perform any visual checks on the night he eloped. Subsequent investigation revealed that other aides were also unaware of the policy for visual bed checks overnight.

SETTLED

$300,000

STORYLINE

A woman was found on the floor during the night and returned to her bed by staff. They did not notify their supervisor, nor did they document the event in her chart. During subsequent days, the resident repeatedly complained of wrist pain, but no treatment other than aspirin was provided by nursing staff. Ultimately, she fell again, suffering significant injuries, and died two weeks later.

MedPro Group senior care cases opened between 2016-2020

Independent Living

CLINICAL SEVERITY

LOW

SETTLED

$5,000

STORYLINE

A man tripped over a rug which had been placed at the entrance to the facility. He fell, suffering a sprained shoulder.

SETTLED

None

STORYLINE

A male resident was exhibiting improper, unwanted "romantic" behavior towards female residents. When confronted by facility staff, he apologized. An attempt to find more affordable housing for him was set in motion, but he became depressed. A crisis center was contacted, and a caseworker consulted with a psychiatrist who ordered an involuntary "observation" hold. The resident then spent 36 hours in a behavioral facility. He later alleged false imprisonment.

MedPro Group senior care cases opened between 2016-2020

Independent Living

CLINICAL SEVERITY

MEDIUM

SETTLED

None

STORYLINE

A resident of a facility which provided rental housing for low-income elderly community members fell, fracturing her wrist. She told building management that she had tripped when turning around too quickly. Her daughter however, alleged that her mother slipped on a wet floor. There was no security footage of the event.

SETTLED

$300,000

STORYLINE

A woman began to require a higher level of care, but cost was a barrier. To help her remain independent, staff provided undocumented care, such as medication and walking assistance. Despite the extra help, she fell several times; the final fall occurred when construction was underway in the dining room of her facility. Signage in the hallway instructed residents to “leave walkers outside dining room.” The resident fell in the hallway outside of the dining room, fracturing her shoulder. Her family alleged that this led to a rapid decline in her health and ultimately to her death.

MedPro Group senior care cases opened between 2016-2020

Independent Living

CLINICAL SEVERITY

HIGH

SETTLED

$55,000

STORYLINE

During an outing sponsored by the facility, a man became tired and sat on the seat of his rolling walker. The bus driver attempted to push the resident back to the bus, but the walker hit an obstacle on the sidewalk, causing the resident to fall backwards, hitting his head. He was treated for scalp lacerations, and four days later experienced a seizure (unknown if related).

SETTLED

$600,000

STORYLINE

A resident was murdered by another resident's private duty caregiver. Investigation revealed that families of residents living in the facility routinely provided building keys to third party caregivers, exterior access doors were routinely left unlocked, the front entrance was unstaffed, parking lot gates were left open overnight, and there were no security cameras.

MedPro Group senior care cases opened between 2016-2020

Contributing Factors

"Contributing factors reflect both provider and [resident] issues. They denote breakdowns in…clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation."

CRICO Strategies. (2020). The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss. Retrieved from https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict.

Multiple Residents with Varying Needs

In caring for individuals, staff are managing multiple residents with varying needs. Despite best intentions, processes designed for safe resident outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the [resident]'s outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

Across All Facility Types

At a high level, the identified contributing factors are strikingly similar across all facility types.

Clinical Judgment

Inadequate resident assessments

Administrative

Failure to follow policies/protocols

Communication

Suboptimal communication among staff and between staff, the residents, and their families

Behavior-related

Resident behaviors contributing to events

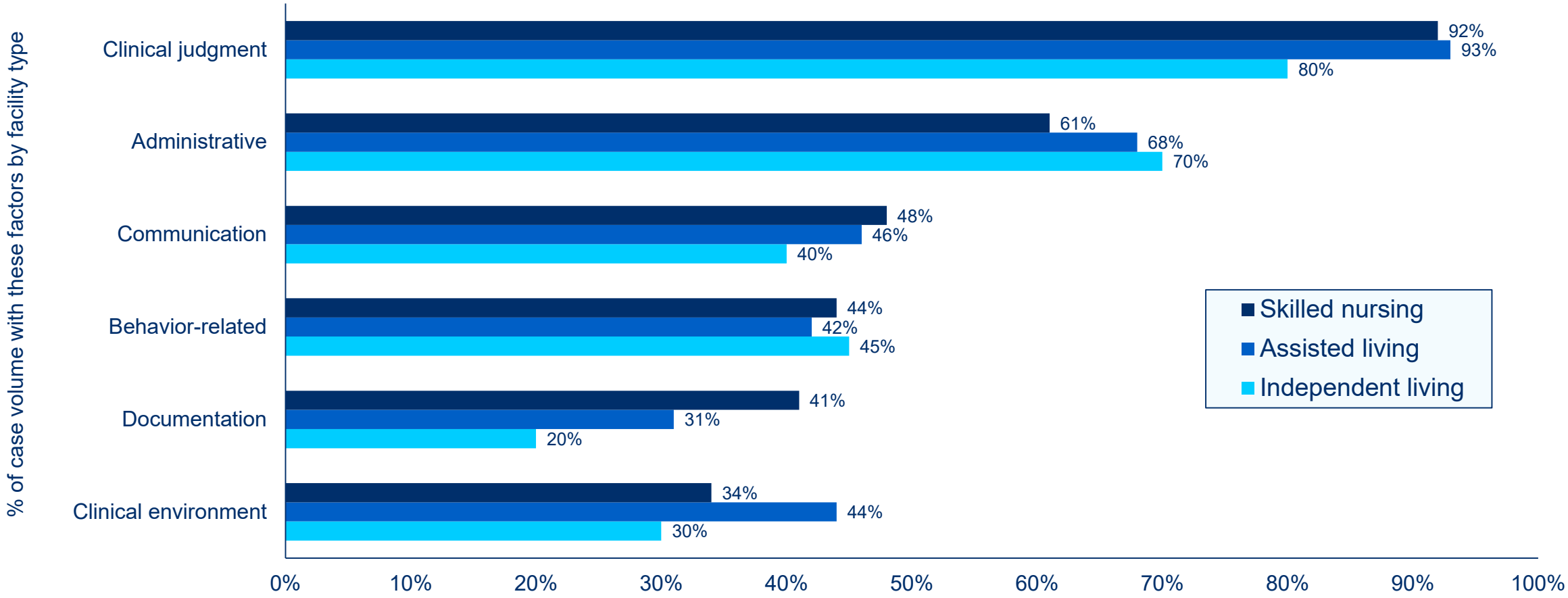
Documentation

Insufficient/lack of documentation reflective of care/services provided

Clinical Environment

Events occurring during weekend, night, and/or holiday shifts

Most Common Failed Processes of Care



MedPro Group senior care cases opened between 2016-2020; *The number of independent living cases is low, therefore rendering any percentage-based statement about “common failed processes of care” less than optimal.

Most Common Contributing Factor Details

Factors	Common specific issues	% of cases with these specific issues			Descriptions
		Skilled nursing	Assisted living	Independent living	
Clinical judgment	Inadequate resident assessments	43%	33%	10%	Inadequate resident assessments create missed opportunities for care, allowing conditions to worsen and/or physiological changes to go unnoticed.
Administrative	Failure to follow policies/protocols	45%	44%	45%	Non-adherence to policies is common in fall and pressure-ulcer related cases. These cases often involve inadequate assessments and failure to follow existing care plans. Insufficient staff training is associated with failure to follow policies.
Communication	Suboptimal communication between providers/staff related to changes in resident conditions	30%	28%	25%	As with inadequate assessments, breakdowns in communication create missed opportunities for care. Suboptimal communication with residents/families is noted at almost the same percentage of case volume.
Behavior-related	Resident behaviors contributing to events	42%	36%	40%	Behavior-related events are most often associated with falls, and include resident non-compliance with fall precautions.
Documentation	Insufficient/lack of documentation reflective of care/services provided	34%	21%	15%	Insufficient documentation of care plans, provision of daily services, and resident assessments can make subsequent malpractice cases more difficult to defend, and can also lead to breakdowns in the chain of communication among the resident's care team.
Clinical environment	Events occurring during weekend, night, and/or holiday shifts	32%	43%	30%	During these times, staffing levels might be reduced. Commonly associated with this factor are issues with inadequate assessments/monitoring, failures to follow policies, and suboptimal communication among providers.

MedPro Group senior care cases opened between 2016-2020; *The number of independent living cases is low, therefore rendering any percentage-based statement about "common failed processes of care" less than optimal.

Factors Predictive of Cases Closing with Indemnity Paid*

CRICO Strategies analyzed 37,000 cases to determine which breakdowns in health care processes indicate the highest odds of a case closing with an indemnity payment.**

Administrative

Failure to have or follow a policy or protocol

2.45

ODDS RATIO

Clinical Judgment

Patient assessment failures

1.85

ODDS RATIO

Documentation

Absent or insufficient documentation

1.76

ODDS RATIO

*Not limited to senior care cases; **Closed between 2014-2018; CRICO Strategies. (2020). The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss. Retrieved from https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict; MedPro Group is a member of CRICO Strategies' Community Benchmarking System (now known as Candello Compare) which represents more than 30% of all US MPL cases.

Skilled Nursing

SETTLED

$425,000

CONTRIBUTING FACTORS

Administrative
Failure to follow policy to verbally report incident and to downgrade diet.

Communication
Failure to inform supervisor of changes in resident condition.
Failure to read medical record.

STORYLINE

Due to escalating behavioral issues, the resident was admitted to a behavioral health hospital on a temporary basis. While there, he aspirated on medications, causing aspiration pneumonia.

Upon return to the skilled nursing facility, he was placed on a pureed diet. His speech therapist gradually increased his diet to include solid food. Subsequently, the resident experienced a ‘choking incident’ which was observed and handled by a staff nurse. Although the nurse later completed an incident report (which was overlooked during a staff meeting two days later), she did not verbally notify the director of nursing as required because she (the nurse) “was busy with other residents.”

Facility policy allowed any staff member to downgrade a resident’s diet following such an incident, but the nurse failed to do so. Three days later, the resident was found in the cafeteria choking on a large amount of food. Despite rescue attempts, he became unresponsive and died two days later. The facility was cited and fined for severe violations of care as a result of this incident.

Skilled Nursing

SETTLED

$495,000

CONTRIBUTING FACTORS

Administrative
Failure to follow policy regarding response times to resident requests for assistance. Insufficient staffing levels.

Clinical Judgment
Inadequate resident assessments/monitoring.

Communication
Suboptimal communication among all members of resident's care team.

STORYLINE

A stroke had rendered the resident non-ambulatory. During the time she resided at the facility, she suffered at least eight falls. She died following injuries sustained in the final fall.

During the following state agency investigation, numerous egregious issues were discovered, including:

- **Surveillance video showing staff** allowing her to sit for lengthy periods of time on multiple occasions
- **Repeated lengthy response times** to her requests for assistance (and delay in replacing her missing medical alert pendant)
- **Failure to re-assess her** after each fall and to generate a fall awareness/care plan
- **Failure to get her out of bed** and to provide alternative feeding measures when she refused meals
- **Video evidence of one staff transfers** when policy mandated two-person assists

MedPro Group senior care cases opened between 2016-2020

Assisted Living

SETTLED

$600,000

CONTRIBUTING FACTORS

Clinical Judgment

Failure of staff to follow an order (immediate transfer of resident to ER).

Failure of staff to appreciate significance of changes in resident's condition.

Communication

Failure of staff to escalate concerns/ suboptimal communication of details of resident's condition.

STORYLINE

The resident required assistance with bathing, dressing, grooming, medications and toileting. He ambulated slowly and required assistance in transferring to and from bed. He was assessed as a high fall risk and a care plan was put in place.

The facility recommended that the family arrange for 1:1 care, however, the family declined. The resident was found on the floor of his room two days in a row, sustaining skin abrasions each time. Staff noticed that he appeared to be more confused and recommended that his wife send him to the ER for evaluation; she declined to do so.

The resident's condition deteriorated following the falls, with evidence of increased confusion, weakness and slurred speech. Staff notified the facility's physician assistant who ordered the resident to be sent to the ER. However, the physician assistant did not fax the order to the facility until the next day. The staff then arranged for non-urgent ambulance transport instead of calling 911/EMS. The transport did not arrive until early evening of the day after the fall.

While the resident was in the ER, the emergency medicine physician attempted to call the facility for more information, but calls went unanswered. An MRI showed evidence of several strokes. The resident was placed on hospice care and died a few days later. Subsequent investigation by the Department of Social Services determined that staff failed to seek medical attention in a timely fashion (staff were not required to have a physician order prior to seeking medical attention).

MedPro Group senior care cases opened between 2016-2020

Assisted Living

SETTLED

$950,000

CONTRIBUTING FACTORS

Administrative
Failure of staff to follow multiple policies/procedures.
Inadequate staff training/education

Clinical environment
Night shifts

Clinical judgment
Choice of care setting
Inadequate assessments/monitoring

Communication
Failure to notify physician and caregiver of elopement attempt

Documentation
Insufficient documentation of adverse events

STORYLINE

The resident was admitted to the facility after a psychiatric hospitalization for paranoid delusions, visual hallucinations, and alcohol abuse. He had exhibited violent behavior with hospital staff, and was diagnosed with psychosis/associated dementia. While hospitalized, the plan had been to find placement in a secured facility.

Despite this plan, his caregiver opted to release resident to the assisted living facility (not a secured/locked-down facility). Records show that the facility was informed of the resident's history and his propensity for wandering and agreed to accept him. Orders were in place for him to receive psychotropic medications which were never obtained nor administered.

The first night, he attempted to climb out of his window. Nursing staff did not notify the caregiver, but told the aide to "keep an eye on him." The next night, he was found wandering the facility, was redirected back to his room, but subsequently discovered to be missing again. He was found outside the facility on the ground. Surveillance video showed him pushing out a window screen and falling to the concrete. He underwent surgery to repair multiple fractures, but never returned to baseline. He was subsequently admitted to a skilled facility.

An investigation revealed that staff had failed to assess resident for wandering propensities, and did not prepare/initiate an appropriate care plan. Documentation reflected that a 1:1 aide would be provided by the facility, but that did not occur.

Independent Living

SETTLED

$27,500

CONTRIBUTING FACTORS

Administrative
Failure of staff to follow multiple policies/procedures
Inadequate staff training/education

Clinical judgment
Failure to ensure resident's safety during transport

STORYLINE

The independent living resident was wheelchair-bound and dependent upon a round-the-clock personal aide. While a facility staff member was transporting the resident to an appointment in a facility-owned van, the resident's wheelchair tipped over while the driver was negotiating a turn. The driver believed he had properly secured the chair, but had done so improperly. He was not familiar with the particular secure locking options for that chair.

The resident sustained a head injury, a neck fracture, and abrasions. He was treated at a hospital and discharged back to the facility two days later. It was discovered that facility had other options for safe resident transport which were not used, resulting in a violation of policy/procedure. The resident died less than two months after this incident.

Independent Living

SETTLED

$765,000

CONTRIBUTING FACTORS

Administrative
Failure of staff to follow multiple policies/procedures
Inadequate staff training/education

Clinical judgment
Choice of care setting
Inadequate assessments/monitoring

Documentation
Insufficient documentation of adverse events

STORYLINE

The independent living resident was known to have bilateral leg weakness, resulting in several falls, subsequent to which he was often found on the floor, unable to call for assistance. Not every incident was documented. The facility did provide him with a fall alert necklace. Staff eventually contacted the resident's daughter and informed her that they would be placing him on two-hour courtesy checks; however, this protocol was never implemented.

The resident fell again in his apartment, and became wedged between the toilet and the vanity. Because of this event, he had never appeared as expected to pick up the dinner he had ordered. No one from the facility attempted to contact him or his family. On the third day, his daughter visited and found him where he had fallen, and unable to move. He was admitted to the hospital with multiple pressure ulcers which progressed quickly to Stage III & IV. He had also suffered multiple rib fractures. He spent more than 40 hours wedged in the bathroom with no food, water or assistance and was no longer able to live independently. (It was not clear whether he was wearing the fall alert necklace.)

The 'community' protocol in place at this facility required a resident check if the resident had not appeared or 'checked in' for three days. This protocol was not followed.

Focused Analysis & Risk Mitigation Strategies

The following section details the contributing factors associated with — and how best to mitigate the risk of — resident falls, pressure ulcers, elopements and assaults.

The risk strategies are designed to improve the lives of your residents, increase safety for your staff, and reduce the risk of injury.

Resident Falls: Commonly Noted Contributing Factors

Factors	Most common factor details	% of cases with these specific issues		
		Skilled nursing	Assisted living	Independent living**
Clinical judgment	Inadequate assessments/monitoring (specifically related to resident's behavior status)	61%	62%	Some cases involved inadequately trained staff (related to transport assistance, and/or failure to ensure that the environment was free from fall hazards). Inadequate assessment of the appropriateness of independent living environments for some residents was also noted.
Administrative	Failure to follow policies/protocols	53%	39%	
Clinical environment	Events occurring during weekend, night and/or holiday shifts	49%	46%	
Communication	Suboptimal communication among members of resident care teams	21%	22%	

Dementia is commonly noted as a co-morbidity (in 80% of assisted living, and in 55% of skilled nursing cases).

Fractures are the most common injury* in both settings (in 73% of skilled, and in 68% of assisted facility cases). Death after a fall is noted in 33% of skilled, and in 45% of assisted living cases.

MedPro Group senior care cases opened between 2016-2020; *More than one injury possible per case; **The number of fall-related independent living cases is very low, therefore rendering any percentage-based statement about "commonly noted factors" less than optimal.

Risk Mitigation Strategies: Resident Falls

Although not all falls can be prevented, it is critical to have a systematic process of assessment, intervention and monitoring that results in minimizing fall risk. We recommend a multifaceted approach to fall prevention that considers the unique needs and circumstances of each individual.

- Conduct daily assessments of residents, and ensure all staff, licensed and unlicensed, are fully trained in how to conduct assessments.
- Develop/revise resident care plans based on daily assessments, and then implement the measures identified in the care plans.
- Ensure ongoing verbal and written communication with the team regarding the resident's current fall risk status and preventative interventions needed.
- Maintain active clinical management oversight to ensure staff compliance with fall prevention measures.
- Investigate all fall events thoroughly. Include a review of any recent changes in resident behavior, medications, illness, and possible environmental fall hazards (e.g. throw rugs, broken or missing handrails) for insights into possible reason(s) for the fall.

Key Points

Focus on resident care/assessments, an organizational culture of safety, environmental safety, training/education of staff, incident response processes and robust documentation of falls, investigations, care plan updates and implementation of revised care plans.

For more information, reference our checklist covering fall prevention in senior care.

Pressure Ulcers

Factors	Most common factor details	Skilled nursing (% of cases with these specific issues)*
Clinical judgment	Inadequate assessments/monitoring of skin integrity	**77%**
Documentation	Insufficient documentation of skin assessments, care provided, and actions taken to reduce risk for pressure ulcer development/worsening	**41%**
Administrative	Failure to follow policies/protocols related to skin assessments and management of pressure ulcers; often noted in conjunction with insufficient documentation of assessments and failure to escalate observations of worsening skin conditions (communication-related)	**38%**
Communication	Suboptimal communication between providers/staff related to changes in resident skin condition	**29%**

As would be expected, pressure ulcer-related cases are **more common in skilled nursing** facilities (28% of case volume) as opposed to in assisted living facilities (just 9%).

Almost three-fourths of all such cases involve a clinically severe resident injury.

MedPro Group senior care cases opened between 2016-2020; *Due to the limited volume of assisted living cases involving pressure ulcers, the focus here is on skilled nursing cases.

Risk Mitigation Strategies: Pressure Ulcers

Preventing pressure injuries requires an interdisciplinary approach to care and coordination among many individuals, including the multiple disciplines and teams involved in developing and implementing residents' care plans. Additionally, an organizational culture and operational practices that promote teamwork and communication will facilitate an increased focus on pressure injury prevention and optimize residents' care and safety.

- Conduct daily skin care assessments of residents, and ensure all staff, licensed and unlicensed, are fully trained in how to conduct assessments.
- Develop/revise resident care plans based on daily assessments, and then implement the measures identified in the care plans (should include requirements for recurring turning/repositioning and use of cushioning devices as needed).
- Ensure ongoing verbal and written communication with the team regarding the resident's current skin status and preventative interventions needed.
- Maintain active clinical management oversight to ensure staff compliance with pressure injury prevention measures.
- Investigate all occurrences thoroughly. Include a review of any recent changes in behavior, diet, new or increased incontinence, medications that might result in sedentary behavior, illness and physical injuries for insights into possible reason(s) for the change in skin condition.

Key Points

Focus on skin assessments/care, training/education of staff related to pressure injury stages, resident positioning and mobilization, the impact medical devices can have on skin integrity, robust documentation of skin assessments/interventions taken.

For more information, reference our checklist covering pressure injury prevention in senior care.

Resident Elopement

Elopement-related cases are infrequent, but are significantly expensive* to resolve. On average, they are almost twice as expensive to resolve as the average of all cases. Two-thirds of them result in serious injuries or death. In every case, inadequate monitoring by staff was identified as a critical issue, as were staff failures to follow policies related to safety/security and monitoring. Nighttime elopements are most common.

Storyline

Despite a prior history of elopements at another facility, no elopement assessment was conducted upon arriving at a new facility, and in fact, the resident's chart was marked as "no risk." He was noted to be agitated and confused. Two weeks after admission, the resident left the building through a non-alarmed open staff break room door overnight, and was found outside the next morning, having succumbed to hypothermia (temperatures were in the 30's). Despite a facility policy for every two hour resident checks, the nurse's aide admitted that she "looked in the doorway, saw a lump in the bed and assumed the resident was in bed."

MedPro Group senior care cases opened between 2016-2020; *in terms of total dollars paid

Assault

While cases involving assaults were not frequently noted, instances of facility staff failing to take preventative measures to mitigate the known risk of resident upon resident assault were noted.

Storyline

A female resident on a memory care unit was punched in the face and knocked to the ground, sustaining a hip fracture. The resident who attacked her was at the facility as part of a mental health evaluation, and had previously tried to strangle another resident. At that time, the staff had "re-educated" the resident that his behavior was unacceptable.

MedPro Group senior care cases opened between 2016-2020

Risk Mitigation Strategies: Resident Elopements & Assaults

Mitigating resident elopements and assaults begins with conducting a thorough pre-admission investigation of all potential residents. In addition, constant vigilance of each resident's behaviors, such as wandering and aggression, must be performed to ensure a safe environment for everyone.

- Review the prospective resident's history for wandering events, along with anxiety disorders and preoccupation with past events and relocation.
- Examine the facility's physical environment to determine whether adequate safety and security measures are in place to prevent residents from exiting the unit and building.
- Provide staff training and conduct periodic elopement drills on all shifts.
- Review current and past behavioral diagnoses, particularly those that involve aggressive, sexual or violent encounters.
- Perform state and FBI background checks on residents for criminal acts, and a search on the National Sex Offender Registry for reported sexual offenses.
- For current residents with escalating behaviors, facilitate transfer to a higher level of care.

Key Points

A review of the prospective resident's history prior to admission is crucial. In addition, understanding the limitations in the facility's scope of services is critical to determine the proper placement and retention of each resident.

For more information, reference this resource: Preventing elopement (strategies for assessing for at-risk behaviors and response plans/protocols)

Environmental Safety

Issue	Examples*
Infection Prevention/Control	Exterior doors with openings between/under doors large enough for small rodents to enter; open items in freezer not dated; no covers on soiled linen containers; dead insects in dining room light fixtures; personal staff items stored in medication room.
General Safety/Security	No AED anywhere in building; exterior doors not identified for fire/police operations; visitors are not identified upon entering the facility; not all lift equipment has weight limit signage; food refrigerator/freezer temperatures not checked daily.
Physical Environment	Napkins placed under dining room table legs to level the tables; broken window screens; no covered holder for ice scoop in ice chest; damaged walls; storm drain blocked in outdoor courtyard resulting in accumulating water.
Trip & Fall Hazards	Uneven landscaping stones in residents' outdoor walkway; carpeting repaired with staples and tape; differences in sidewalk heights; edges of non-slip strips in physical therapy room rolled up in places; power strips hanging by cords under tables.
Fire-Related	Lack of fire extinguisher symbols (staff cannot easily identify location of nearest extinguisher); hair dryer cords repaired with adhesive tape; fire department not participating in annual drill at facility; bird nest atop sprinkler head in porch area.

*MedPro Group aggregated examples from onsite senior care client assessments, 2016-2020

Risk Mitigation Strategies: Environmental Safety

Assessing the safety of living environments is as critically important to the well-being of residents as is mitigating the risk for falls and pressure ulcers. Environmental safety is complex, covering many facets related to the physical structure of facilities, fire prevention, security measures, and all equipment and living spaces.

- **Conduct routine assessments** for missing/broken handrails, and for floors which are wet or uneven, and/or contain throw rugs, clutter or electrical cords.
- **Ensure sufficient number of working surveillance cameras,** both inside (in hallways, nurse stations, dining and activity rooms) and outside (all entrances/exits, parking lots, courtyards).
- **Focus on staff training** related to the facility's fire plan, evacuation processes, location of emergency exits and fire extinguishers, and ensure that fire drills are performed and documented at least monthly.

Key Points

Focus on trip and fall hazards, fire safety, security plans and implementation, maintenance of transfer and transport equipment, violence prevention, and emergency preparedness.

For more information, reference these resources: Emergency preparedness (strategies for staff training and emergency exercises, evacuation and shelter-in-place plans, fire safety, and more); Developing a violence prevention program (strategies to protect both residents and staff)

Additional & Emerging Issues in Senior Care

Additional and Emerging Issues in Senior Care*

The impact of COVID-19

- **As of the date of this report,** the number of COVID-related claims and suits remains small, although the volume of reported "incidents" (non-claim/suit) is high.
- **Common "incident" themes** include residents contracting COVID while in senior care facilities, and failures to diagnose and treat those with COVID in a timely manner.
- **Any vaccine mandates** specific to the healthcare industry have the potential to increase existing staff shortages.

Infection control in general

- **Failure to isolate symptomatic from non-symptomatic residents**
- **Failure to notify family of resident condition in a timely manner**
- **Failure to provide personal protective equipment to staff and residents**
- **Failure to maintain social distancing between residents**

*MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2020

Additional and Emerging Issues in Senior Care*

Assisted Living Facilities

- Misleading marketing advertisements which over-promise and under-deliver, including staff to resident ratios
- Staff with inadequate qualifications/training
- Services provided outside scope of licensure
- Residents with dementia located in the open units of the facilities
- Admission of dangerous residents due to failure to conduct state and federal criminal background checks, sexual assault checks, and checks for prior aggressive and/or violent behavioral health diagnoses
- Failure to follow established policies and procedures designed for safe care of residents
- Inadequate resident assessments, care plans, and management oversight
- Inadequate security
- Lack of appropriate corporate owner investment in and commitment to the management of facilities and staff recruitment/retention
- Staffing shortages
- Failure to transfer resident to a higher level of care when appropriate
- Repairing rather than replacing a broken medical alert pendant
- Failure of timely and appropriate care for unresponsive residents (unknown DNR status)

Memory care units

- **Lack of qualified and trained staff**
- **Lack of monitoring residents with aggressive behaviors**
- **Failure to maintain resident safety (elopement)**
- **Failure to move resident to higher level of care (due to physical decline or behavioral escalation)**
- **Failure to protect resident from abuse (physical, mental, and sexual)**
- **Failure of timely and appropriate care for unresponsive residents (unknown DNR status)**

*MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2020

Additional and Emerging Issues in Senior Care*

Independent Living

- **Lack of a written agreement** to check on residents might not negate the responsibility of staff to escalate concerns about resident well-being if a courtesy check reveals changes (such as decreased resident alertness)
- **Relying on private duty staff** to provide care (potential unreliability)
- Lack of communication and coordination between the facility and a nursing agency contracted to provide resident care in the facility
- **Failure to provide written agreement services** such as daily safety checks, monitoring of departures from and returns to the facility, and notifying family and/or provider regarding changes in resident conditions
- **Failure to respond to emergency alarms** (such as resident injury or non-responsiveness) placed in resident apartments
- **Failure to educate residents about safety precautions**, including the need to keep external doors locked, to verify the identity of visitors before unlocking external doors, the location of pull boxes for fire alarms, and the existence/location of emergency numbers
- **Failure of timely and appropriate care** for unresponsive residents (unknown DNR status)

*MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2020

Additional and Emerging Issues in Senior Care*

Other Issues Across All Facility Types

- Hiring of staff (employees and agency) with criminal backgrounds and/or sex offense history
- Critical to preventing assaults by non-residents is the vetting of all staff, vendors, contractors, volunteers and surveyors.
- Unsecured resident access to non-resident care areas, such as a walk-in freezer or boiler room, outside, etc.
- Failure to conduct hourly courtyard checks
- Unsupervised smoking areas
- Unassisted/unsupervised visits to the beauty salon or other establishments outside of the senior care facility
- Disaster plans: developing, implementing and adhering to disaster plans designed to ensure resident and staff safety during severe weather events is of critical importance. These events include hurricanes, tornados, winter storms, and wildfires, including subsequent long-term power outages.

*MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2020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MedPro Group Data

- **MedPro is partnered with Candello,** a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.
- **Derived from the essence of the word candela**, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.
- **Using Candello's sophisticated coding taxonomy to code claims data**, MedPro is better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.
- **Leveraging our extensive claims data**, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.

Disclaimer

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