Senior Care

A Clinically Coded Case Analysis

2024

MedPro Group

Report Scope

This report details stories and data arising out of MedPro's senior care cases which closed with indemnity paid. Even though well-meaning staff act on behalf of facility residents, failures in the process of care do occur, and can result in a long-lasting impact on both residents and their caregivers.

We trust you'll read our data and associated case stories with an eye on both clinical risk management and on how these events might have been prevented, for the benefit of residents, their caregivers, and staff members.

Throughout this report, we'll answer the following questions, among others, and support the answers with data:

What do recent actuarial financial severity trends look like?

Which case types are most common?

Who is most likely to be responsible for the resident's injury, and how serious are the injuries?

Where, and in which facility type do most of the events occur?

How do failed processes of care, known as contributing factors, impact resident outcomes?

Key Points

Almost 1500 clinically coded senior care cases closed with indemnity paid were referenced for this report.

While cases from all settings (skilled nursing, assisted living, independent living, and a few home health, group home, behavioral health, and geri-psych) are included, the primary focus throughout is on skilled and assisted living facility case volume.

Cases arising in skilled nursing facilities account for the majority of case volume, although assisted living facility average financial severity is almost 20% higher than skilled nursing case severity.

The percent of cases across the entire senior care book of business closing with indemnity payment has seen a gradual downward trend, while the average indemnity payment has remained fairly stable over the experience period. Across the country, nine states account for 71% of case volume and 68% of total dollars paid.*

Resident falls, inadequate resident monitoring, and management of and/or failure to prevent pressure ulcers are the most commonly identified clinical risk issues. Dementia is the most commonly noted co-morbidity in fall-related cases.

As of the date of this report, the number of COVID-related claims and suits remains relatively small, although the volume of reported “incidents” (non-claim/suit) is high.

The distribution of contributing risk issues impacting resident outcomes is varied, spanning inadequate resident assessments, suboptimal communication, insufficient/lack of documentation reflective of care/services provided, failures to follow existing policies/protocols, resident behaviors, and events arising during overnight/weekend/holiday shifts.

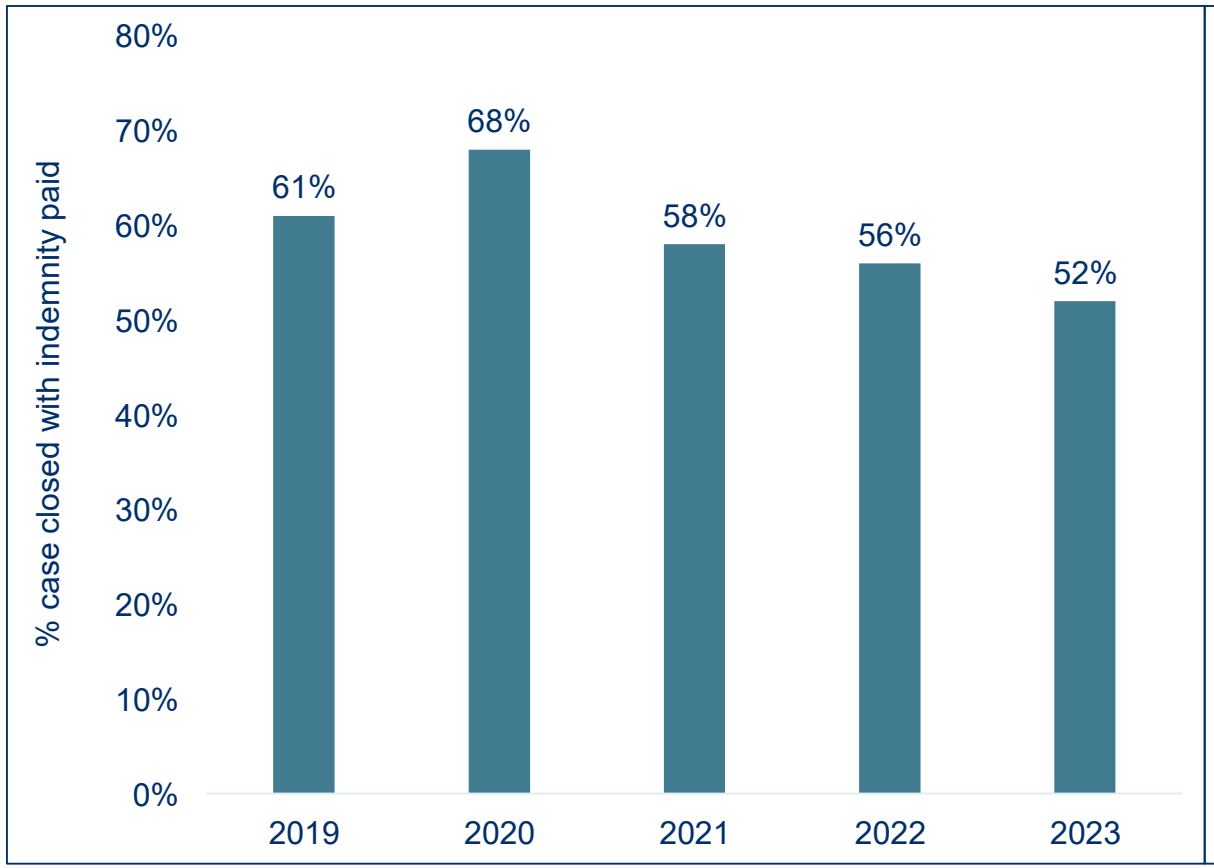
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *total paid = expense + any indemnity paid

Financial Severity Analysis

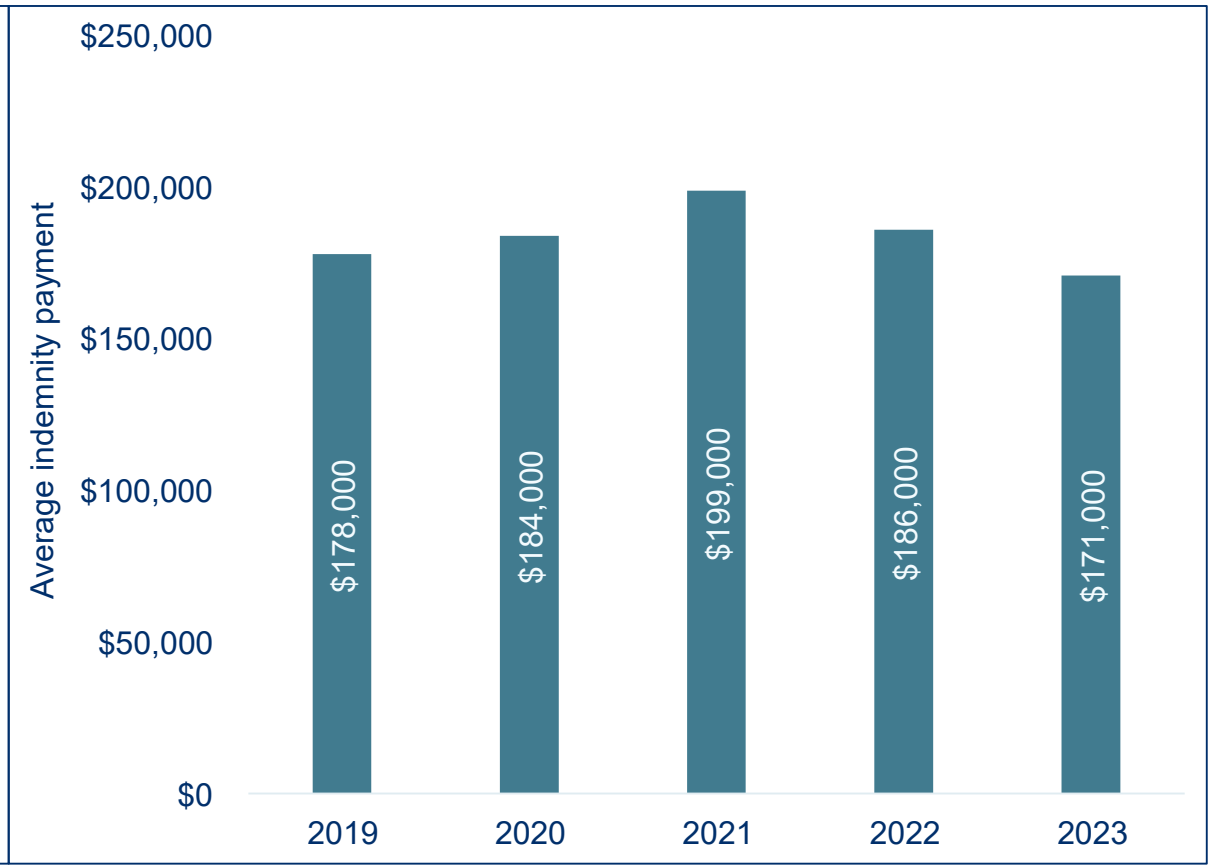
The following section details countrywide financial severity metrics for all clinically coded senior care closed with indemnity paid

Countrywide Indemnity Payment Metrics

The percent of cases that close with indemnity payment has seen a gradual downward trend, falling from 61% to 52% over the experience period.



The average indemnity payment on closed cases has remained fairly stable over the experience period, at an average of $183,000.



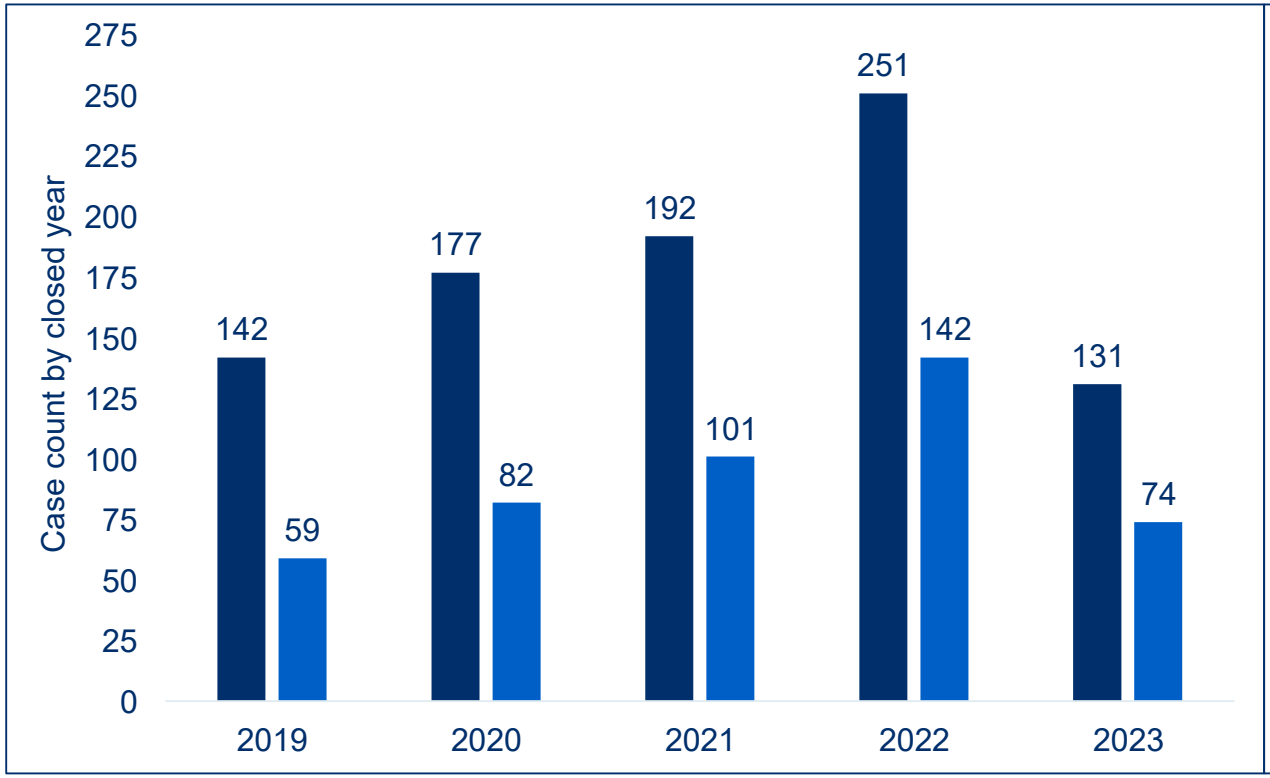
Close year

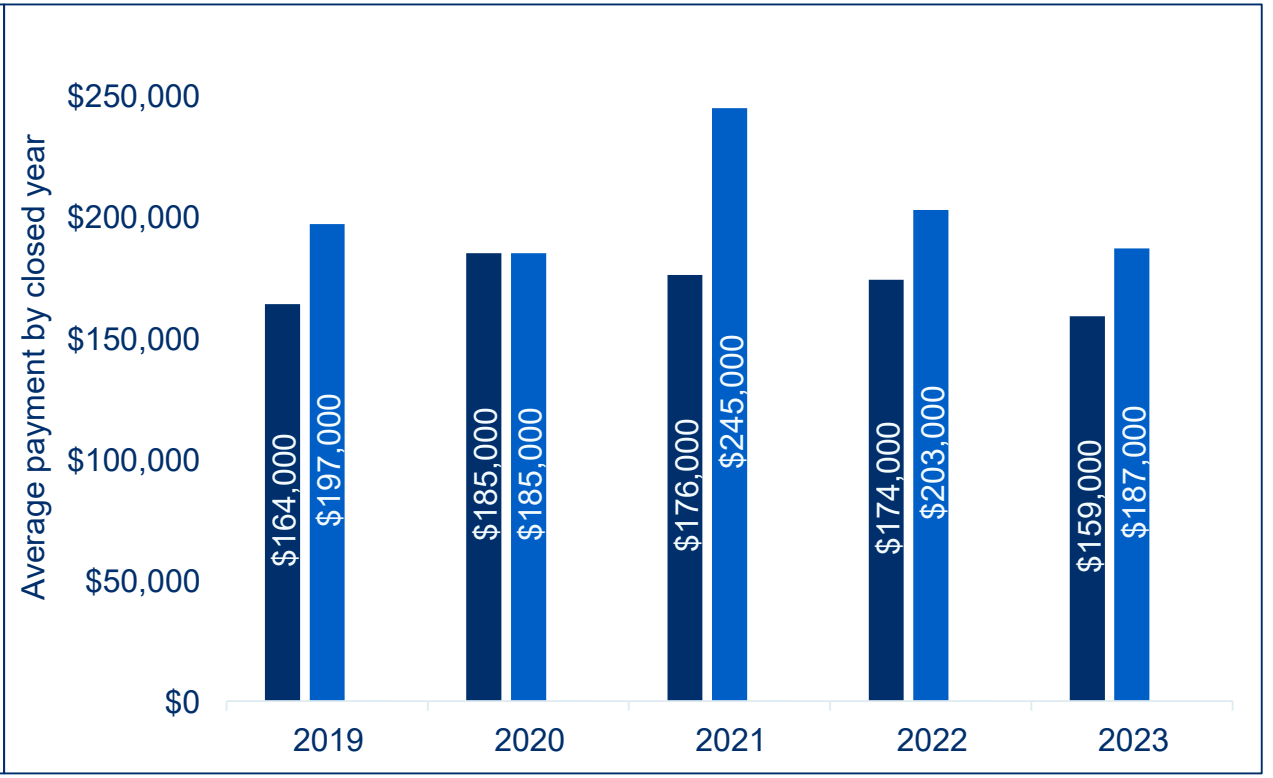
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); financial valuation as of 9/30/2023

Indemnity Payment Metrics by Facility Type

Within this data set, the number of skilled nursing facility cases is nearly double that of assisted living facilities.

The average indemnity payment for assisted living cases is $206,000 - almost 20% higher than the average of $172,000 for skilled nursing cases.



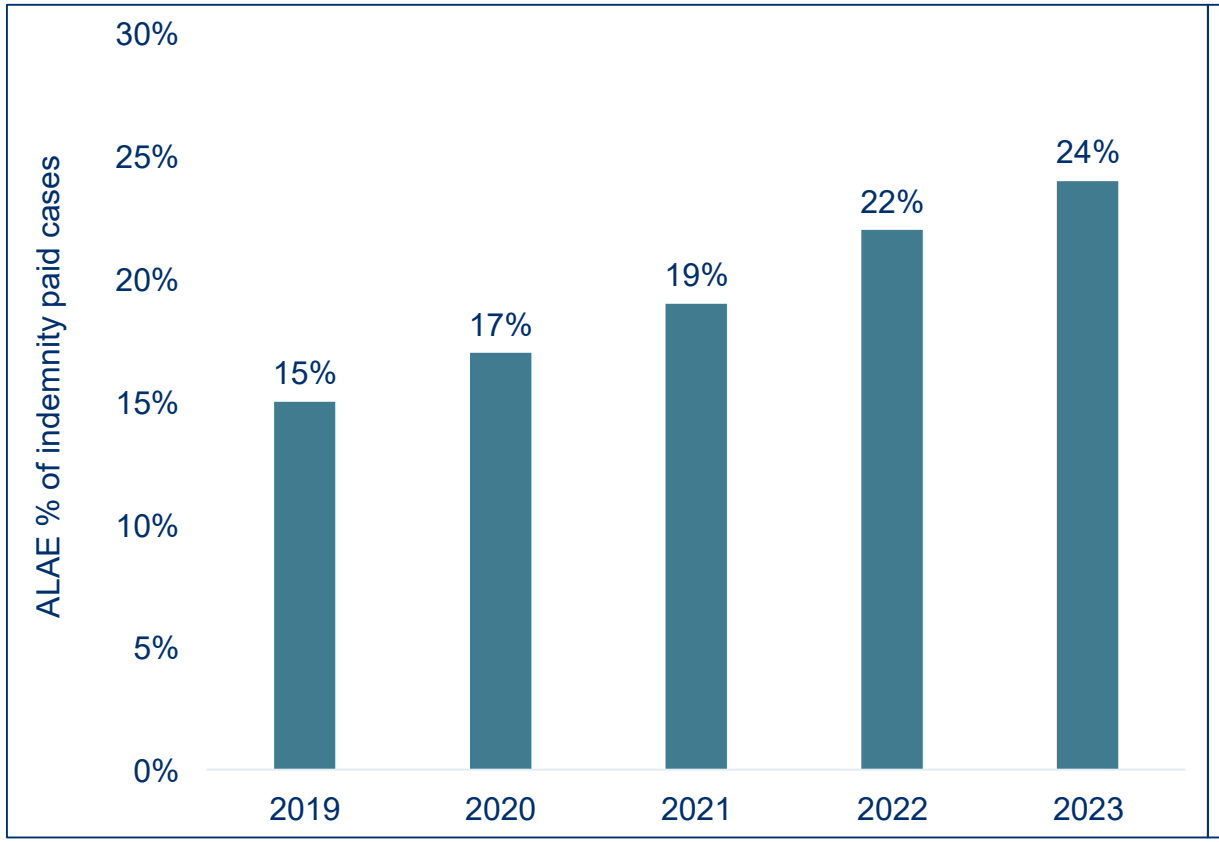


Skilled nursing | Assisted living

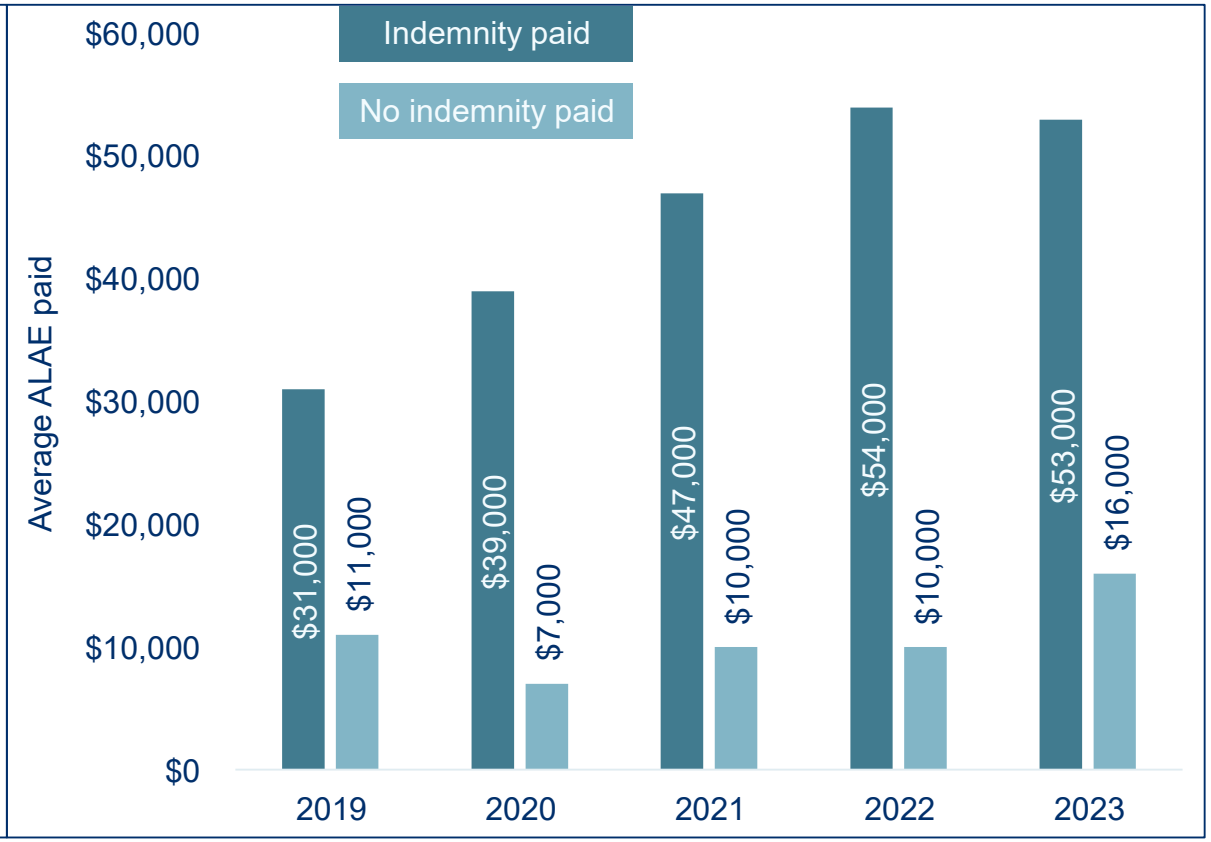
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484; Skilled N=982; Assisted N=476); financial valuation as of 9/30/2023

Countrywide ALAE* Payment Metrics

For cases closed with indemnity payment over the experience period, the percent spent on ALAE has been steadily rising.



The average amount of paid ALAE on cases closed with indemnity payment = $45,000, significantly higher than the $11,000 average ALAE on cases with no indemnity paid.

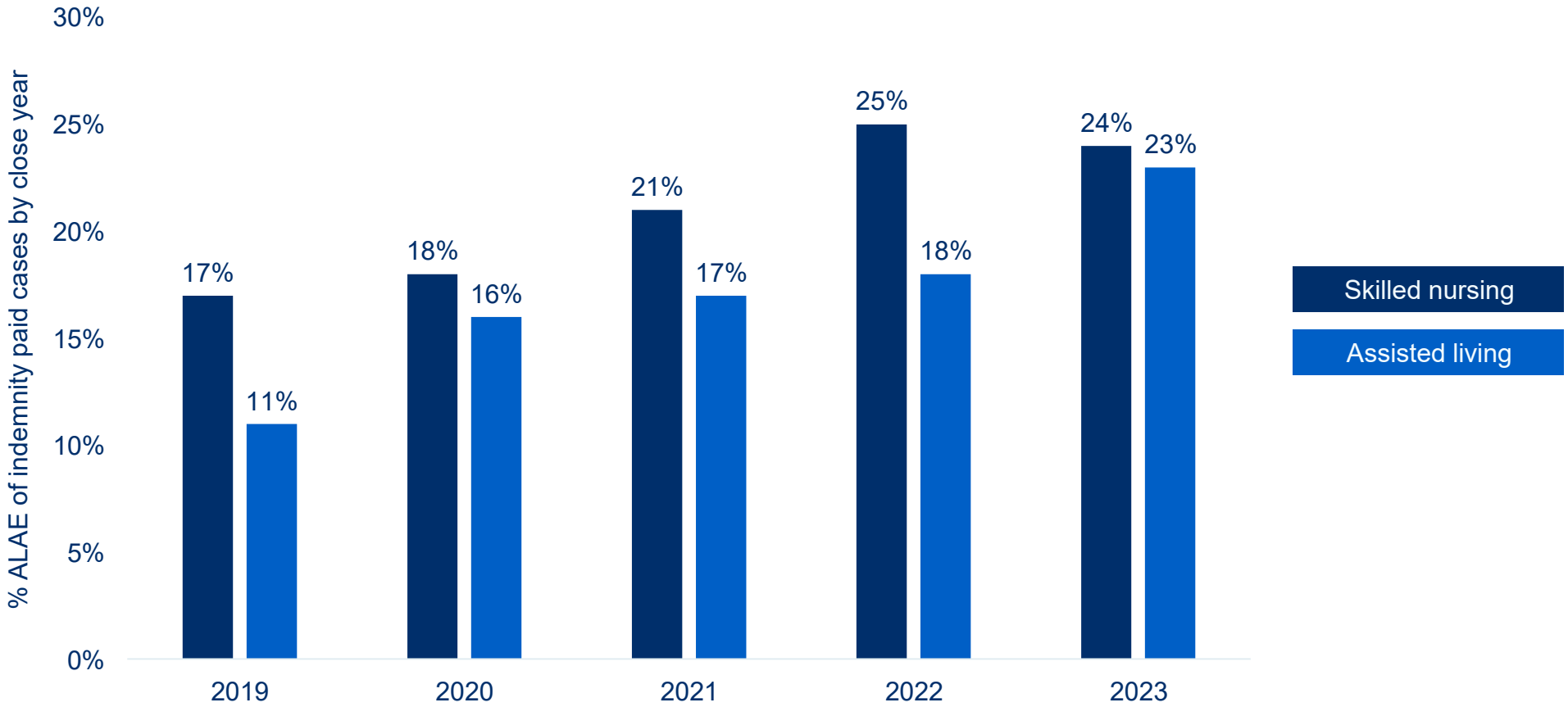


Close year

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); closed with zero indemnity paid 1/1/2017 through 6/30/2023 (N=1899); *ALAE = allocated loss adjustment expenses (costs of defending cases); financial valuation as of 9/30/2023

ALAE* Payment Metrics by Facility Type

The average percent paid on ALAE for skilled nursing facilities is 21% - slightly higher than the assisted living facility average of 17%.



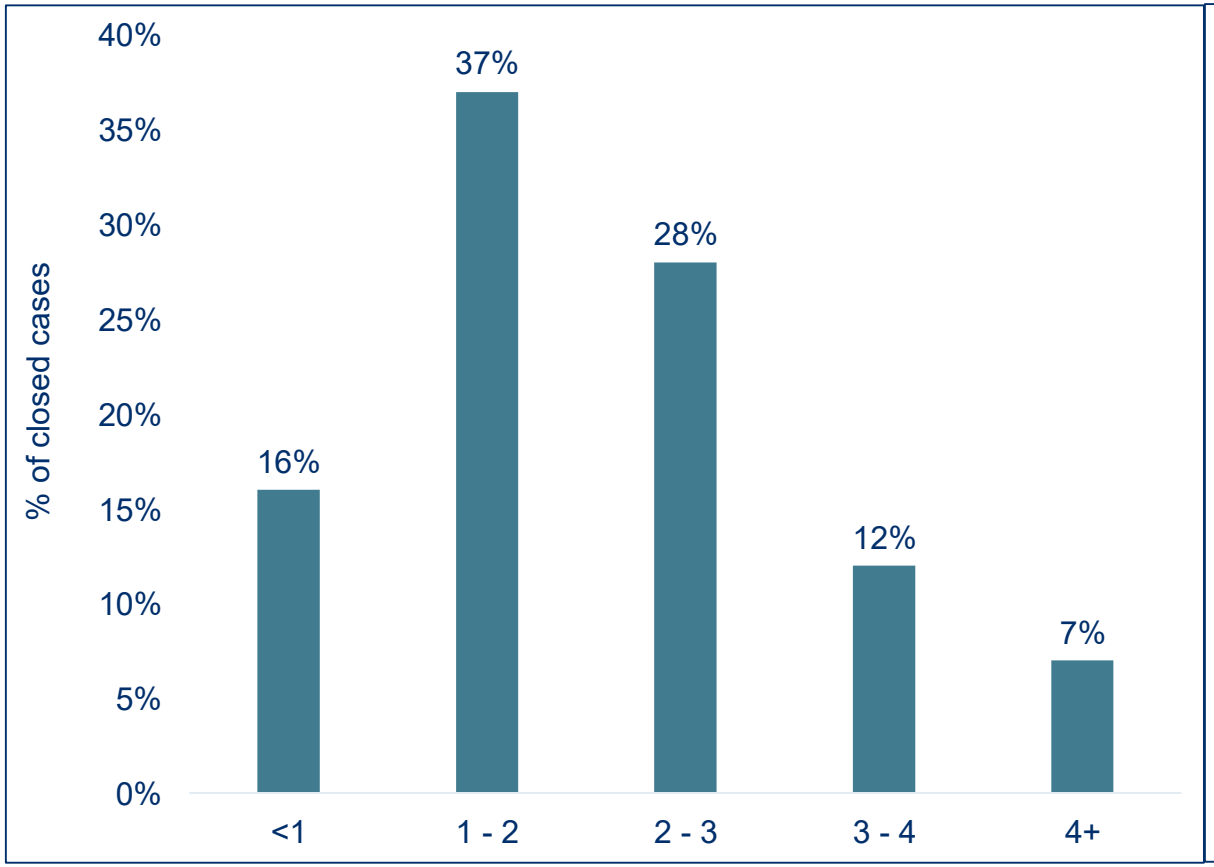
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484; Skilled N=982; Assisted N=476); *ALAE = allocated loss adjustment expenses (costs of defending cases); financial valuation as of 9/30/2023

Average Indemnity and ALAE* by Profit Status

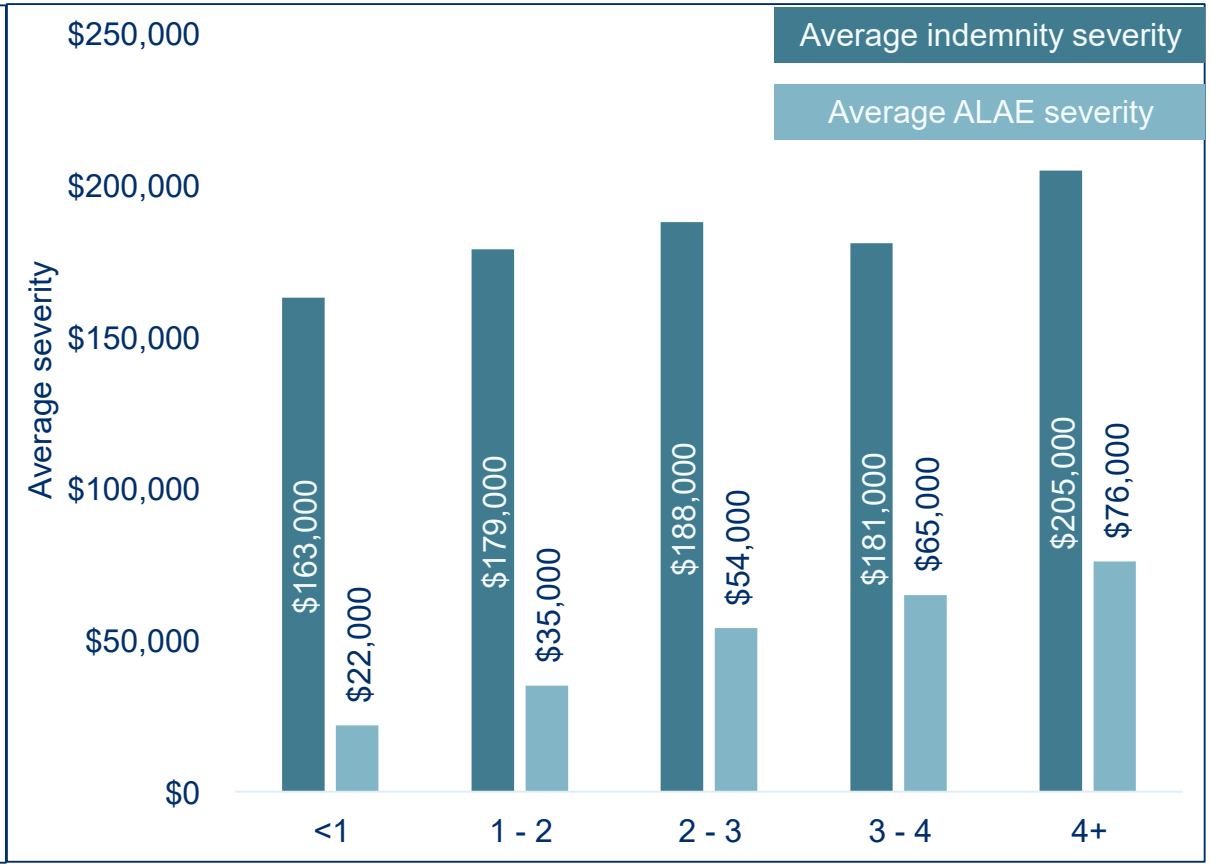
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *ALAE = allocated loss adjustment expenses (costs of defending cases); financial valuation as of 9/30/2023

Years from Open to Closed Metrics

Of all closed cases with indemnity paid, 80% close within three years of opening.



Average indemnity and ALAE* payments both steadily increase the longer a case remains open.



Years from open to close

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *ALAE = allocated loss adjustment expenses (costs of defending cases); financial valuation as of 9/30/2023

Distribution of Case Volume by State

9 states noted account for:

- 71% of all case volume
- 68% of total dollars paid* on closed cases

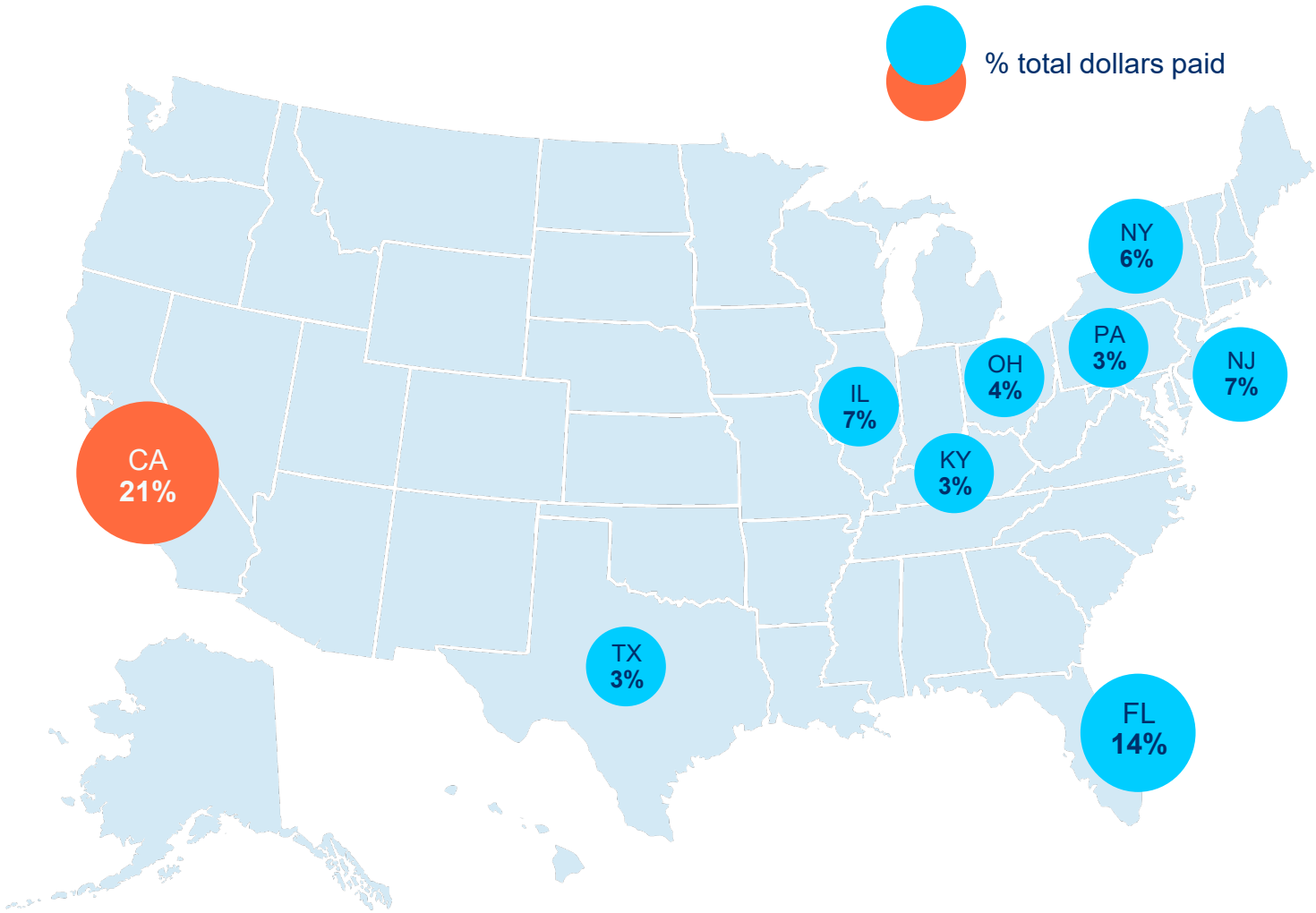
All other states account for </= 2% of case volume each.

Average total dollars paid per closed case across all states (excluding CA) = $203,000.

CA represents 12% of case counts, but 21% of total dollars paid *(see addendum for details)*.

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

CA	$403,000	NY	$190,000
KY	$256,000	FL	$167,000
NJ	$226,000	PA	$153,000
OH	$208,000	TX	$127,000
IL	$204,000		



MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *total paid = expense + any indemnity paid; financial valuation as of 9/30/2023

Distribution of Large Losses by State

6 states noted account for:

- 60% of all large losses*
- 61% of total dollars paid** on closed cases

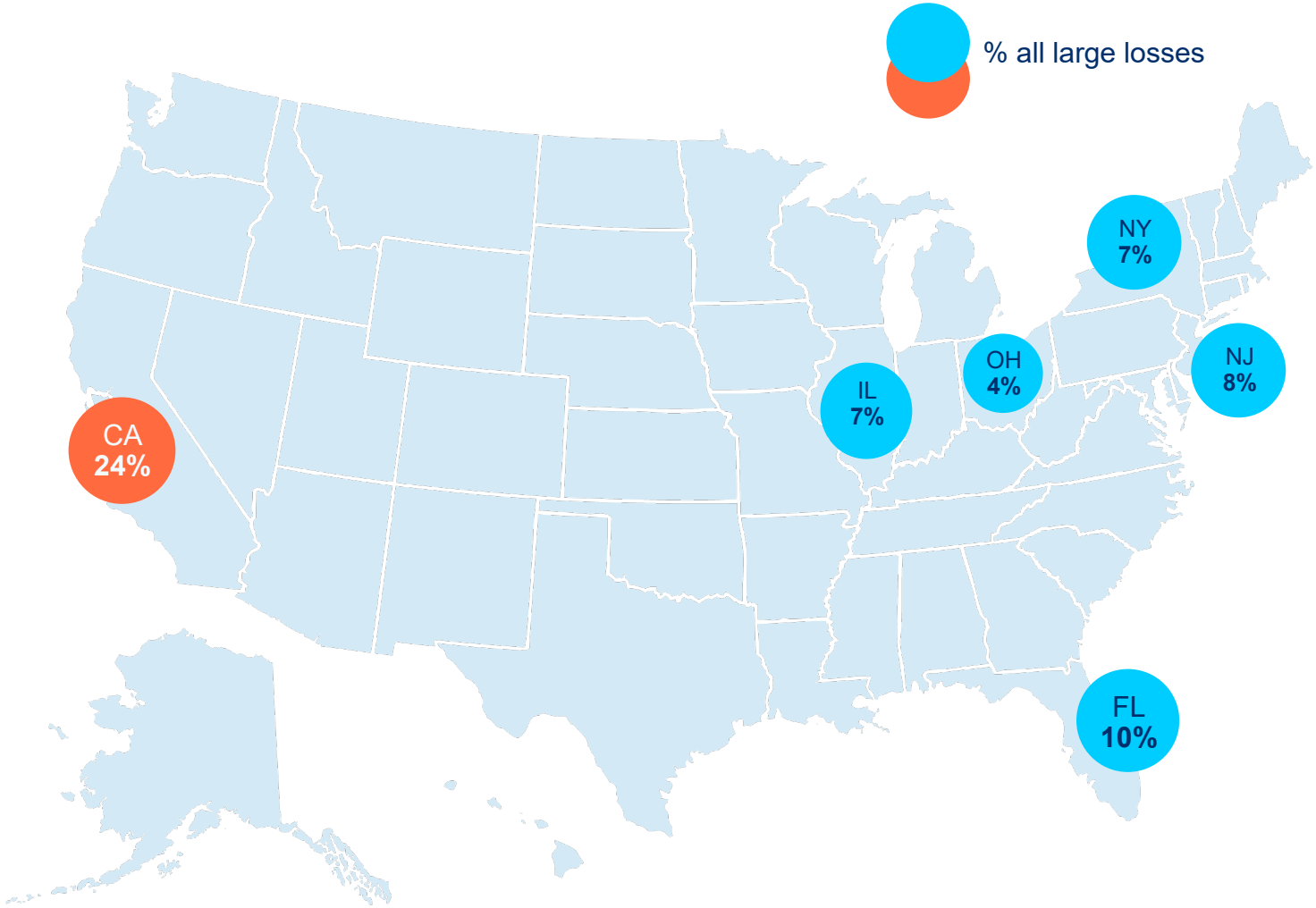
24% of all large losses are from CA *(see addendum for details).*

All other states account for </= 3% of all large losses each.

Average total dollars paid per large loss case across all states (including CA) = $461,000.

Average total dollars paid per large loss case for each of the 6 states noted:

CA	**$591,000**	**NJ**	**$382,000**
OH	**$427,000**	**IL**	**$358,000**
FL	**$420,000**	**NY**	**$338,000**

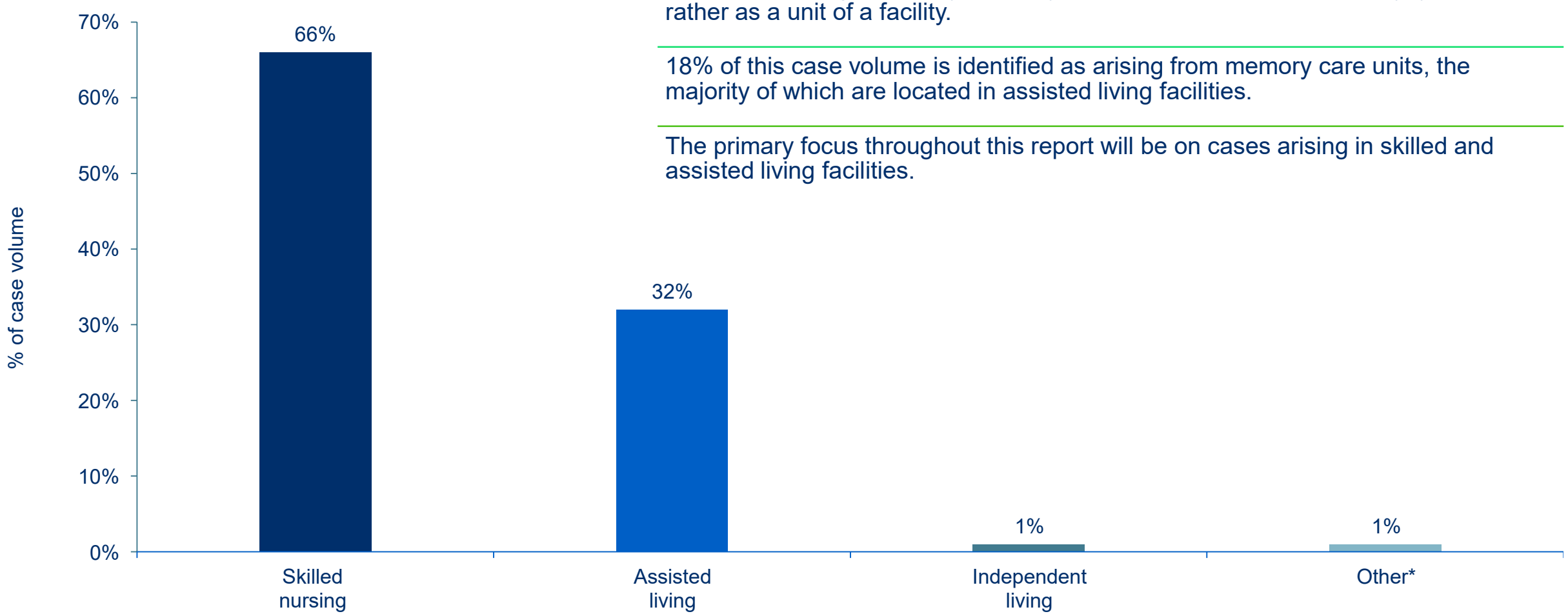


MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *large losses = >/= $250K indemnity paid; **total paid = expense + any indemnity paid; financial valuation as of 9/30/2023

Clinical Risk Analysis

The following section details clinical risk insights across all senior care cases closed with indemnity paid.

Case Volume Distributed Across Facility Types



Within the coding taxonomy, memory care is not specified as a facility type, but rather as a unit of a facility.

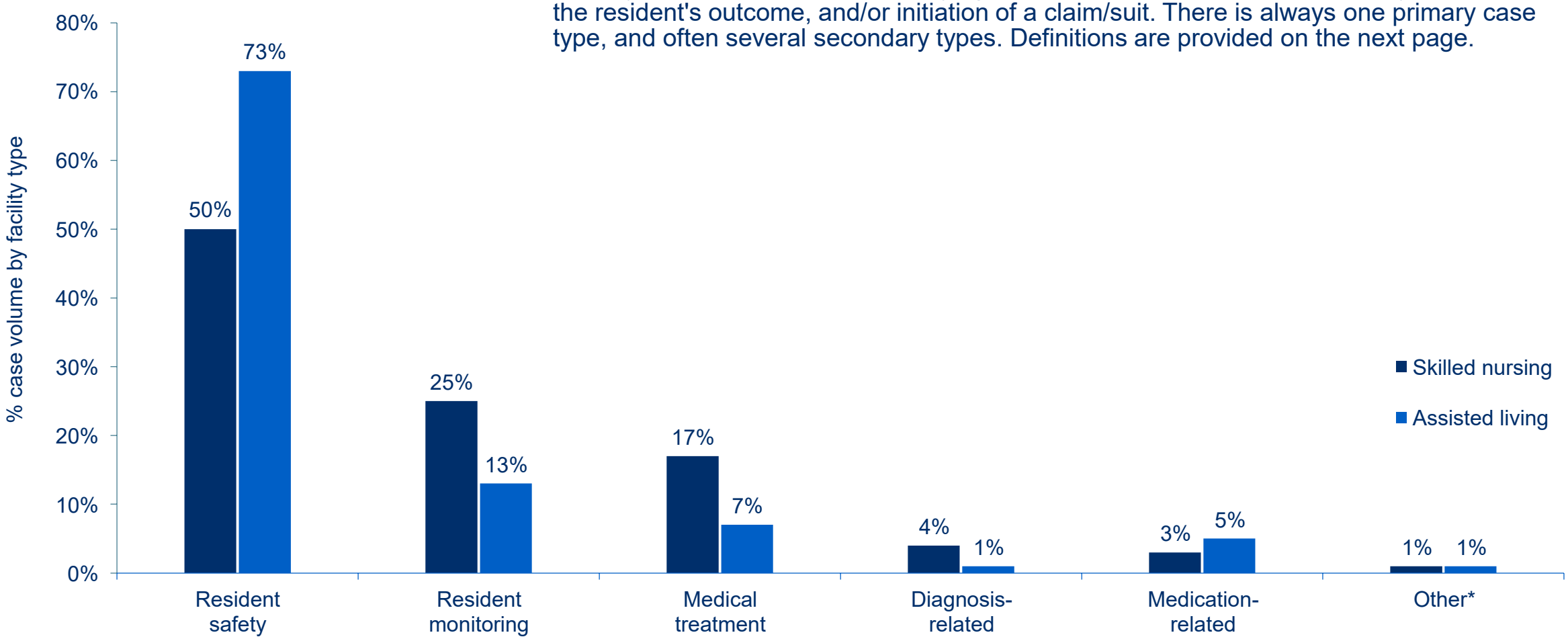
18% of this case volume is identified as arising from memory care units, the majority of which are located in assisted living facilities.

The primary focus throughout this report will be on cases arising in skilled and assisted living facilities.

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (N=1484); *Other = mix of home health, group home, behavioral health, geri-psych

Primary Case Types by Facility

Case types characterize the underlying processes of care which most directly impacted the resident's outcome, and/or initiation of a claim/suit. There is always one primary case type, and often several secondary types. Definitions are provided on the next page.



MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); *Other = case types with no significant volume, i.e. confidentiality breaches, provider behavior

Primary Case Types Defined

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

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.

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

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 closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476)

Focus on Resident Safety & Monitoring Cases

% case volume by facility type

	Resident falls	Inadequate monitoring of physiological status	Pressure ulcers	Other safety issues	Failure to protect from assaults	Failure to prevent elopement
Skilled nursing	41%	23%	24%	8%	2%	0%
Assisted living	52%	12%	7%	14%	7%	1%

Many of the resident safety cases in both facility types are associated with suboptimal staffing levels, inadequately trained and supervised staff, and nighttime shifts.

The higher proportion of resident safety cases in assisted living facilities is also associated with situations in which a resident might be better suited for care delivered in a skilled nursing facility. Although regulations differ from state to state, assisted living facilities are typically staffed with fewer nurses and certified care givers.

Pressure ulcer-involved cases are captured with a diagnosis code, not as a case type. They are primarily associated with inadequate monitoring and improper management of medical treatment case types.

Other safety issues noted in these cases are varied, including:

Injuries sustained during resident transfers with lift devices

Injuries sustained during vehicle and wheelchair transportation

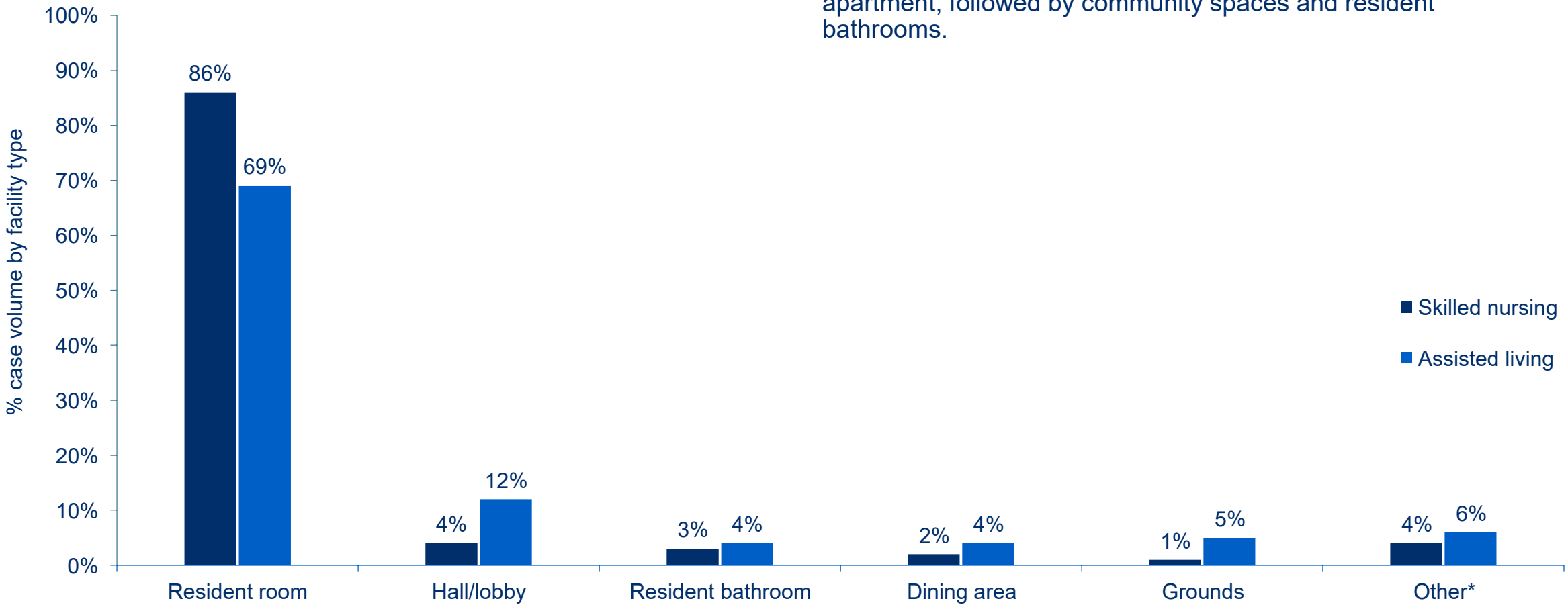
Hyperthermia or hypothermia suffered when residents are outdoors and unobserved

Choking

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476)

Locations

The most common identified locations are in a resident's room or apartment, followed by community spaces and resident bathrooms.

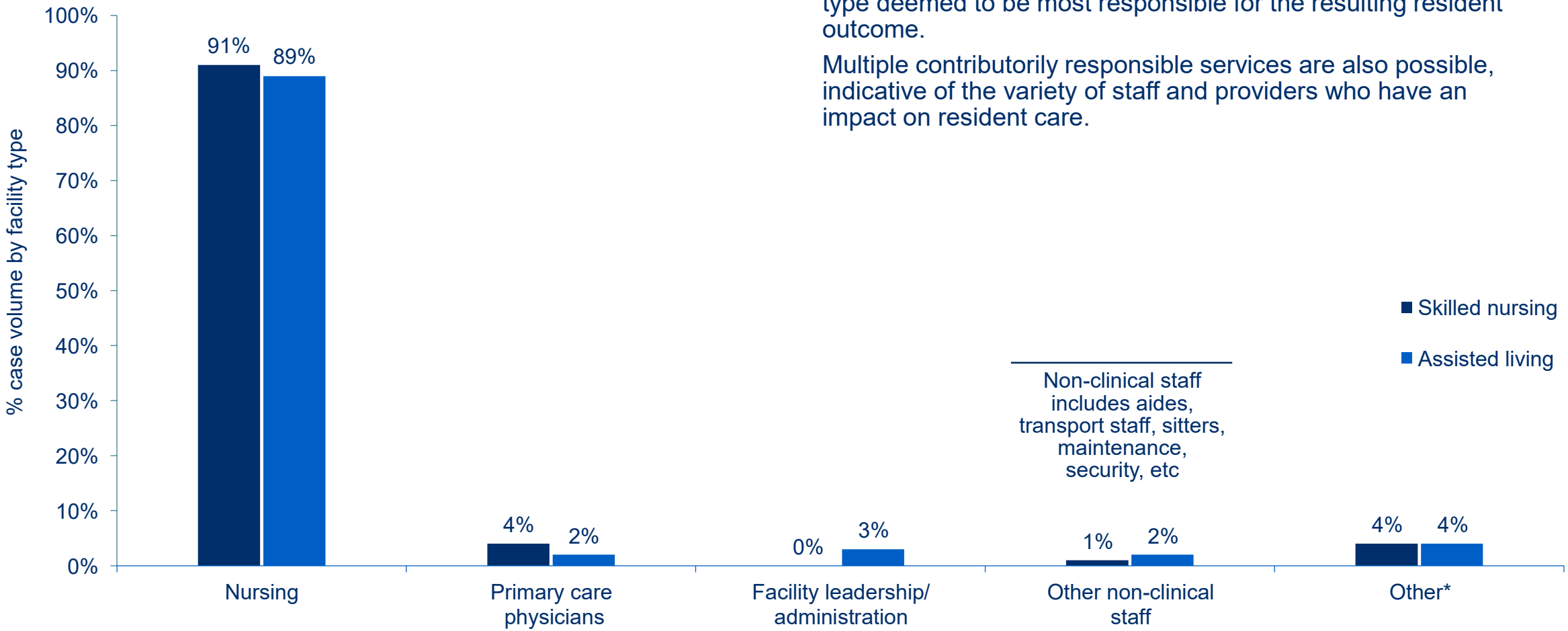


MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); *Other = locations with no significant volume, i.e. stairwells, therapy rooms

Most Common Primary Responsible Services

The primary responsible service is the one specialty/provider type deemed to be most responsible for the resulting resident outcome.

Multiple contributorily responsible services are also possible, indicative of the variety of staff and providers who have an impact on resident care.



MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); *Other = services with no significant case volume

Clinical Severity*

% case volume by facility type

Clinical Severity Categories	Sub-categories	Skilled	Assisted	Definitions
LOW	Emotional Injury Only	3%	5%	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 Injury	33%	33%	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury			Burns, drug side effect; recovery delayed
	Permanent Minor Injury			Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	64%	62%	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 Injury			Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death			Death
		47%	44%	% of each facility type's case volume resulting in resident death

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Contributing Factors

The following section details **failures in the process of care**, with a specific focus on those reflected in resident falls, pressure ulcers, elopements and assaults.

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

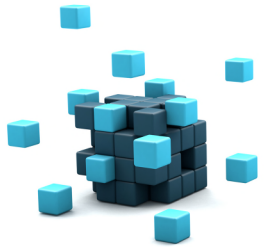
Contributing Factors

Staff are managing multiple residents with varying needs. Despite best intentions, processes designed for safe resident outcomes can, and do, fail. These process failures, also known as contributing factors, are strikingly similar across facility types.

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.

Definitions of the most commonly identified factor categories in senior care cases are noted here:



Clinical judgment
Inadequate resident assessments

Administrative
Failure to follow policies/protocols, inadequate staffing levels, and insufficient training/education

Communication
Suboptimal communication among staff, and between staff, residents and families

Documentation
Insufficient/lack of documentation reflective of care/services provided

Behavior-related
Resident behaviors contributing to events

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

Most Common Contributing Factor Categories

% case volume by facility type

	Clinical judgment	Administrative	Communication	Documentation	Behavior-related	Clinical environment
Skilled nursing	96%	68%	55%	50%	42%	37%
Assisted living	98%	73%	54%	34%	42%	40%

The distribution of factors across both facility types is relatively consistent, with the exception of documentation-related issues.

Suboptimal documentation can make defense of malpractice cases more difficult.

More than one factor is identified per case, therefore totals >100%

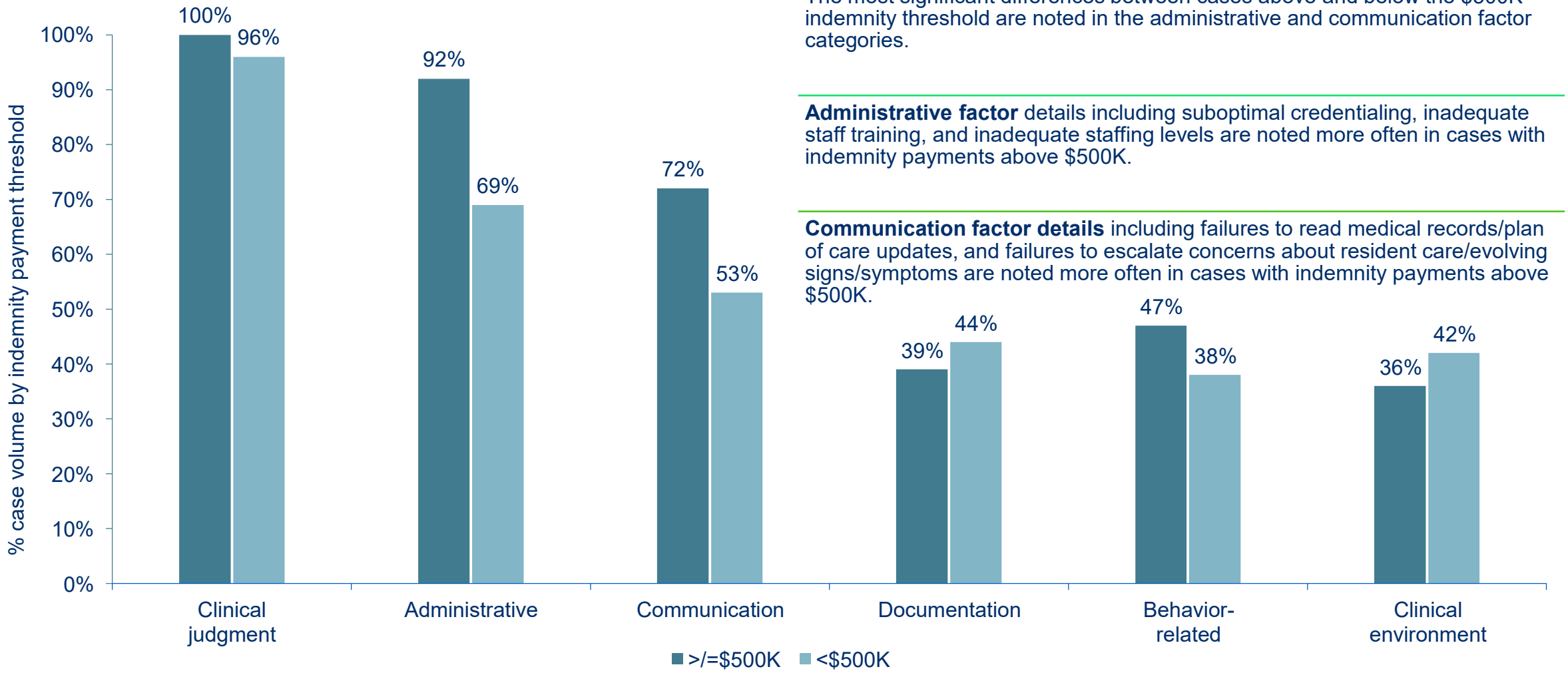
MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476)

Most Common Contributing Factor Details

Category	Most commonly identified details under the categories	% cases with these factor details		Descriptions
		Skilled nursing	Assisted living	
Clinical judgment	Inadequate resident assessments	46%	37%	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	53%	54%	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, managerial oversight, and staffing level issues are commonly associated with failures to follow policies.
	Inadequate staffing levels, training/education	35%	41%	
Communication	Suboptimal communication between providers/staff related to changes in resident conditions	38%	36%	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.
Documentation	Insufficient/lack of documentation reflective of care/services provided	40%	27%	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 members of the resident's care team.
Behavior-related	Resident behaviors contributing to events	41%	38%	Behavior-related events are most often associated with falls, and include resident non-compliance with fall precautions.
Clinical environment	Events occurring during weekend, night, and/or holiday shifts	36%	39%	During these times, staffing levels might be reduced. Commonly associated with this factor are issues with inadequate assessments/monitoring, failures to follow policies, suboptimal communication, and a higher proportion of elopements and assaults.

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); More than one factor is identified per case, therefore totals >100%

Focus on Contributing Factors in the Most Financially Severe Cases



The most significant differences between cases above and below the $500K indemnity threshold are noted in the administrative and communication factor categories.

Administrative factor details including suboptimal credentialing, inadequate staff training, and inadequate staffing levels are noted more often in cases with indemnity payments above $500K.

Communication factor details including failures to read medical records/plan of care updates, and failures to escalate concerns about resident care/evolving signs/symptoms are noted more often in cases with indemnity payments above $500K.

MedPro Group senior care cases closed with >/=$500K indemnity paid 1/1/2017 through 6/30/2023 (Skilled + Assisted N=78); closed with <$500K (Skilled + Assisted N=1380); More than one factor is identified per case, therefore totals >100%

Focus on Resident Falls: Key Points & Contributing Factors

Dementia is the most commonly noted co-morbidity

- Identified in 82% of assisted living and in 56% of skilled nursing facility cases

Fractures are the most common injury

- Identified in 65% of assisted living and in 69% of skilled nursing facility cases
- Death after a fall is noted in 42% of both assisted and skilled cases

Most common contributing factors include

- Failure to follow fall management protocols
- Weekends/nights/holidays
- Verbal and written miscommunication among staff related to resident fall assessments and reports of falls

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); For more information, reference our checklist covering fall assessment and prevention in senior care.

Focus on Resident Falls: Risk Mitigation Strategies

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.

Focus on managerial 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.

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

Focus on Pressure Ulcers: Key Points & Contributing Factors

70% of all pressure ulcer cases involve a clinically severe patient outcome

- 68% of these clinically severe patient outcomes = resident death due to the cascade of events following poorly managed pressure ulcers

Most common contributing factors include

- Inadequate / inconsistent skin integrity assessments
- Failure to escalate observations of worsening skin conditions to supervising staff and/or physician
- Insufficient documentation of skin assessments
- Insufficient documentation of the care provided
- Insufficient documentation of the actions taken to reduce the risk for pressure ulcer development / worsening

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); For more information, reference our checklist covering pressure injury prevention in senior care.

Focus on Pressure Ulcers: Risk Mitigation Strategies

Preventing pressure injuries requires an interdisciplinary approach to care and coordination among the many individuals 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.

Focus on managerial 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.

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

Focus on Resident Elopements & Assaults: Key Points, Contributing Factors, & Risk Mitigation Strategies

Elopement-related cases are infrequent, however, half 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.

Review prospective residents' histories 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.

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

Review prospective residents' 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: 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.

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476); For more information, reference our checklist covering elopement prevention in senior care and our article covering development of a violence prevention program in senior care facilities.

Focus on COVID-19: Emerging Issues

As of the date of this report, the number of COVID-related claims and suits remains relatively small, although the volume of reported "incidents" (non-claim/suit) is high.

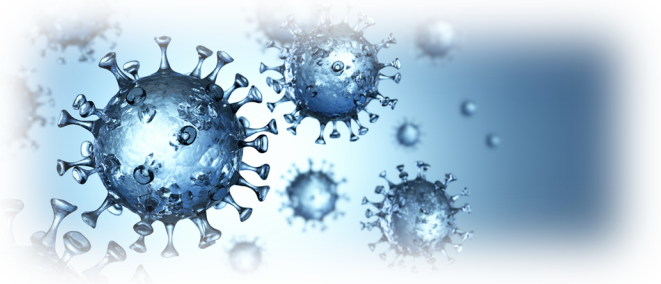
Common "incident" themes include residents contracting COVID while in senior care facilities, failures to diagnose and treat those with COVID in a timely manner, and delay in care related to resulting staff and supply chain shortages.

As we move beyond the pandemic, the following issues are emerging:

Facility leadership with no formal senior care leadership experience prior to March 2020

Lack of knowledge and skills of pre-COVID operations and procedures required to manage and deliver appropriate resident care and to meet state regulation standards

Need for re-evaluation of existing facility policies and procedures



MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Skilled N=982; Assisted N=476)

Case Examples

These case examples are provided to guide 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 assess current practices in your facility.

Resident Falls

INDEMNITY PAID
$400,000

SKILLED NURSING

A male resident, with a significant history of falls, vision impairment and chronic pain, was admitted for rehabilitation following a hospital stay. Although he was noted as a fall risk upon admission, the actual admission assessment documentation reflected no falls, no vision impairment and no pain impacting his ability to function. No fall risk plan was developed. His plan of care called for physical therapy, but no such appointments were ever documented. One week after admission, he was found on the floor of his room; he had sustained several spinal fractures and was unable to recover. A care plan for falls was initiated after the resident fell, but he never returned to the facility. Significant staffing shortages were noted.

INDEMNITY PAID
$500,000

ASSISTED LIVING

A male resident, whose care plan called for assistance with activities of daily living and escorts to and from meals, was otherwise independent and used a walker for mobility. Several falls were noted within the first few months of admission, but none triggered a re-evaluation of the resident's plan of care. During his final fall at the facility, the patient sustained blunt trauma when he hit his head, but was only "stabilized" and taken back to his room. Prompt medical care was not sought, nor was his family contacted. Later, after speaking with his son, the resident was taken to the emergency department, and was diagnosed with neck, rib and hand fractures. He was ultimately transferred to a skilled nursing facility, but was unable to recover from his injuries, which were noted to be a factor in his subsequent death. A state department of health survey based on this event cited the assisted living facility for inadequate policies, staffing, training, incident reporting and documentation.

Resident Pressure Ulcers

INDEMNITY PAID
$335,000

SKILLED NURSING

A female resident was admitted with a stage 4 pressure ulcer following hospitalization. Within a week, the ulcer had expanded significantly, requiring surgical debridement. Over the course of three months (during which a low air loss mattress was ordered but didn't arrive), the resident lost 30 pounds and began to intermittently refuse care (including wound care and food). The wound became infected, leading to septic shock, and ultimately, her death. Staff charting about adherence to the resident's care plan during those three months was inconsistent (and often wrong), and staffing levels were insufficient to meet the needs of this resident whose health was rapidly declining. The family alleged neglect, but were unable to find a facility for alternative placement.

INDEMNITY PAID
$165,000

ASSISTED LIVING

A wheelchair-bound female resident was admitted with no skin concerns identified in her care plan, which was developed and managed by home health nursing staff. Three months later, an area of redness on her buttocks appeared, but the home health agency was not notified. Facility staff implemented repositioning every two hours. Within two weeks, a stage 2 wound had developed on her ankle and a stage 1 wound on her sacrum. Home health was then notified. The wounds progressively worsened, to the point of necrosis, and yet the resident was re-certified to remain in the assisted living facility. After another three weeks, wound debridement was required, and although now the family was actively seeking to move the resident to a skilled nursing facility, the process was delayed due to the COVID-19 pandemic. The resident's condition deteriorated rapidly, with the development of osteomyelitis ultimately resulting in her death. Even as the wounds worsened, the care plan reflected no specific orders/interventions other than regular repositioning.

Resident Monitoring

INDEMNITY PAID
$400,000

SKILLED NURSING

A female resident with dementia, and a history of choking on food at a prior facility, was admitted for rehabilitation after being hospitalized for aspiration pneumonia. Her nutrition was to be delivered via an existing PEG tube. On her last day of admission, she refused mouth care by keeping her mouth clamped shut, however, she was noted to have dried secretions around her mouth. Later that day, she exhibited breathing difficulty, and became unresponsive while the head of her bed was being adjusted. A code was called and CPR was begun. Upon attempting intubation, the EMS team documented removal of a 'foreign object' from her throat, described as a 'large piece of chicken'. The resident was unable to recover and died. Subsequent expert review noted staff failure to follow existing policies related to notifying nursing staff of the resident's refusal of care, and mismanagement of the code process until the EMS team could arrive.

INDEMNITY PAID
$200,000

ASSISTED LIVING

A male resident with advanced Parkinson's disease, Lewy body dementia, diabetes and a history of verbal and physical aggression, was admitted to the facility's memory care unit. On day 15, a skin tear was found on his buttocks; the wound was cleaned and dressing was applied but no wound staging was done. The next day, the resident became unresponsive to verbal stimuli. Upon transfer to the hospital, his blood sugar level was noted to be 516. Although his blood sugar levels were to have been monitored at the facility, this had not been done. A sacral ulcer was also noted and diagnosed as a stage 3 pressure wound; his family told the hospital staff that the wound had been there for three weeks, however the only note in the resident's chart about it was the 'skin tear' finding from the previous day. The resident was noted to have lost 22 pounds in 16 days at the facility. The facility never administered the resident's required weekly dose of diabetic medication. Hospital records documented concerns of neglect due to dehydration and malnutrition.

Resident Elopement and Assault

INDEMNITY PAID
$125,000

ASSISTED LIVING

A male resident with dementia, who had resided at the assisted living facility for over a year, was typically cooperative and had not been deemed to be at risk for elopement. One evening, he was noted to be agitated and asking for his car keys. Overnight, around 2am, the front door alarm sounded. Facility staff looked around outside, but didn't see anyone. However, they did not conduct a resident count after returning inside as per facility policy. Two hours later, the resident was located by bystanders. His face was bleeding and he was found to have sustained nasal, hand and wrist fractures.

INDEMNITY PAID
$200,000

ASSISTED LIVING

The daughter of a non-verbal female resident with dementia on the memory care unit asked that her mother's door be kept locked at all times. Although the facility staff agreed to do so, the request was not noted on the resident's plan of care. A male resident, with a known history of dementia, wandering and aggressive behaviors, was observed exiting her room one evening wearing only a robe. When staff entered the room, the female's clothing had been removed. Staff reported the incident to the administrator, who opted to wait until the morning to investigate. There were significant delays thereafter in reporting the incident to the proper authorities, resulting in an inconclusive sexual assault exam. Of note, a home health aide who had been in the facility two weeks prior to this incident, reported that the male resident attempted to initiate inappropriate contact, although facility staff stated they hadn't previously observed him to exhibit sexually inappropriate behavior.

Addendum

The following pages offer additional insights covering California-specific financial severity, independent living facilities, environmental safety, and other issues pertinent to maintaining the safety and well-being of senior care residents.

Focus on California

California represents 12% of total case volume, 21% of total dollars paid*, and 24% of all large losses.**

Indemnity payments on assisted living cases drive California's financial severity in this data set.

Financial severity trends for California's assisted living facility cases are driven by the current regulatory and legal environments. Inconsistently applied caps on awarded damages, plaintiff attorney fees awarded as part of damages, and strict liability (with the potential for daily fines) applied to violations of the "Residents' Rights" act, all combine to drive up medical professional liability severity.

Despite the financial severity, the clinical risk issues noted in California cases are really no different. The distribution of allegations, responsible services, clinical severity, injuries and contributing factors across the cases is similar to that of all other states.

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (CA N=173); *total paid = expense + any indemnity paid; **large losses = >/=$250K indemnity paid; financial valuation as of 9/30/2023

Focus on Independent Living Facilities

The few independent living cases present in this data set primarily reflect residential safety issues (most often falls and assaults), and less frequently, inadequate monitoring of residents with known medical issues (including the issue of whether emergency pendants/call lights in resident apartments are functioning and/or being monitored).

Other issues noted include failure to provide written agreements for 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.

Some cases involved inadequately trained staff (primarily related to transport assistance), and/or staff failure to ensure that the community environment was free from trip/fall and other hazards.

Inadequate assessment of the appropriateness of independent living environments for some residents was also identified.

MedPro Group senior care cases closed with indemnity paid 1/1/2017 through 6/30/2023 (Independent living N=14)

Focus on Independent Living Facilities

Specific examples of independent living facility issues revealed during onsite assessments and communication with facility staff are as follows:
Reliance on private duty staff to provide care
Lack of communication and coordination between the facility and nursing agencies contracted to provide resident care in the facility
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 (knowing a resident's DNR status is crucial)

MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2023

Focus on Environmental Safety Assessments

Observations include all facility types

Failures to conduct routine/regularly scheduled environmental safety assessments

- Assessments should include a check of floors, walls, ceilings, doors, handrails - anything in the resident's environment
- Assessments should include 3-5 staff; ideal representation includes those from infection control, security, facilities, nursing and administration

Failures to ensure all safety devices are in working order

- Includes internal/external cameras, security call boxes, door alarms, duress alarms

Failures to ensure staff training on critical facility-specific safety and security-related plans and strategies

- Violence prevention
- Active shooter
- Fire safety
- Environmental disaster (includes hurricanes, tornados, winter storms, wildfires, long-term power outages)

MedPro Group aggregated examples from onsite senior care client assessments, 2016-2023

Focus on Environmental Safety: Risk Mitigation Strategies

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 (including equipment and living spaces), infection, fire, fall and violence prevention, and emergency preparedness measures.

The links below provide valuable guidance designed to assist senior care facility management and staff in assessing safety in five key areas.

Infection Prevention/Control

Fire Prevention/Response

Trip/Fall Hazards

Violence Prevention

Emergency Preparedness

Resident Elopement

Focus on Other Pertinent Senior Care Safety Issues

Turnover of leadership and employed staff

- Familiarity with residents, and the buildings in which they reside, is key to improving resident safety and resident/family satisfaction.
- Orientation of incoming leadership and staff to facility-specific policies and procedures is critically important.

Suboptimal orientation of agency staff

- Orientation of agency staff - not only to the residents for whom they will be caring, but also to the critical processes, plans and strategies of the facility itself - should not be neglected.

Caring for residents with behavioral/psychiatric diagnoses

- Conducting in-person pre-admission assessments is a key first step toward identifying:
  - potential residents with prior aggressive and/or violent behavioral health diagnoses;
  - whether properly qualified staff are available to care for residents with psychiatric disorders; and,
  - whether appropriate behavioral health services are available within the local community.

MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2023

Focus on Other Pertinent Senior Care Safety Issues

Background checks of all employees, contractors, volunteers, and vendors

- Failures to identify applicable criminal and/or sex offense history can undermine the safety of residents and employees.
- *Note: A facility/community-employed staff member should accompany any delivery/service vendors who have not been formally vetted at all times while they have access within the building.*

Resident assessment process

- Documentation of assessments with details pertinent to "what is happening" with each resident, services received, and care plan revisions allows for staff and leadership to communicate, understand, and best meet the evolving needs of residents.
- Well-documented assessments can identify residents who would benefit from transfer to a higher level of care (i.e., assisted living to skilled nursing), including those with dementia who are living in non-secured areas of the facility

Security and general safety processes

- Identifying opportunities for unsecured resident access to non-resident care areas, such as a walk-in freezer, boiler room, or an external exit door, are critical to preventing elopements.
- Identifying all visitors, especially those staying overnight with a resident, is a key security process. All staff working in the building during this time should be introduced to any overnight visitors, and the visitors should be limited as to where they can traverse within the building.
- Conducting frequent courtyard checks and supervising resident smoking areas are critical, and often overlooked, opportunities to enhance resident safety.

MedPro Group aggregated examples from onsite senior care client assessments and phone/email interactions with clients, 2016-2023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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 case types 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

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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- Information about current trends related to patient safety and risk management

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- Promotion of new resources and educational opportunities