Aging Services Claims Report 2014

LEARNING FROM THE PAST, CHANGING FOR THE FUTURE

If you take care of your employees, they will take better care of the residents.

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Introduction

CNA is pleased to present its eighth report on claims related to aging services risk exposures. The report provides side-by-side comparative analyses of CNA insureds' professional liability closed claims from January 1, 2007 through December 31, 2011, with the corresponding closed claims from January 1, 2012 through December 31, 2013. (The earlier group of claims is referred to as the 2012 dataset, and the later group is referred to as the 2014 dataset.) This analysis permits a direct comparison of claim characteristics, including trends in frequency and severity, during the two periods. The report also reviews claims with settlement or judgment awards equal to or greater than $1 million. In addition to analyzing professional risk exposures, this report examines closed claims associated with commercial and cyber risk exposures.

The report demonstrates that resident safety remains an abiding challenge for aging services organizations. Our goal is to help aging services leaders better understand the risks associated with providing care for the aging population, and to offer practical actions to enhance resident services.

2014 Executive Summary

Professional Liability Closed Claims

Comparison of Number and Severity of Closed Claims

- The 2012 dataset comprises 1,558 closed claims, and the 2014 dataset comprises 843 closed claims.
- The average total paid for closed claims in the 2012 dataset was $211,477, compared with an average total paid of $211,159 in the 2014 dataset.

Business Segments (pages 9 and 10)

- The percentages of CNA-insured beds for each business segment (i.e., for-profit and not-for-profit) are similar to one another over time.
- For-profit facilities had the higher percentage of closed claims in both datasets.
- For-profit facilities' average total paid was $9,502 higher per closed claim than not-for-profit facilities' closed claims in the 2012 dataset, and $26,713 higher in the 2014 dataset, due to higher average paid indemnity and expense for managing the claims.

Type of Facility (page 12)

- Skilled nursing facilities had a disproportionately high percentage of closed claims across both datasets.
- The skilled nursing facility average total paid for closed claims decreased from $218,072 to $200,837 across the two datasets.
- As documented on page 12, the frequency of assisted living facility closed claims decreased 0.1 percent, while the average total paid increased from $205,370 to $225,542. (See additional comments regarding ALF findings on page 13.)
- The frequency of continuing care retirement community closed claims decreased 0.3 percent, while the average total paid increased from $168,422 to $317,741. (See additional comments regarding CCRC findings on page 13.)

Allegations (page 14)

- Resident falls, pressure ulcers, improper care and failure to monitor are the four most frequent allegations in both datasets.
- Elopement, failure to follow physician's order, gross improper care and failure to inform physician are the allegations with the highest average total paid in both datasets.

Injuries (page 15)

- Death, fractures and pressure ulcers continue to be the three most frequent injuries, constituting approximately 82 percent of closed claims in each dataset.
- Death and loss of limb/amputation are among the injuries with the highest average total paid in both datasets.

Falls (page 37)

- The two datasets combined have 2,401 closed claims; 991 closed claims are associated with resident falls.
- Most of the falls occur at the resident's bedside, in the resident's bathroom or in other areas of the resident's room.
- Failure to monitor the resident is associated with 452 of these 991 closed claims.

Resident Elopement (pages 39 and 40)

- Combining the two datasets, there are 49 closed claims associated with resident elopements.
- The percentage of closed claims associated with elopements remained constant in the 2012 and 2014 datasets.
- As documented in Figure 9 on page 14, the average total paid decreased from $368,789 in the 2012 dataset to $339,658 in the 2014 dataset for closed claims associated with resident elopement.
- Cognitive impairment is associated with 43 of the 49 elopement claims.
- The risk of elopement is prevalent during the first month of residency, and significantly increases again after 12 months.

Resident Abuse (page 41)

- The number of closed claims where the primary allegation is resident abuse remained low, but increased from 3.9 percent in the 2012 dataset to 4.3 percent in the 2014 dataset.
- The average total paid for resident abuse decreased slightly.
- Resident abuse was virtually always perpetrated by an employee or another resident.

Medication Errors (page 41)

- The percentage of closed claims involving medication error decreased from 4.2 percent in the 2012 dataset to 2.6 percent in the 2014 dataset.
- Average total paid for closed claims where the primary allegation was medication error decreased by $5,075.

Enterprise Risk Management

Commercial Risk Exposures (pages 44 and 45)

- Water damage and weather-related property damage were the most frequent causes of loss for commercial closed claims.
- Of the causes of property loss associated with more than 10 percent of closed claims, fire was the costliest.

Cyber Risk Exposures (page 46)

Of all CNA data breach claims between 2003 and 2013, 23 percent involved healthcare, making it the industry with the highest incidence of cyber claim activity for CNA insureds.

Auto Risk Exposures (page 49)

Aging services organizations are experiencing a significant increase in auto accidents involving employee drivers and resident passengers. This increase is being seen in both the number and severity of auto claims for aging services organizations.

Datasets and Methodology

Two datasets are utilized in Parts One, Two and Three of this report. The 2012 dataset includes 1,558 professional liability claims that closed between January 1, 2007 and December 31, 2011. The 2014 dataset includes 843 professional liability claims that closed between January 1, 2012 and December 31, 2013. Closed claims with an indemnity payment of less than $5,000, as well as claims from adult day care programs and home healthcare providers, were excluded from both datasets. *Please note that percentages in charts or graphs may not equal exactly 100 percent due to rounding.*

The following inherent limitations to the datasets should be noted:

- The datasets include only CNA-insured aging services organizations, rather than the total universe of aging services facilities.
- Indemnity and expense payments include only monies paid by CNA on behalf of its insureds. Deductibles and other possible sources of payment in response to a claim are not included.
- The CNA primary professional liability insurance indemnity limit is $1 million per claim, although judgments awarded against a defendant may be higher, and therefore, the 2012 and 2014 datasets are limited to claims with indemnity payments not greater than $1 million. CNA payments could exceed $1 million for clients who purchase both primary and excess coverage from CNA.
- Resolving these claims may take many years. Claims that fulfill the inclusion criteria are included in the respective dataset based on when they closed, regardless of when the incident occurred.
- Inclusion criteria in this report differ from prior CNA aging services claims reports and reports from other sources. *Please note the 2012 dataset includes closed claims that were not contained in the aging services report CNA published in 2012. Therefore, the two studies' findings should not be directly compared.*

Definitions and Abbreviations

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

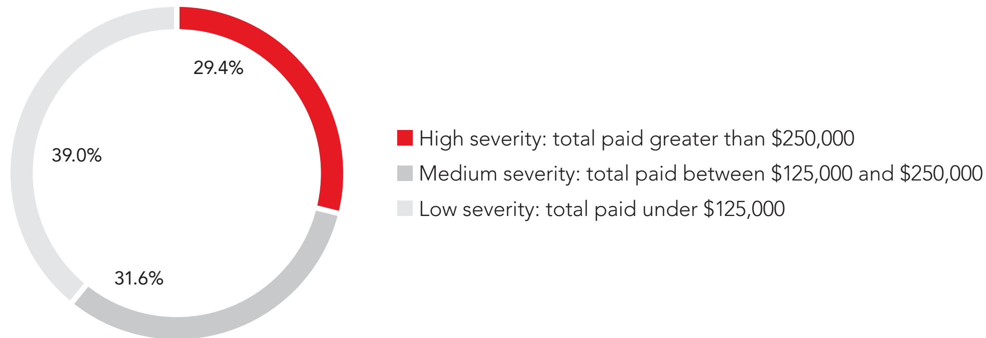
- **Average total paid** refers to average paid amount (indemnity plus expense costs divided by the number of closed claims) paid by CNA.
- **Book of business** is measured by the number of facility beds insured by CNA.
- **Business segment** reflects the not-for-profit or for-profit tax status of the organization.
- **Expenses** are monies paid by CNA for the investigation, management and/or defense of a claim or lawsuit.
- **Frequency** and **distribution** refer to the percentage of closed claims with a specified attribute, such as type of facility, allegation or injury.
- **Gross improper care** includes egregious deviation from standards, such as the failure to notify a physician of an injury for a prolonged period, repeated administration of the wrong medications or alteration of resident care records.
- **Improper care** refers to failure to follow an established nursing care/service plan, reasonable standard of care, or organizational policy and procedure.
- **Incurred claims** are those reported claims that result in an indemnity and/or expense payment.
- **Indemnity payments** are monies paid by CNA for the settlement or judgment of a claim.
- **Reported claims** are all claims reported to CNA, including those that do not result in a payment.
- **Severity** refers to monies paid by CNA on behalf of CNA-insured clients resulting from the settlement of a claim or a jury verdict. It is expressed as the average paid indemnity, average paid expense or average total paid (i.e., indemnity plus expense).
- **Sexual assault** is an injury classification encompassing rape and attempted rape.
- **Short-term stay** refers to admissions where the intent is rehabilitation and planned discharge, rather than extended care.

Abbreviations in this document include the following:

- **ALF:** assisted living facility
- **CCRC:** continuing care retirement community
- **FP:** for-profit
- **ILF:** independent living facility
- **NFP:** not-for-profit
- **SNF:** skilled nursing facility

Distribution of Closed Claims by Total Paid: 2007-2013

1 RANKING OF CLOSED CLAIMS by Total Paid: 2007-2013



Closed claims with **highest total paid** accounted for nearly **30 percent** of closed claims in the combined dataset.

Book of Business and Business Segments

More detailed information on closed claims associated with each type of facility follows in Part Two.

Business Segment: Frequency and Severity

2 INSURED BEDS AND CLOSED CLAIMS by Business Segment

Business segment	Percentage of insured beds 2012	Percentage of insured beds 2014	Total number of closed claims 2012	Total number of closed claims 2014	Percentage of closed claims 2012	Percentage of closed claims 2014
Not-for-profit	47.2%	44.7%	450	274	28.9%	32.5%
For-profit	52.8%	55.3%	1,108	569	71.1%	67.5%
Total	100.0%	100.0%	1,558	843	100.0%	100.0%

For-profit entities have a disproportionately **high percentage** of the closed claims in both datasets. The **gap narrowed** in the **2014 dataset** where not-for-profit claims accounted for almost one-third of all closed claims.

3 SEVERITY OF INSURED BEDS AND CLOSED CLAIMS by Business Segment

Business segment	Average paid indemnity 2012	Average paid indemnity 2014	Average paid expense 2012	Average paid expense 2014	Average total paid 2012	Average total paid 2014
Not-for-profit	$164,869	$155,834	$39,851	$37,295	$204,720	$193,128
For-profit	$165,191	$174,509	$49,030	$45,333	$214,222	$219,841
Overall average	$165,098	$168,439	$46,379	$42,720	$211,477	$211,159

The difference between for-profit and not-for-profit average indemnity payments increased from a difference of only $322 in the 2012 dataset to a difference of $18,675 in the 2014 dataset.

Closed Claims by State: 2007-2013

4a SEVERITY BY STATE Distribution of Closed Claims

- High severity: average total paid greater than $250,000
- Medium severity: average total paid between $125,000 and $250,000
- Low severity: average total paid under $125,000
- Not categorized: states with fewer than five closed claims

4b CLOSED CLAIMS BY STATE: 2007 – 2013

State	Total number of closed claims	Percent of closed claims	Average total paid	Ranking
CA	158	6.6%	$273,738	High
TN	77	3.2%	$278,978	High
WA	41	1.7%	$256,079	High
KY	35	1.5%	$279,906	High
NM	32	1.3%	$336,280	High
OK	20	0.8%	$253,163	High
MS	9	0.4%	$321,980	High
WV	7	0.3%	$277,840	High
OR	7	0.3%	$264,147	High
AL	6	0.2%	$416,561	High
NY	481	20.0%	$221,697	Medium
PA	220	9.2%	$185,207	Medium
NJ	173	7.2%	$209,312	Medium
MD	126	5.2%	$170,781	Medium
IL	112	4.7%	$220,962	Medium
MA	111	4.6%	$164,866	Medium
OH	90	3.7%	$162,936	Medium
GA	88	3.7%	$211,366	Medium
FL	78	3.2%	$201,534	Medium
CT	77	3.2%	$228,887	Medium
VA	73	3.0%	$199,677	Medium
NC	47	2.0%	$223,078	Medium
SC	43	1.8%	$213,527	Medium
TX	43	1.8%	$141,442	Medium
IN	33	1.4%	$140,371	Medium
WI	28	1.2%	$224,349	Medium
MN	28	1.2%	$172,591	Medium
AZ	22	0.9%	$228,176	Medium
MO	18	0.7%	$128,008	Medium
RI	15	0.6%	$215,774	Medium
CO	15	0.6%	$163,033	Medium
KS	7	0.3%	$217,408	Medium
LA	5	0.2%	$184,600	Medium
DC	5	0.2%	$175,768	Medium
MI	31	1.3%	$120,706	Low
IA	10	0.4%	$117,203	Low
NE	9	0.4%	$78,714	Low
VT	5	0.2%	$98,752	Low
All other	16	0.7%	N/A	N/A
Total	2,401	100.0%	N/A	N/A

Only states with five or more closed claims are included in chart 4b. It should be noted that the average total paid in states with fewer closed claims may be more affected by the CNA book of business than by the litigation environment in those states.

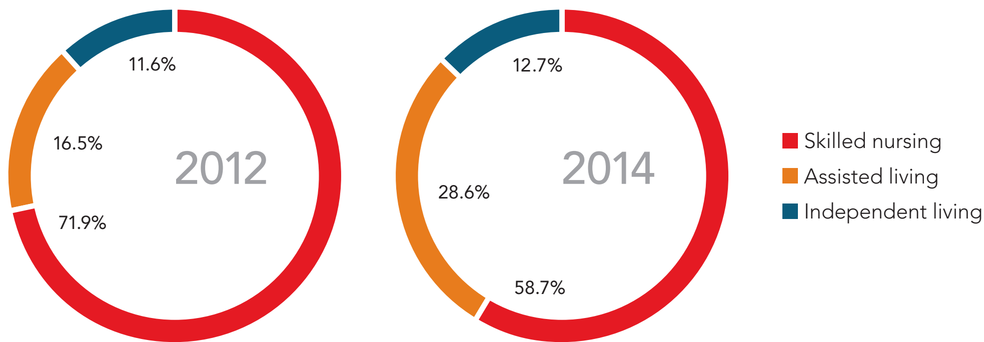
Type of Facility

5 TYPE OF FACILITY Insured Beds and Closed Claims

Facility type	Percentage of insured beds 2012	Percentage of insured beds 2014	Percentage of closed claims 2012	Percentage of closed claims 2014	Average total paid 2012	Average total paid 2014
SNF	69.9%	62.7%	79.5%	80.2%	$218,072	$200,837
ALF	17.0%	18.2%	11.4%	11.3%	$205,370	$225,542
CCRC	10.6%	13.6%	7.8%	7.5%	$168,422	$317,741
ILF	2.5%	5.5%	1.3%	1.1%	$117,771	$88,542
Total	100.0%	100.0%	100.0%	100.0%	$211,477	$211,159

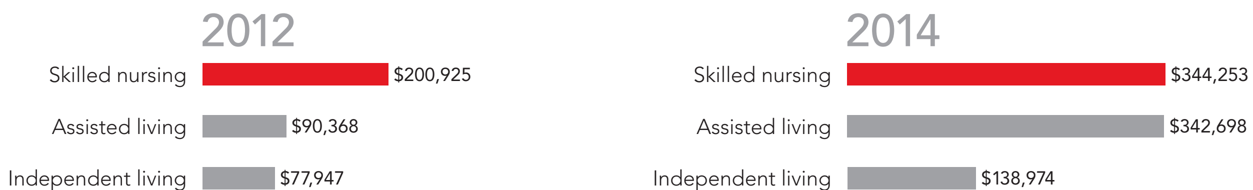
In both datasets, SNFs represent a disproportionately high percentage of closed claims. On average, total paid decreased $17,235 for SNFs and increased $20,172 for ALFs and $149,319 for CCRCs.

6 TYPE OF FACILITY BY LEVEL OF CARE Distribution of Closed Claims at CCRCs



In the 2014 dataset, the percentage of CCRC-based assisted living closed claims increased while CCRC-based skilled nursing closed claims decreased.

7 TYPE OF FACILITY BY LEVEL OF CARE Average Total Paid for Closed Claims at CCRCs



Additional comments regarding variations between the datasets:

CCRC closed claims

- Additional review of CCRC closed claims regarding level of care revealed differences between the 2012 and 2014 datasets. The percentage of CCRC assisted living closed claims increased from 16.5 percent in the 2012 dataset to 28.6 percent in the 2014 dataset. However, the percentage of CCRC skilled nursing closed claims decreased from 71.9 percent in 2012 to 58.7 percent in 2014.
- The increase in average total paid for CCRCs in the 2014 dataset is affected by an increase in the percentage of closed claims with total paid over $250,000 as compared to the 2012 dataset. This is partially driven by an increase in the number of claims with total paid that closed near or at policy limits, from one closed claim in the 2012 dataset to five closed claims in the 2014 dataset. Two of these closed claims are related to assisted living residents and four are related to skilled nursing residents.

ALF closed claims

- The increase in average total paid for ALFs in the 2014 dataset is affected by an increase in the percentage of closed claims with total paid over $250,000, as compared to the 2012 dataset.
- The increase in the average total paid for ALF closed claims may reflect numerous factors, including increasing acuity of residents upon admission, residents remaining in the assisted living setting although their acuity is beyond the facility's capabilities, unmet expectations of residents and family members, and the absence of state-specific regulations limiting indemnity payments made by assisted living facilities (as opposed to other types of settings).

SNF closed claims

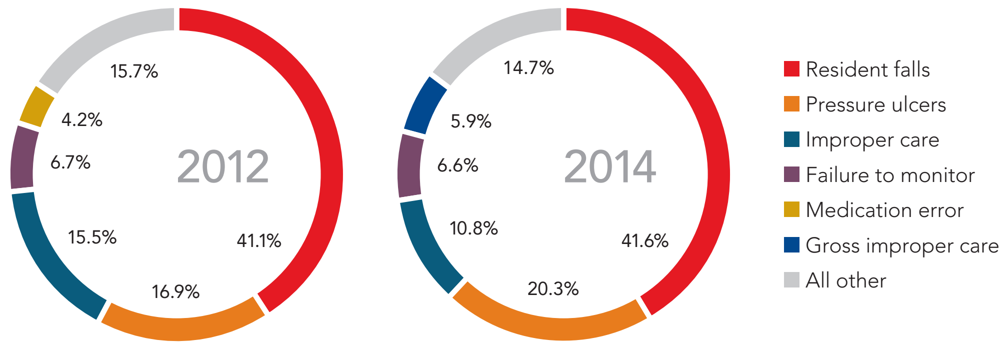
The decrease in average total paid for SNFs in the 2014 dataset is affected by a decrease in the percentage of closed claims with total paid over $250,000, as compared to the 2012 dataset.

ILF closed claims

The decrease in average total paid reflects one closed claim in the 2012 dataset with a high total paid.

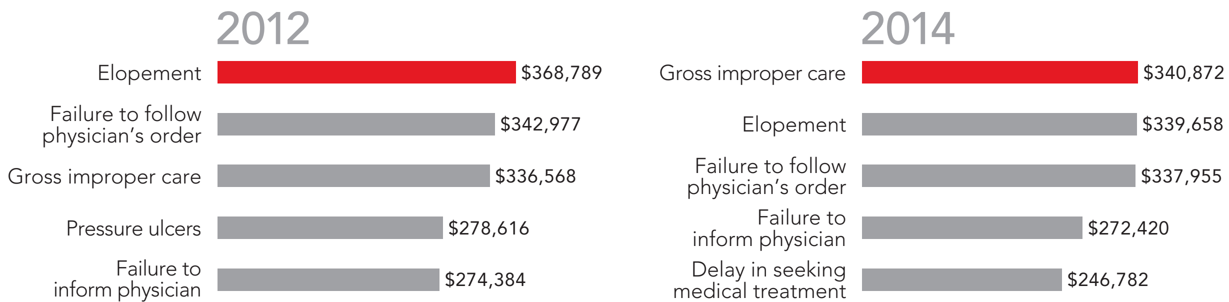
Allegations

8 ALLEGATIONS Highest Frequency Closed Claims



Allegations with over 10 percent of the closed claims – including resident falls, pressure ulcers and improper care – did not change over time.

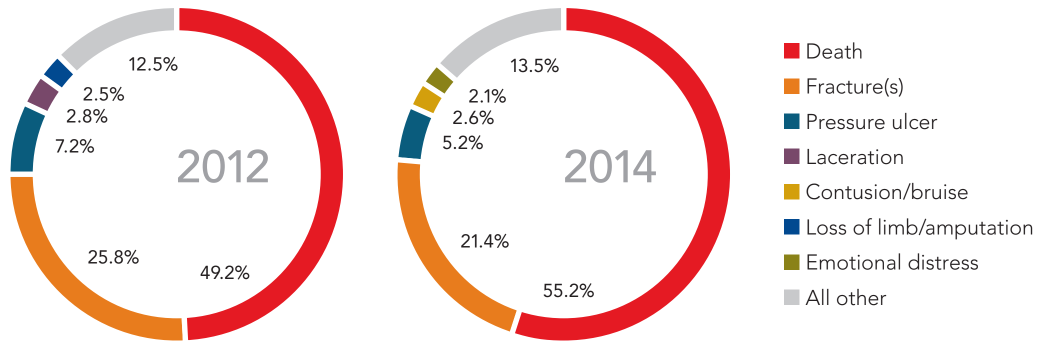
9 ALLEGATIONS Highest Average Total Paid for Closed Claims



Elopement, failure to follow physician's order, gross improper care and failure to inform physician were among the allegations with the highest average total paid in the two datasets. The average total paid for these allegations declined (other than for gross improper care).

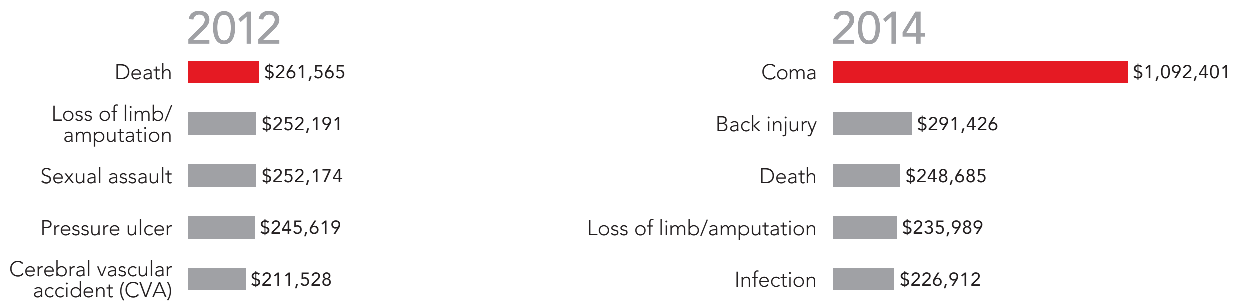
Injuries

10 INJURIES Highest Frequency Closed Claims



Death and fractures consistently account for approximately 75 percent of aging services injuries.

11 INJURIES Highest Average Total Paid for Closed Claims



Unlike allegations, injuries with the highest average total paid were not consistent across the two datasets.

Additional comments:

- The 2014 average total paid for coma was affected by one claim in which a skilled nursing facility resident experienced a self-inflicted injury, resulting in permanent disability. All coma injuries involved residents in a skilled nursing facility or the skilled nursing unit of a CCRC.
- There were three back injuries in the 2014 dataset, all resulting from resident falls.

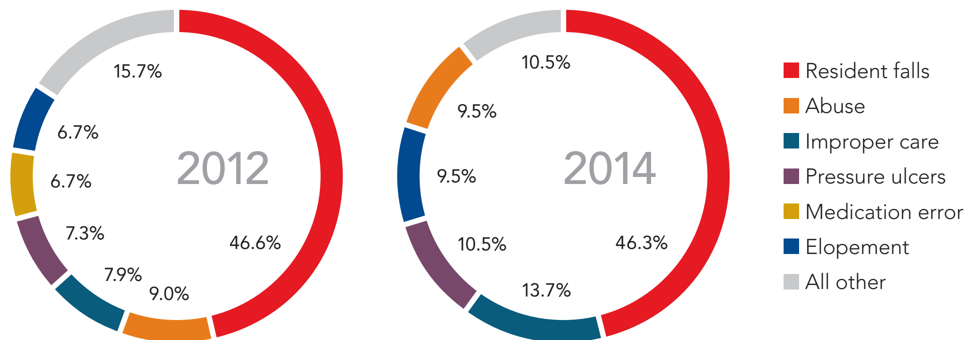
PART TWO ANALYSIS OF CLOSED CLAIMS BY TYPE OF FACILITY

Analysis of Assisted Living Facility Closed Claims

- Number of closed claims: 178 closed claims in the 2012 dataset, 95 closed claims in the 2014 dataset.
- Average total paid: $205,370 in the 2012 dataset, $225,542 in the 2014 dataset.

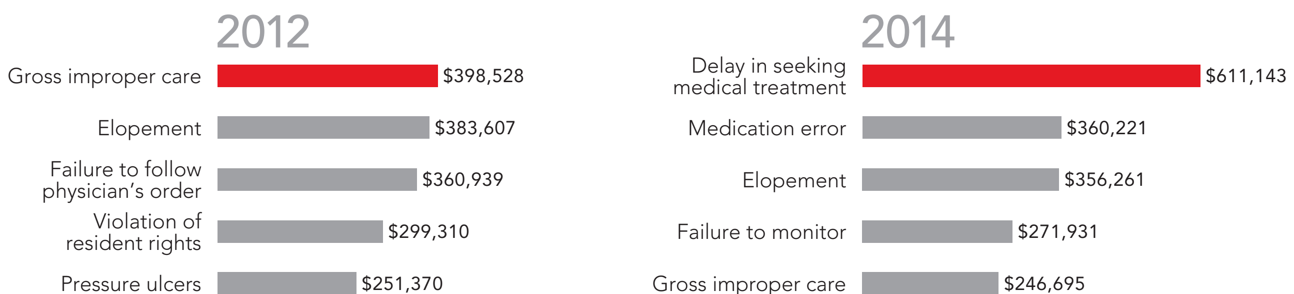
Allegations

12 ALLEGATIONS AT ASSISTED LIVING FACILITIES Highest Frequency Closed Claims



Although exact percentages changed, the highest-frequency ALF allegations are the same for both datasets. Resident falls were by far the most common allegation.

13 ALLEGATIONS AT ASSISTED LIVING FACILITIES Highest Average Total Paid for Closed Claims



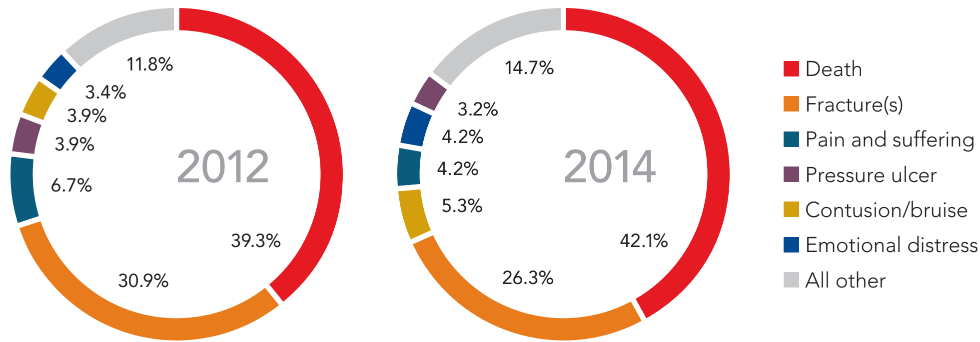
The ALF allegations with the highest average total paid differed between the two datasets, with the exceptions of gross improper care and elopement.

Additional comment:

Delay in seeking medical treatment and gross improper care each had one closed claim in the 2014 dataset.

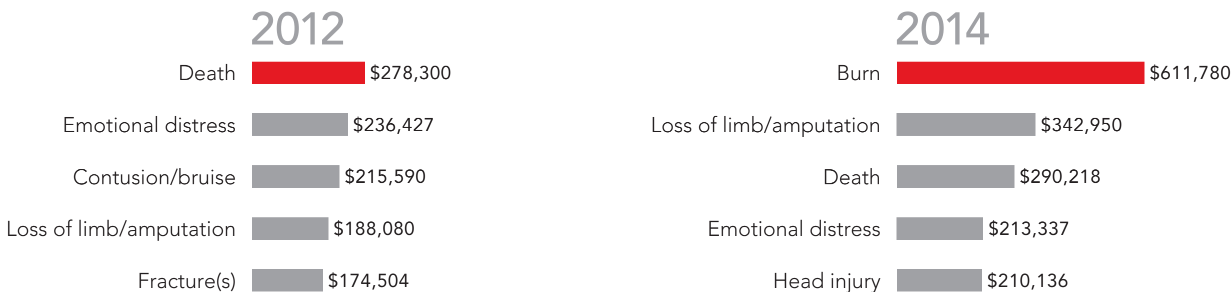
Injuries

14 INJURIES AT ASSISTED LIVING FACILITIES Highest Frequency Closed Claims



Death and fracture comprised the highest percentages of injuries across the continuum of care, including ALFs.

15 INJURIES AT ASSISTED LIVING FACILITIES Highest Average Total Paid for Closed Claims



The ALF injuries with the highest average total paid differed in the two datasets.

Additional comments:

- The resident care factors which led to the two 2014 closed claims associated with loss of limb or amputation were considered more egregious than in the two such claims in the 2012 dataset.
- Burn accounted for the highest average total paid in the 2014 dataset but represented a single claim.

ALF Case Scenario: Gross Negligent Care

Summary of Facts and Injury

An 89-year-old resident with a primary diagnosis of Alzheimer's disease had been living at the ALF for two years. She suffered several chronic medical conditions for which she received medication. She was known to be at risk for falls, having experienced 10 falls in the facility despite use of a low bed against the wall, periodic use of a wheelchair with transfer assistance and hourly monitoring when she was in bed.

On the night in question, the certified nursing assistant checked the resident at 1:30 a.m. and found that she had foaming sputum in her mouth, and was complaining of difficulty breathing. At the 2:30 a.m. check, the resident was found to have been incontinent of both bowel and bladder. The certified nursing assistant completed hygiene care. Shortly afterward, she and a second certified nursing assistant found the resident on the floor. They returned her to bed, noting that she did not appear to have suffered any injury from the fall. The certified nursing assistant called the director of resident care (DRC), who was also the facility's director of nursing. The DRC instructed the certified nursing assistant to increase monitoring of the resident to every 30 minutes.

When the resident failed to improve after 30 minutes, the certified nursing assistant made several attempts to recontact the DRC. However, when the telephone was not answered, she took no further actions. The certified nursing assistant later testified that she had been told never to call 911 without permission from the DRC, notwithstanding the facility's written policy, which states that staff should call 911 for medical emergencies.

When the morning shift certified nursing assistant came on duty, she immediately called 911. The resident was transported to the hospital for treatment of respiratory distress and was placed on a ventilator. When it was determined that her condition would not improve, the family agreed to a Do Not Resuscitate order and the resident died four days later.

The DRC and certified nursing assistant contradicted each other's recollections of the matter, but neither had called 911 as dictated by facility policy.

Allegations

The resident's family members filed a lawsuit seeking compensatory and punitive damages against the ALF, certified nursing assistant and DRC. The suit alleged wrongful death as a result of negligence, as well as willful misconduct, fraud, and violation of state and local rules and regulations. They also contacted the police with a criminal complaint of endangering the welfare of the elderly, but no criminal charges were filed.

Assessment of Risk Exposures

The state Department of Health identified numerous violations of the facility's policies and applicable regulations, and cited both defendants for failing to call 911 despite their awareness of the resident's condition. In addition, the facility was cited for failing to have skilled nursing staff available at the time of the incident.

Defense medical experts agreed that the resident should have been hospitalized sooner and that the delay contributed to her death. The defense experts further found that:

- The facility failed to have a nurse available, leaving the resident's care in the hands of a certified nursing assistant who could not perform a resident assessment.
- The certified nursing assistant and DRC failed to follow facility policy by not notifying 911 immediately upon their becoming aware of the resident's failing condition.
- The DRC failed to respond to telephone calls, while knowing that a resident was seriously ill and in respiratory distress.

Given the defendants' departures from organizational policy and protocol, deviation from the standard of care for respiratory distress, Department of Health citations related to the resident's care, less than optimal documentation and conflicting accounts of the incident by named insureds, the decision was made to attempt to settle the matter.

Resolution

The resident's family agreed to a settlement near policy limits.

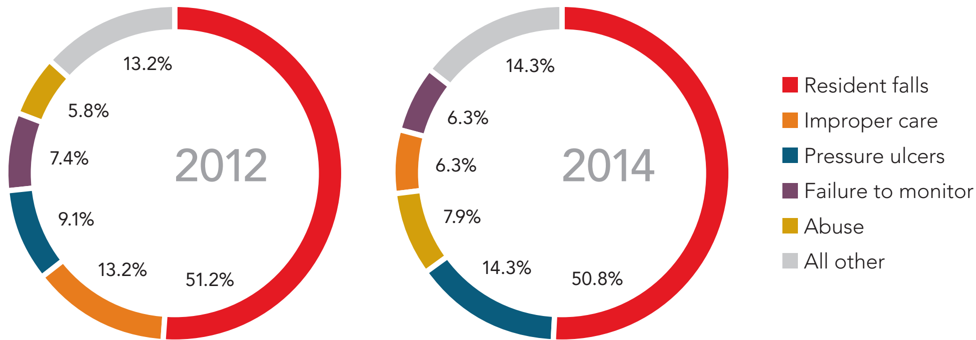
Analysis of Continuing Care Retirement Community Closed Claims

- Number of closed claims: 121 closed claims in the 2012 dataset, 63 closed claims in the 2014 dataset.
- Average total paid: $168,422 in the 2012 dataset, $317,741 in the 2014 dataset.

Allegations

16 ALLEGATIONS AT CONTINUING CARE RETIREMENT COMMUNITIES

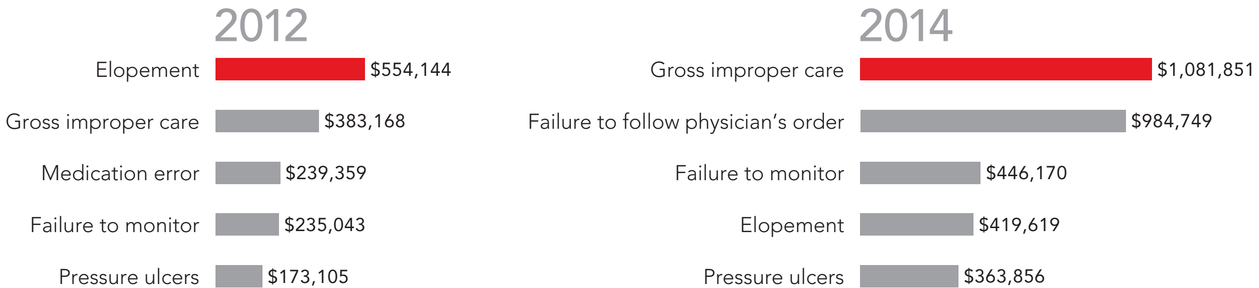
Highest Frequency Closed Claims



While the hierarchy of allegations is not the same across the two datasets, CCRC allegations with the highest frequency do not vary.

17 ALLEGATIONS AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Average Total Paid for Closed Claims



Of the top five allegations, four were the same in both datasets, but the order and average total paid varied.

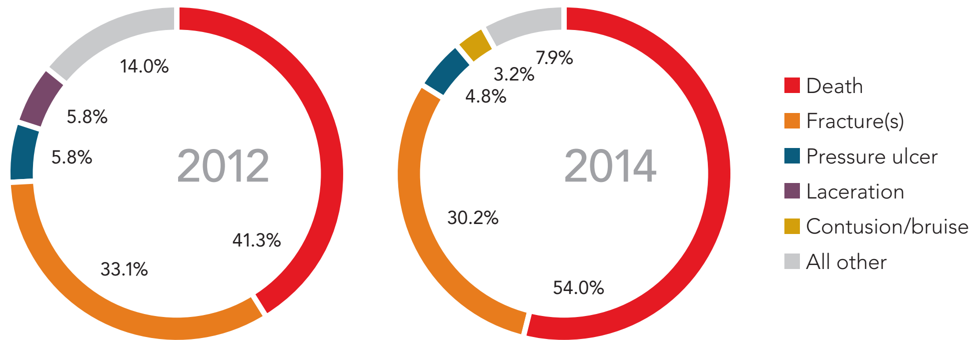
Additional comments:

- The 2014 dataset includes one gross improper care closed claim which was resolved with a total paid over $1 million and included multiple allegations, whereas the 2012 dataset included three gross improper care closed claims, each with total paid significantly under $1 million.
- The 2014 dataset included a single claim involving the failure to follow the physician's order which resulted in the resident's death and was resolved at near policy limits.
- Average total paid for pressure ulcers doubled in the 2014 dataset and involved nine claims. Seven of the nine closed claims involved the resident's death. The 2012 dataset had 11 closed claims alleging pressure ulcers, and three of them involved the resident's death.
- Elopement remains one of the highest average total paid allegations in both datasets. (Additional elopement discussion can be found on page 39.)

Injuries

18 INJURIES AT CONTINUING CARE RETIREMENT COMMUNITIES

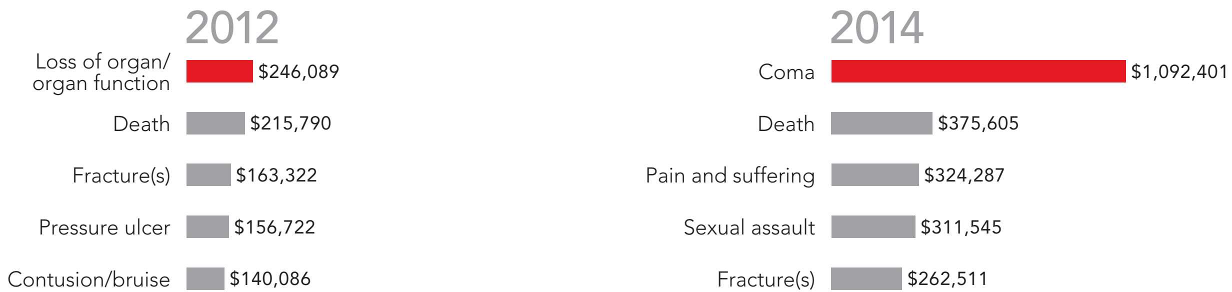
Highest Frequency Closed Claims



The CCRC findings demonstrated death and fracture were the most frequent injuries.

19 INJURIES AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Average Total Paid for Closed Claims



Only death and fractures are included among the highest average total paid in both datasets. In the 2014 dataset, coma reflects a single closed claim.

Skilled Nursing Unit Case Scenario: Resident Fall

Summary of Facts and Injury

An 80-year-old man suffering from Parkinson's disease and mild dementia was admitted for short-term rehabilitation to the CCRC's skilled care unit. In view of his high risk for falls, his care plan included use of a wheelchair when not in physical therapy, staff assistance for transfers, staff attendance while in the bathroom and a call bell within his reach at all times.

On the day of the fall, the certified nursing assistant had completed the resident's daily care and wheeled him to his bathroom so he could attend to his grooming needs. Despite the care plan's instructions, the certified nursing assistant did not remain in the bathroom with the resident. Instead, she chose to remove soiled linens and was further distracted by another resident's call for assistance. She returned to find the resident on the floor, and the call bell was out of reach.

The resident suffered a femoral fracture and was transferred to the hospital for surgical repair. One week after surgery, the resident returned to the CCRC skilled unit for physical therapy and rehabilitation. He had declined significantly during the hospital stay, and was experiencing confusion, as well as stiffness and rigidity of his extremities. His admission care plan included use of a wheelchair at all times when out of bed, use of bed and wheelchair fall alarms, help with all personal care needs and two-person transfer assistance. Despite provision of nursing and rehabilitation care, the resident continued to decline rapidly. Three weeks later, he developed a urinary tract infection, septic shock and hypotension. He was discharged to the hospital, but did not respond to treatment. The family consented to a Do Not Resuscitate order, and the resident died shortly thereafter.

Allegations

The family sued multiple parties. Allegations against the CCRC included negligent hiring of the certified nursing assistant who had left the resident unattended, negligent nursing supervision and care, and resident abuse. The plaintiffs further sought punitive damages, alleging gross negligence.

Assessment of Risk Exposures

Although this resident's plan was a short-term stay for rehabilitation, he required significant skilled-level nursing staff supervision and care. It is important to note that short-term stays involve residents with all levels of care needs and corresponding levels of risk for injury. This claim demonstrates that very costly claims can and do occur in CCRCs, even for residents planning short-term stays.

Resolution

Given the acknowledged departure from the care plan by the certified nursing assistant and inadequate documentation, the decision was made to settle all claims against the CCRC, with an eventual payment in the high six-figure range.

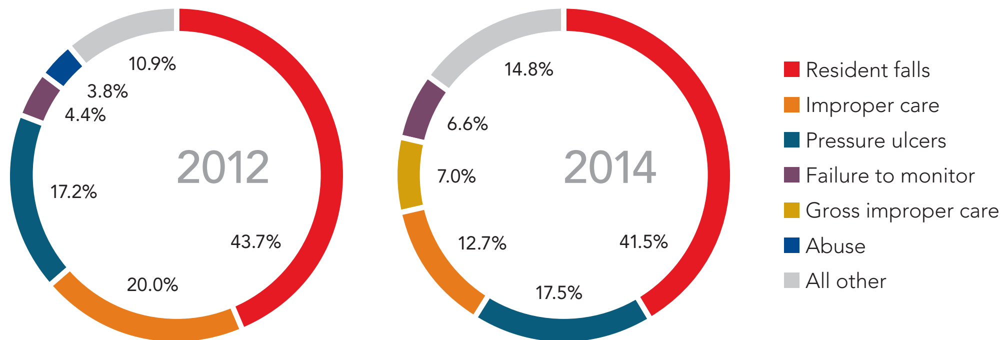
Analysis of Skilled Nursing Facility Closed Claims

- Not-for-profit number of closed claims: 320 closed claims in the 2012 dataset, 229 closed claims in the 2014 dataset.
- For-profit number of closed claims: 919 closed claims in the 2012 dataset, 447 closed claims in the 2014 dataset.
- Not-for-profit average total paid: $219,293 in the 2012 dataset, $190,013 in the 2014 dataset.
- For-profit average total paid: $217,647 in the 2012 dataset, $206,382 in the 2014 dataset.

Allegations

20 ALLEGATIONS AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES

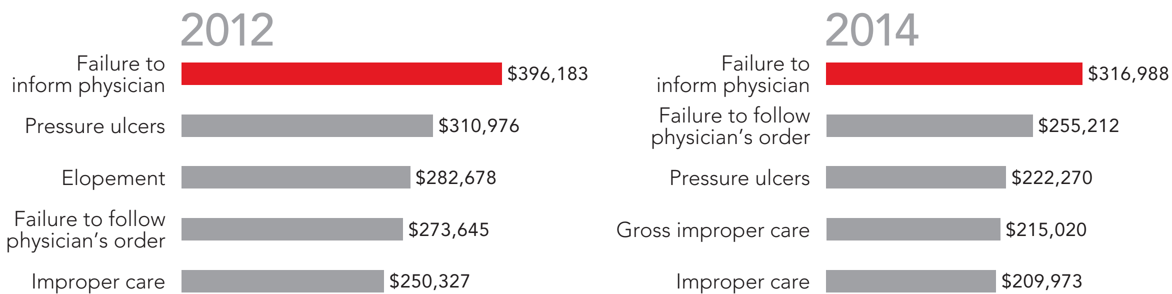
Highest Frequency Closed Claims



Resident falls, improper care and pressure ulcers had the highest percentage of closed claims in both datasets. No other allegations accounted for more than 10 percent of the closed claims.

21 ALLEGATIONS AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES

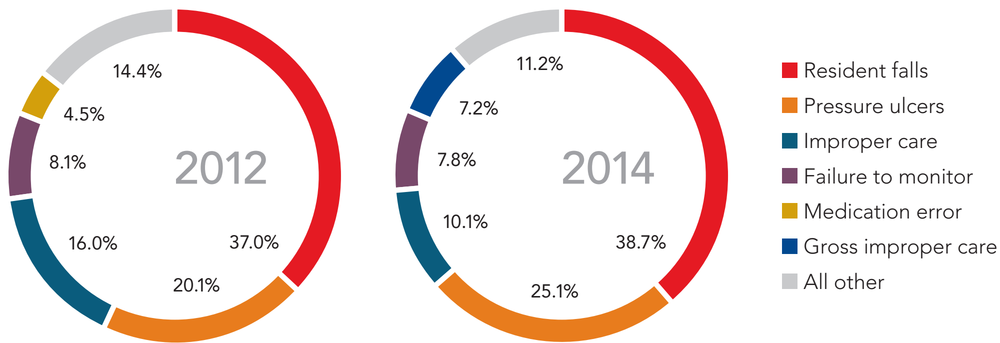
Highest Average Total Paid for Closed Claims



Failure to inform physician, pressure ulcers, failure to follow physician's order and improper care were among the costliest not-for-profit SNF closed claims.

22 ALLEGATIONS AT FOR-PROFIT SKILLED NURSING FACILITIES

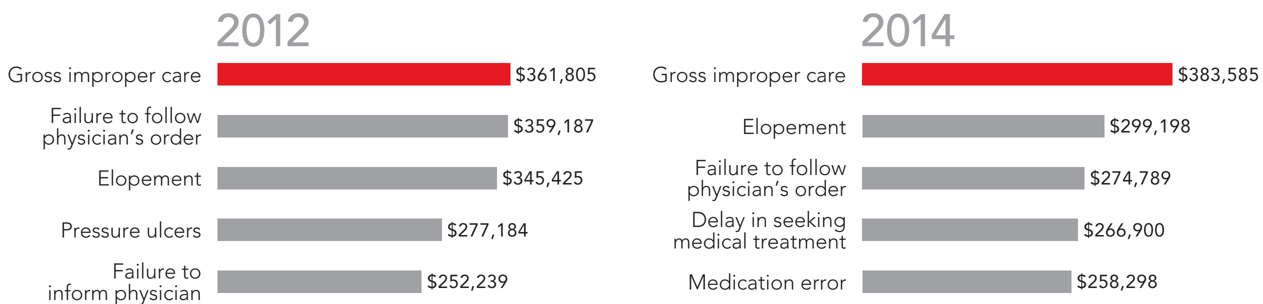
Highest Frequency Closed Claims



Medication error was replaced by gross improper care for the top five allegations in the 2014 dataset.

23 ALLEGATIONS AT FOR-PROFIT SKILLED NURSING FACILITIES

Highest Average Total Paid for Closed Claims



Medication error and delay in seeking medical treatment were replaced in the 2014 dataset by pressure ulcers and failure to inform physician.

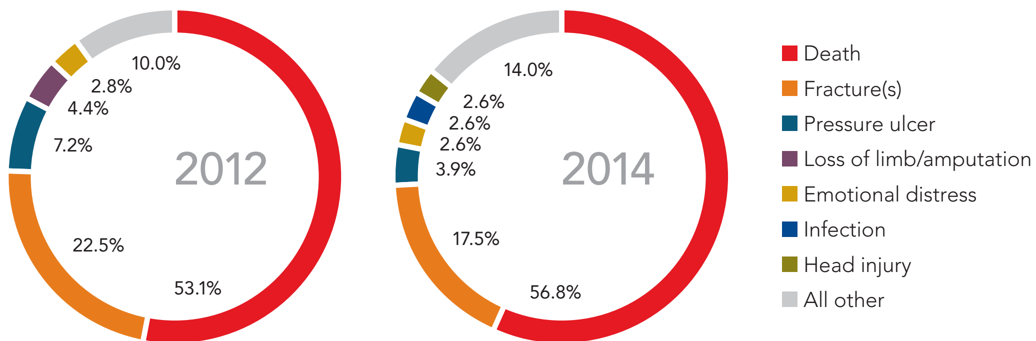
Additional comments:

- The average total paid for elopements decreased in the 2014 dataset as a result of two closed claims where the injuries sustained by the residents resolved with no residual disability.
- In the 2014 dataset, medication error was affected by one medication error closed claim that was resolved at near policy limits while the remaining six medication error closed claims were resolved at far lower amounts.

Injuries

24 INJURIES AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES

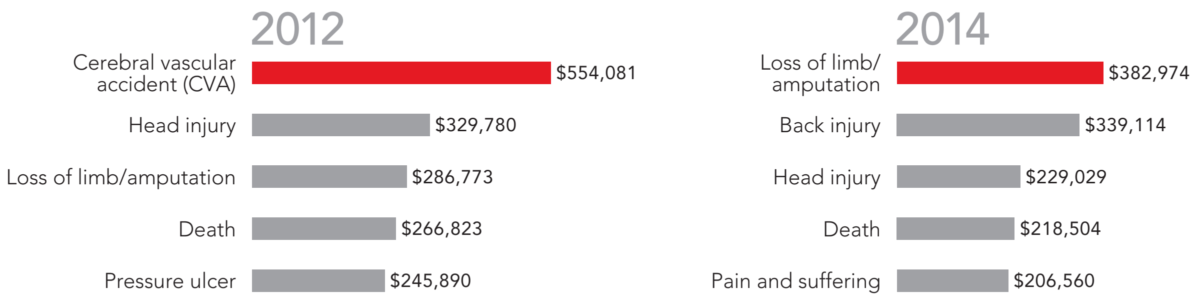
Highest Frequency Closed Claims



Death and fractures comprised approximately 75 percent of the closed claims in both datasets.

25 INJURIES AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES

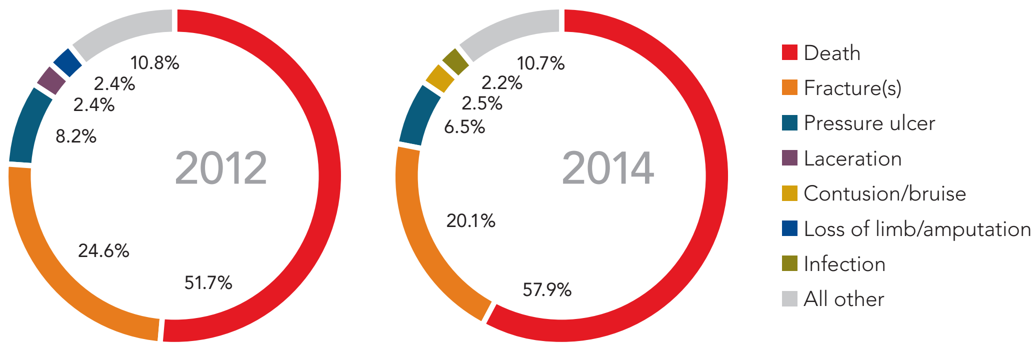
Highest Total Average Paid for Closed Claims



While head injury, loss of limb/amputation and death are among the highest total average paid closed claims for both datasets, their average total paid varied.

26 INJURIES AT FOR-PROFIT SKILLED NURSING FACILITIES

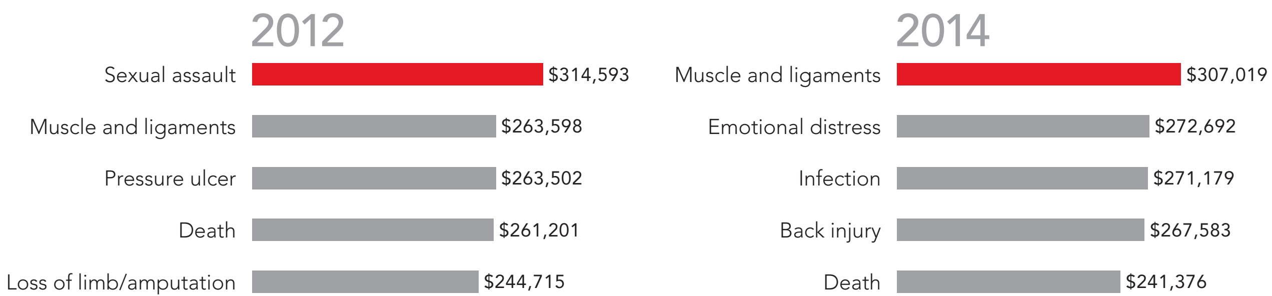
Highest Frequency Closed Claims



Death and fractures had the highest percentage of closed claims in both datasets, as well as for both business segments.

27 INJURIES AT FOR-PROFIT SKILLED NURSING FACILITIES

Highest Average Total Paid for Closed Claims



Only two injury categories, death and muscle and ligaments, were represented in both datasets.

SNF Case Scenario: Pressure Ulcer

Summary of Facts and Injury

The resident was transferred from a hospital, where he had been diagnosed with thoracic and lumbar disease and showed evidence of extensive nerve damage. Because of his known history of substance abuse and malnutrition, the resident was told by the neurosurgeons that he needed to be stabilized at the SNF's short-term rehabilitation unit and examined at the hospital's spine clinic before being scheduled for surgery. Once admitted to the insured's SNF, he rejected efforts to help him maintain a healthy dietary intake and refused physical therapy, as well as exercise regimes for range of motion, turning and movement. The SNF repeatedly notified the physicians of the resident's noncompliance and resultant continuing decline.

A pattern ensued, in which the resident would be seen once a month in the hospital's spine clinic, would unsuccessfully request a surgical intervention and be returned to the SNF. He declined severely, was no longer ambulatory and remained noncompliant with physical therapy and nutritional recommendations, despite well-documented efforts on the part of the SNF staff.

The resident complained of chest pain and shortness of breath, and developed contractures and foul-smelling sacral pressure ulcers. He then underwent four subsequent hospitalizations, each in a different facility, and was readmitted to the SNF between each admission. Over the course of these hospitalizations, he was diagnosed and treated for infected wounds, sepsis, rhabdomyelosis, muscle necrosis, MRSA, bacteremia, meningitis and malnutrition. He developed four Stage II gluteal pressure ulcers, a gangrenous Stage III pressure ulcer of his right heel, and Stage II pressure ulcers of his right foot and leg. He subsequently underwent a right above-the-knee amputation. Afterward, he was transferred to another SNF, where he continued to receive treatment.

Allegations

The resident sued multiple parties, alleging deviation from acceptable standards of care. The initial hospital was alleged to have denied the resident/patient appropriate surgical treatment of his spinal condition because of his lack of insurance – a highly inflammatory allegation that may greatly influence a jury. The specific allegations against the SNF were failure to diagnose, properly prevent and treat his pressure ulcers, resulting in his right above-the-knee amputation.

Assessment of Risk Exposures

One of the plaintiff's own experts indicated that the resident's ultimate decline was a result of the first hospital's failure to provide the resident/patient an immediate surgical intervention when he originally presented with symptoms and the MRI diagnosis of spinal disease was rendered.

Defense experts strongly defended the SNF's care and treatment of the resident. The experts opined that, given the resident's persistent and well-documented noncompliance, his pressure ulcers were unavoidable. Although most documentation was adequate, portions of the record could not be located, which seriously limited legal defense options. Defense counsel believed there would be significant jury sympathy for the resident and the decision was made to attempt to settle the claim on behalf of the SNF.

Resolution

The claim was resolved for a settlement in the mid-six-figure range.

2014 Dataset Analysis of Short-term-stay Closed Claims

Short-term-stay admissions for physical rehabilitation services have become more frequent in aging services facilities, due in part to the higher reimbursement stream for these stays. As stated in Definitions (page 7), short-term stay refers to admissions where the intent is rehabilitation and planned discharge, rather than extended care. As noted on page 6, the 2014 dataset includes 843 closed claims. On average, short-term-stay closed claims cost 10.4 percent more than long-term-stay closed claims.

28 LENGTH OF STAY (Combined Business Segments)

Short-term-stay closed claims, which accounted for 19.0 percent of closed claims in the 2014 dataset, were costlier on average than long-term-stay closed claims.

Short-term-stay closed claims summary data:

- *Business segment:* 30.0 percent not-for-profit and 70.0 percent for-profit.
- *Type of facility:* 86.9 percent skilled nursing facilities, 8.8 percent continuing care retirement communities and 4.4 percent assisted living facilities.
- *Allegations:* 46.2 percent falls, 16.3 percent pressure ulcers and 12.5 percent improper care.
- *Resident falls:* 40.5 percent were related to failure to monitor and 50.0 percent involved improper care. Also, 68.9 percent occurred in the resident's room.
- *Injuries:* 51.2 percent deaths, 23.8 percent fractures, 5.0 percent muscle and ligaments, and 3.8 percent pressure ulcers.

This consistency of injuries between long-term and short-term closed claims is surprising, given that short-term residents usually are admitted at a higher functional level than long-term residents. Short-term residents present unique risk factors, which should not be underestimated:

- *Short-term residents may have higher expectations* for achieving or surpassing their prior level of functioning.
- *Short-term residents often undergo a variety of therapies,* including pain management, rehabilitation and supportive care following an acute event or surgical procedure.
- *When higher-functioning residents become injured as a result of an untoward or reportable event, they may be more likely to initiate a claim against the facility,* possibly resulting in a larger damage award than a claim by a resident who was significantly compromised prior to admission.
- *Short-term residents (including seniors) are more likely to be employed,* and lost wages may be added to total damages.
- *While the reimbursement rate for short-term Medicare residents is higher,* the severity of their claims also tends to be higher.

Suggested actions:

The following suggestions supplement the basic preventive measures and suggestions noted in the "Resident Falls" section on page 38.

- *Provide special training for staff* regarding factors that are likely to place short-term residents at risk for significant injuries.
- *Ensure that care plans take into consideration specific risk factors* associated with short-term stays.
- *Emphasize to staff the need to monitor residents according to the care plan,* especially in resident rooms.

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

Eighteen claims from the two datasets were resolved with an indemnity payment of $1 million or more. (Note that – as stated in the "Datasets and Methodology" section on page 6 – while primary policy limits for aging services facilities are typically $1 million, some insureds purchase excess coverage from CNA, creating the potential for total indemnity payments greater than $1 million.)

Analysis demonstrated that for-profit insureds had a higher percentage of these claims. Furthermore, skilled nursing facilities represented over half of all the highest-severity closed claims. It also should be noted that CCRCs experienced a disproportionate share of the highest-severity closed claims.

The most frequent allegations among the highest-severity closed claims were pressure ulcers, gross improper care and elopement, and the most frequent injuries were death and pressure ulcer. Claims with the highest paid indemnity often involved failure to comply with facility policies and procedures, missing or altered documentation, and/or suspected staff improprieties. These actions or failures to act rendered the claims difficult to defend successfully. Chart 29 provides a summary of the highest-severity closed claims.

29 SUMMARY OF CLOSED CLAIMS with a Minimum Indemnity Payment of $1 Million

Summary	Allegation	Injury	Type of facility/ business segment	Location by state
1. The resident died as a result of burns sustained when she was smoking without appropriate supervision and set her chair on fire.	Failure to monitor	Death	ALF/ for-profit	Nevada
2. The overall care of the resident met criteria for gross improper care, including citations by the state regulatory agency for several areas of noncompliance, such as the administrator's lack of proper licensing. Ultimately, the resident eloped and died due to exposure to extreme weather.	Gross improper care	Death	ALF/ for-profit	Nevada
3. The resident sustained a fracture of unknown origin, and the jury accepted the plaintiff's assertion that the facility concealed the fact that a staff member had dropped the resident. Believing the facility to have engaged in a cover-up, the jury awarded the plaintiff a seven-figure judgment.	Gross improper care	Fracture(s)	CCRC (SNF)/ for-profit	Kentucky
4. A delayed diagnosis and treatment of a hip fracture resulted in an infected and ultimately fatal hematoma, which timely intervention could have prevented. The hematoma was not reported to facility leadership for eight days, despite family complaints that the resident was in pain. Missing documentation rendered the claim indefensible.	Gross improper care	Death	CCRC (SNF)/ not-for-profit	Kentucky
5. Improper management of the resident's pressure ulcers resulted in severe infection and multi-system organ failure. The resident was subsequently hospitalized and died of sepsis.	Pressure ulcers	Death	CCRC (SNF)/ for-profit	California
6. The resident had not been seen during 4:00 a.m. rounds on the Alzheimer Care Unit, but was not reported as missing. The resident was later found severely injured on facility grounds, and subsequently died of intracranial bleeding. The investigation also revealed that the administrator was not properly licensed.	Elopement	Death	CCRC (ALF)/ for-profit	Oklahoma
7. A resident known to be experiencing increased confusion left her unit unescorted. She subsequently fell down an easily accessible stairwell in her wheelchair and died from her injuries. The resident had been administered a sedative that the family had earlier requested not be given, and the medication was deemed by experts to have contributed to the resident's fatal fall.	Elopement	Death	CCRC (SNF)/ not-for-profit	Oklahoma
8. A resident with no prior history of wandering behavior was transferred from an assisted living unit to the SNF unit for rehabilitation following hip surgery. She eloped from the SNF unit in freezing weather for an undetermined time and died of hypothermia.	Elopement	Death	CCRC (SNF)/ not-for-profit	Washington
9. The facility failed to obtain appropriate transfer orders/ information from the hospital upon admission, resulting in incorrect administration of antibiotics. This led to worsening osteoporosis and eventual paraplegia.	Improper care	Paralysis	SNF/ not-for-profit	New Jersey

Summary	Allegation	Injury	Type of facility/ business segment	Location by state
10. The resident was found on the floor with multiple facial fractures and heavy facial and scalp bleeding. The resident's bed alarm was not functioning, and there was evidence of improper actions by the administrator to hide the facts of the incident, making the claim indefensible.	Resident falls – failure to monitor	Death	SNF/ for-profit	West Virginia
11. Staff diverted the resident's pain medication, due to inadequate staff supervision. Other facility policies and procedures also were disregarded, including staff training and communication requirements.	Gross improper care	Death	SNF/ not-for-profit	Michigan
12. Nursing staff failed to properly manage pressure ulcers, resulting in their rapid enlargement and infection, which ultimately led to the resident's death. In addition, staff failed to follow the facility's skin care policies and procedures, and to properly document care given.	Pressure ulcers	Death	SNF/ for-profit	Illinois
13. The resident suffered bowel impaction for several days and was unable to eat, resulting in malnutrition that contributed to his death. The resident's healthcare information records were altered, making it impossible to follow the chronology of care and rendering the claim indefensible.	Gross improper care	Death	SNF/ for-profit	California
14. The resident alleged improper wound care with worsening of wounds, development of new wounds, maggot infestation and infection, resulting in amputation of the resident's leg. Questions regarding appropriateness of staffing, as well as, improper and inadequate documentation further hampered the legal defense.	Pressure ulcers	Pressure ulcer	SNF/ for-profit	California
15. The family of a resident who suffered multiple pressure ulcers complained to the physician, who upon examining the resident, immediately admitted her to the hospital, where she died from Stage IV pressure ulcers, infection and sepsis. The facility was cited by both state and federal regulatory agencies for lack of documentation and failure to follow facility policies and procedures.	Pressure ulcers	Death	SNF/ for-profit	Wisconsin
16. The resident was a child with severe developmental disabilities and extensive care needs who fell down a laundry chute, was asphyxiated and died. More than three hours elapsed before the child was found.	Resident falls – unsafe environment	Death	SNF/ not-for-profit	New York
17. As a result of the facility's failure to carry out the physician's specific wound care orders, the resident's pressure ulcers advanced from Stage II to Stage IV, resulting in muscle and bone death, infection and sepsis. The state Department of Health and Human Services performed an investigation and issued its highest adverse citation.	Failure to follow physician's order	Pressure ulcer	SNF/ for-profit	California
18. The resident was admitted for rehabilitation following hospital care. His leg wounds had healed when he was transferred to the SNF, but an alleged failure to provide proper wound care resulted in a Stage IV leg wound after less than two weeks at the facility. He was transferred back to the hospital and died of urosepsis.	Pressure ulcers	Death	SNF/ not-for-profit	Minnesota

Success Story: Appropriate Resident Care and Strong Documentation Create a Win…

Summary of Facts

The resident was admitted to the insured's SNF for rehabilitation and continued anticoagulation treatment following a total hip replacement. The Coumadin dosage was to be managed by the resident's primary care physician. Upon admission to the SNF, the resident's INR (i.e., time required for blood to clot) was reported as being lower than the surgeon's listed target range. Nursing staff notified the resident's primary care physician, who increased the Coumadin dose and ordered that her INR level be checked again in one week. Further changes in Coumadin levels and dosage were subsequently ordered by the primary care physician, carried out by the nursing staff and appropriately documented in the resident's record.

At the first follow-up visit, the surgeon documented that she was doing well, but noted a small open area in her surgical incision with minimal drainage. Several days later, the nursing staff noticed increased wound drainage and the presence of hard tissue in the surgical wound site, and notified the surgeon. The surgeon agreed to see the resident in his office the following day. At that point, despite increasing drainage, the surgeon discharged her from his office to the SNF. Within one week, the resident was readmitted to the hospital with an infection that required two additional operations and an extended hospital stay.

Allegations

Multiple defendants were named in the lawsuit. Specific allegations against the SNF included improper Coumadin treatment and failure to test the resident's INR level at appropriate intervals. It was alleged that these actions caused infection of her wound site, thus necessitating additional surgery to remove the hip prosthesis so the infection could heal, as well as yet another operation for revision and placement of a second hip prosthesis.

Assessment of Risk Exposures

Supportive expert reviews were obtained from a gerontologist, wound care nurse and gerontological nurse with experience in evaluating nursing home care. They determined that:

- The standard of care was consistently met.
- The staff carried out physician orders precisely as given.
- Staff appropriately identified and monitored the resident's risks for bleeding and wound infection.
- All findings, both normal and potentially abnormal, were appropriately documented and timely reported to the resident's physicians.

Resolution

Given the positive expert reviews, adherence to the standard of care by SNF staff and strong resident record documentation, defense counsel was successful in having the SNF dismissed from the claim with no indemnity payment.

PART THREE A CLOSER LOOK AT ONGOING CHALLENGES

The aging services industry, like all healthcare sectors, faces ongoing challenges in providing high quality, cost-effective services. Following a quick review of some core risk management recommendations applicable to aging services organizations, Part Three focuses on lessons learned from analysis of the two datasets.

Parts Three and Five are not intended to be comprehensive risk management guidelines. CNA and professional organizations have published a wide variety of materials discussing various resident care issues and related risk management recommendations. It is strongly recommended that professionals who are new to the aging services industry and/or resident care, risk management, quality assessment and/or performance improvement (QAPI) refer to publications that describe in detail sound resident care and risk management practices.

The following basic risk management recommendations are broadly applicable to resident care settings:

- *Obtain pre-admission assessments and information,* and include them in the resident's healthcare information record whenever feasible.
- *Complete and document nursing and multidisciplinary team assessments immediately upon admission,* and repeat them in compliance with the organization's policies and procedures.
- *Ensure that initial and revised care or service plans clearly reflect multidisciplinary team assessments,* as well as other available information.
- *Perform follow-up assessments at regular intervals* and following any adverse event or identified change in the resident's condition, in compliance with regulatory requirements and organizational policies and procedures.
- *Update care and service plans* based upon these follow-up assessments.
- *Include family and primary care providers in the resident assessment process,* and instruct staff to communicate with them regarding any change in the care or service plan, or following any adverse and/or reportable event.

The following discussions and suggested actions are intended to augment basic aspects of resident care.

Employee Retention and Accountability

Hallmarks of a high-performing aging services organization include exceptional employee loyalty and above-average retention rates. The organizations that do well in these areas balance accountability with an ethic of caring about employees as individuals and demonstrating fairness and mutual respect. Accountability, in turn, requires clear communication of policies and expectations, while ensuring that staff members have the skills and knowledge required to perform assignments. In any setting, treating staff with concern, dignity and empathy increases the likelihood of them engaging with the organization to successfully meet its goals. On the other hand, disgruntled employees may adversely influence morale, hinder quality improvement efforts and even testify against organizations during depositions or at trial.

Suggested actions:

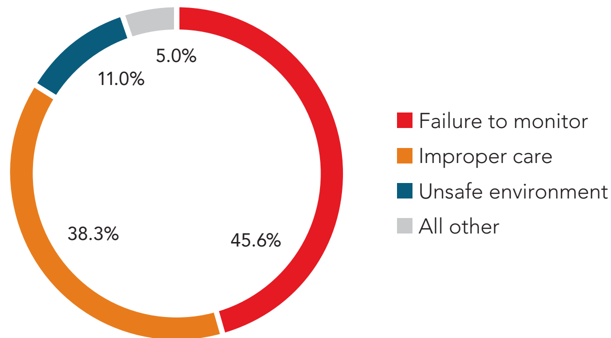
- *Reinforce the importance of earning employee loyalty* among supervisory personnel.
- *Provide a regularly scheduled, objective system for communicating with employees* regarding their performance.
- *Demonstrate appreciation for staff who provide quality resident care on a daily basis,* and openly support employees who "go the extra mile."
- *Continuously emphasize the need to follow resident care/service plans,* as well as organizational policies and procedures.
- *Identify successful quality improvement efforts,* whether they are developed by industry leaders or suggested by employees.
- *Implement innovative ideas* suitable to the organization, and demonstrating support for employees who take initiative in improving resident care.

Resident Falls

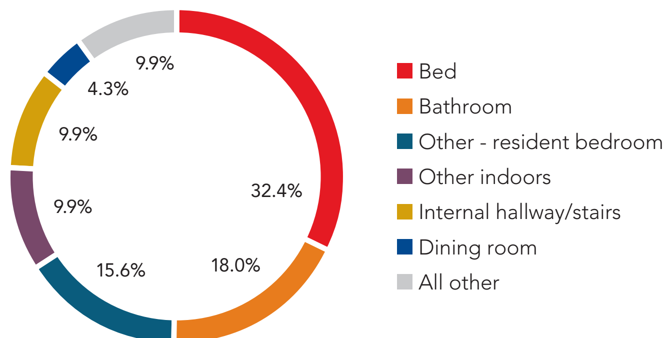
Resident falls continue to be the most common allegation in aging services claims. While zero falls may not be an achievable goal, decreasing resident falls and mitigating the severity of fall-related injuries remain essential to quality improvement and risk management.

The following charts combine all 991 closed claims where the allegation was resident fall. These allegations were extracted from both the 2012 and 2014 datasets.

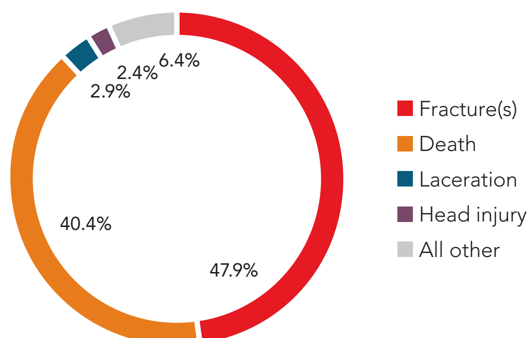
30 ALLEGATIONS ASSOCIATED WITH RESIDENT FALLS



31 LOCATION OF RESIDENT FALLS BY LOCATION



32 INJURIES ASSOCIATED WITH RESIDENT FALLS



Resident falls summary:

- 45.6 percent are associated with failure to monitor.
- 66.0 percent occurred in the resident's room or bathroom.
- 40.4 percent resulted in death.
- Many of the claims note that a resident was left unattended, although the care plan documented the requirement for one-on-one assistance with specific activities.

Suggested actions:

- *Focus fall prevention programs and care plans on the locations of greatest risk,* i.e., bedside, bathrooms and other areas of the resident's room.
- *Equip caregivers with communication devices that permit them to immediately access the resident's care plan,* and also to contact other team members to help with multiple simultaneous resident calls for assistance.
- *Ensure that the team works together effectively to provide one-on-one assistance as established in the care plan,* even when more than one resident is calling for help or attention. This involves planning ahead to provide appropriate staffing levels.
- *Strengthen team functioning* by helping nurses and certified nursing assistants develop critical thinking and communication skills.
- *Include certified nursing assistants in resident care planning,* in order to benefit from their unique knowledge of residents and families.

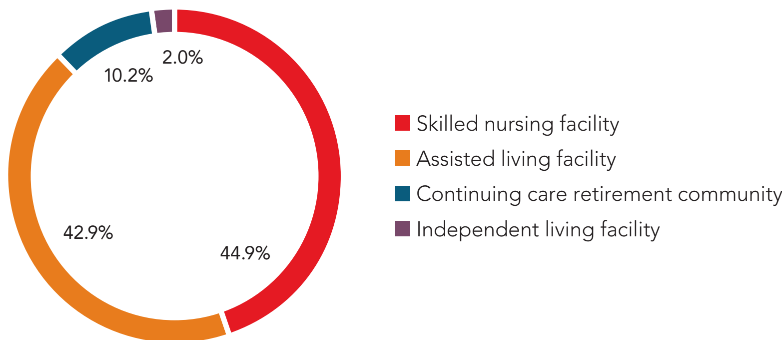
Minimizing Other Serious Events

While no event can be categorized as totally avoidable, the *target goal* for certain events – including resident elopement, abuse, medication errors, and dehydration or malnutrition – should be zero. At the very least, policies and procedures, staffing levels, skill sets and available equipment should be adequate to reduce the potential for these events. In the long run, minimizing resident injury and maintaining appropriate staffing levels is far less costly to the organization's reputation, morale and cash flow than experiencing a lawsuit.

Resident Elopement

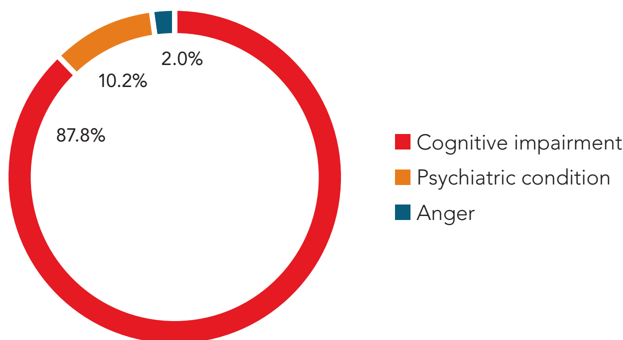
The combined datasets revealed that there were 49 closed claims associated with resident elopement.

33 TYPE OF FACILITY ASSOCIATED WITH RESIDENT ELOPEMENT



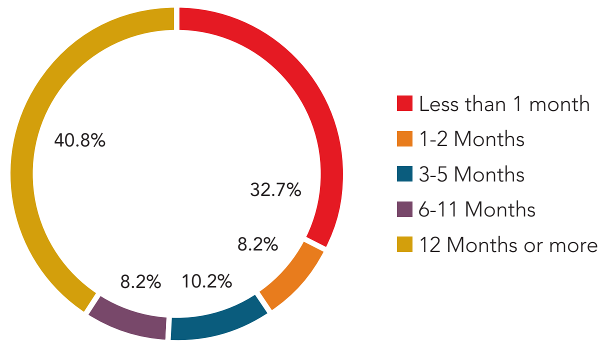
Elopements were primarily from skilled nursing facilities (22 closed claims) and assisted living facilities (21 closed claims).

34 FACTORS ASSOCIATED WITH RESIDENT ELOPEMENT



Cognitive impairment was considered a contributing factor in 43 of the 49 claims.

35 LENGTH OF TIME FROM ADMISSION TO ELOPEMENT



Most elopements occur in the first month after admission and at or after 12 months.

Suggested actions:

- *Monitor residents closely during the first month after admission.*
- *Establish a process to account for every resident by name at every level of service* (including independent living), and ensure that the process is followed consistently.
- *Consider investing in new technology* designed for more effective and less intrusive surveillance of residents who tend to wander.[1]

1 See Rajecki, R. "Newer Tech for Elopement Prevention, Wander Management Keeps Residents Safe, Provides Sense of Freedom." *Long-Term Living,* posted June 2, 2014. Available at **http://www.ltlmagazine.com/article/safe-and-sound**.

Resident Abuse

For purposes of this report, resident abuse encompasses all forms of mistreatment, including verbal, physical, emotional, sexual and financial. The combined datasets include 97 closed claims associated with resident abuse. While the number of closed claims where the primary allegation is resident abuse remained low, it increased from 3.9 percent in the 2012 dataset to 4.3 percent in the 2014 dataset. Of these closed claims, 54 involved employees and 38 involved resident-on-resident abuse. The average total paid for resident abuse closed claims decreased from $188,023 in the 2012 dataset to $186,359 in the 2014 dataset. The following actions can help organizations move toward the target rate of zero tolerance for resident abuse.

Suggested actions:

- *Perform multistate criminal and sexual offender background checks* for prospective employees and residents prior to their employment/admission.
- *Ensure that all staff who come into contact with residents are trained to work with persons with dementia and/or behavioral problems,* especially in terms of detecting and de-escalating agitated, inappropriate or potentially violent behavior.
- *Ensure that care plans address appropriate interventions for residents who are at risk* of either acting in an abusive manner or evoking abusive responses from other residents or staff.
- *Utilize incidents of actual and potential abuse* as lessons learned to improve preventive measures.
- *Prohibit any acts of retaliation* against residents, families or employees who report incidents.

Medication Errors

The percentage of closed claims where medication errors played a significant role in the resident's injury decreased from 4.2 percent to 2.6 percent in the 2014 dataset. This decrease may be a preliminary sign of success in the effort to enhance medication safety. The average total paid of $206,087 in the 2012 dataset was below the average total paid for all closed claims of $211,477. The 2014 dataset decreased to an average total paid of $201,012, which is also below the closed claims average of $211,159. While this progress is encouraging, the data indicate that medication errors remain a source of resident injuries and organizational losses.

Suggested actions:

- *Track and trend medication errors,* utilizing a rolling 12-month calendar.
- *Utilize these data* to implement appropriate systems and staff behavior changes.
- *Monitor the administration of high-risk medications,* including anticoagulant therapy.
- *Avoid mistakes by reading back all telephone orders,* requiring that faxed orders be fully legible and confirming any unclear orders.
- *Check that the ordering practitioner and the administering nurse are well versed in all medications in the organization's formulary,* as well as appropriately prescribed and administered dosages.
- *Ensure that nursing staff have immediate access to medication information* and are able to consult with a pharmacist for questions related to any drug with which they are unfamiliar.
- *Attempt to minimize interruptions* when staff members are preparing and administering medications.

Dehydration and Malnutrition

As every resident has the right to proper hydration and nutrition, failures in this area may result in pain and suffering for the resident. Regulatory sanctions and legal action against the organization may also result. Malnutrition and/or dehydration were a significant factor in many of the closed claims, as inadequate nutrition and hydration have discernible effects on mental status, skin breakdown, wound management and fall prevention. (See the "SNF Case Scenario: Pressure Ulcer" for an example of a resident whose outcome was affected by inadequate nutrition and hydration on page 27.)

Supporting the resident's ongoing hydration and nutrition is integral to the provision of appropriate, safe and compassionate care. Aging services care settings are responsible for monitoring and promptly addressing problems involving eating or drinking.

Suggested actions:

- *Ensure staff possesses proper training* to optimize residents' ability to eat and drink.
- *Proactively address potential barriers to good nutrition,* including general medical and behavioral health conditions, underlying disease, medications, oral and dental factors, nutritional status at admission.
- *Instruct staff to consult with the primary care physician to determine if a resident who requires feeding through artificial means also should be receiving oral liquids/nutrients,* and to document this consultation. The exception is a resident who is totally NPO (i.e., "nothing by mouth"), and could be harmed by oral intake of liquids/nutrients.
- *Honor food preferences* and identify obstacles to eating.
- *Offer appealing beverages at activities* and throughout the day.
- *Encourage residents to eat at the time of day they are most oriented* and least distracted.
- *Stimulate appetite and the sense of smell* by baking and preparing food with residents.[2]

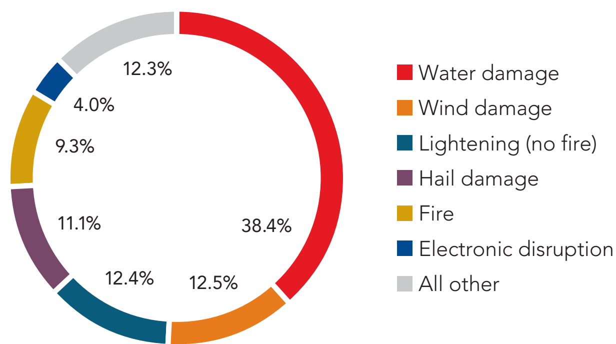
2 See the Alzheimer's Association Campaign for Quality Residential Care's *Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes,* 2009. Available at **http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf**.

Because risks are interconnected, this report includes commercial and cyber risk exposures. Comments regarding the growing number and severity of auto claims for aging services organizations are discussed on page 49. Our goal is to encourage aging services healthcare leaders to adopt a strategic, enterprise-wide perspective on assessing and managing risk.

Commercial Risk Exposures

The following analysis is based on 1,215 claims related to commercial risk exposures that closed between January 1, 2009 and December 31, 2013, and which resulted in a minimum CNA indemnity payment of $5,000. These claims are covered by one or more of CNA's aging services insurance policies, including combined/package (i.e., professional, general, property, auto/fleet, crime and inland marine liability coverages), auto/fleet and/or cyber liability coverage.

36 PROPERTY AND CASUALTY CAUSE OF LOSS with the Highest Percentage of Closed Claims



The top five types of incidents – damage from water, wind, lightning (no fire), hail damage and fire – comprised 83.7 percent of the closed property and casualty claims.

37 PROPERTY AND CASUALTY CAUSE OF LOSS

Average Total Paid for Closed Claims at or Exceeding Overall Total Average Paid of $86,376

Cause of loss	Average paid indemnity	Average paid expenses	Average total paid
Explosion	$784,724	$85,504	$870,228
Fire	$263,388	$5,693	$269,082
Hail damage	$156,899	$4,089	$160,988
Slip/trip	$76,250	$28,959	$105,209
Wind damage	$93,915	$3,065	$96,979
Overall average paid	$83,901	$2,475	$86,376

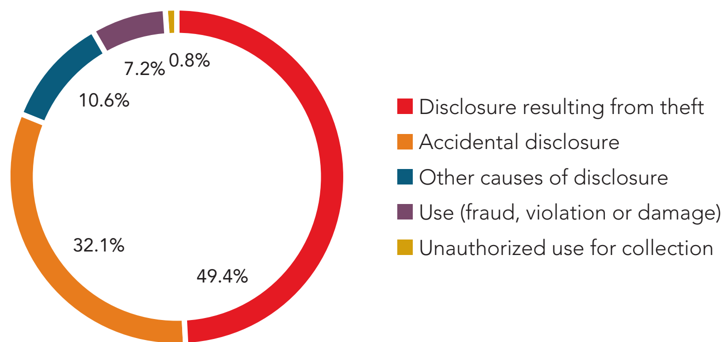
The **overall average** total paid for aging services property and casualty closed claims was **$86,376**. **Fire and hail damage** are in the **top five** for both frequency and severity. The high average total paid for explosions is driven by one large closed claim.

Cyber Risk Exposures

The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) aims to provide patients with appropriate and coordinated care through the use of electronic medical records that can be shared amongst institutions. By encouraging implementation of electronic health record systems, the law has significantly increased the volume of patient data compiled by healthcare institutions – data that must be secured against unauthorized use or release. In addition, the HIPAA Final Omnibus Rule, issued in 2013 and promulgated pursuant to this legislation, broadens the privacy and confidentiality requirements for contractors providing services to healthcare organizations. (A related concern is discoverability of electronic medical records, as discussed in the "Issues That Should Be on Your Radar" section, which follows.)

The Ponemon Institute conducted a recent examination of healthcare cyber security, which found that 90 percent of the 91 surveyed organizations had experienced a data breach in the past year, primarily due to lost or stolen electronic devices and employee mistakes. In addition, hacking-related incidents had doubled from 20 to 40 percent over the past four years. The costs associated with these violations averaged $188 per compromised patient record, with total costs ranging from a few thousand dollars into the millions.[3]

38 CNA HEALTHCARE DATA BREACH EVENTS



Disclosure resulting from theft had the highest percentage of CNA healthcare data breach events.

Of all the industries for which CNA provides cyber liability insurance, the healthcare industry has experienced the highest frequency of claim activity, representing 23 percent of the total CNA data breach claims occurring between 2003 and 2013. However, as the majority of CNA cyber-related claims remain open as of the date of this publication, reliable severity data are not available. One aspect of cyber risk exposures that should be emphasized is potential disclosure of protected health information by vendors. Even in cases where the vendor is totally at fault, the healthcare organization may suffer reputational harm. This exposure underscores the vital importance of selecting reputable, dependable IT systems and vendors.

3 The Ponemon Institute's fourth annual "Patient Privacy & Data Security Study" can be accessed at **http://healthitsecurity.com/2014/03/12/human-error-tops-ponemon-patient-data-security-study-threats/**.

PART FIVE ISSUES THAT SHOULD BE ON YOUR RADAR

The following comments address topics relevant to leaders in aging services. For the most part, they involve emerging issues that are not reflected in the claims data.

Readmissions to Acute Care

It is becoming essential for aging services organizations to effectively collaborate with acute care hospitals to decrease hospital readmissions, in order to reduce the stress of hospital transfers experienced by residents and to minimize potential sanctions for hospitals. Leadership can collaborate in establishing safe guidelines for managing chronic and higher severity conditions and mitigating associated risks. By building constructive, mutually beneficial working relationships with hospitals, aging services providers will be in a better position later to compete for participation in joint ventures and other models of care resulting from the Affordable Care Act (ACA).

Suggested actions:

- *Initiate meetings to establish and maintain open lines of communication* between the organization and hospital regarding readmissions.
- *Discuss options for real-time consultation with hospital staff* to help manage residents who are experiencing problems related to recent admissions or acute episodes of chronic conditions.
- *Address risk exposures related to consultations*, whether they are on-site, over the telephone, or via Skype or other remote visual systems.

Quality Assessment and Performance Improvement (QAPI)

On June 7, 2013, the Centers for Medicare & Medicaid Services (CMS) announced that certain provisions in the ACA would be applied to nursing homes, to enhance accountability for resident quality of care and quality of life. CMS has since produced QAPI tools and resources for SNFs, and is currently developing rules and surveyor guidance to enforce the requirement that facilities have a QAPI program. As of the publication of this document, no date has been set for the release of these documents.

Many SNFs may find the task of creating and implementing a QAPI program challenging, for reasons ranging from insufficient human and IT resources to a resistant organizational culture. However, the potential risks of not implementing a QAPI program are significant, as organizations may be subject to receiving deficiencies in their CMS certification survey and may be cited for Immediate Jeopardy. (See **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf**.)

Suggested actions:

- *Ensure that the organization's strategic plan includes initiation of a QAPI program*, and budget accordingly.
- *Use available state-specific quality improvement organizations* to assist in planning and implementing a QAPI program.
- *Access information from professional societies* and other reliable sources.

Auto Accidents

Driving hazards have become a major risk exposure in terms of both frequency and severity for many aging services organizations. Until recently, CNA had experienced only one aging services auto claim with a $1 million indemnity payment. However, as of this writing, there are three claims pending against CNA insureds that are expected to reach or exceed $1 million. This growing frequency and severity of claims, along with the potential for serious resident and staff injuries, means that organizations must focus attention and devote necessary resources to their auto and fleet safety programs.

Distracted driving has emerged as an especially critical issue. According to the National Safety Council, cell phone use is involved in 26 percent of all vehicle crashes. It is important to note that it is the *conversation itself,* more than the physical act of holding a cell phone, that often contributes to accidents. In addition, the National Highway Transportation Safety Association found that drivers who text while driving are 23 times more likely to be involved in an accident.

Under the doctrine of vicarious liability, employers may be held legally accountable for the negligent acts committed by employees during the course of their employment. Employers also may be found negligent if they fail to implement auto and fleet safety policies and procedures including a policy for the safe use of cell phones while driving.

Suggested actions:

- *Enhance overall auto and fleet safety* by:
  - Strengthening applicable policies and procedures.
  - Taking immediate action following accidents to identify, analyze and address the underlying safety issues.
  - Creating educational programs for all staff members who drive on company business.
  - Discussing specific auto claims made against the organization, identifying the extent of the problem within the overall organization, and developing, adopting and revising safety policies and procedures as needed.
- *Implement a strategy to eliminate distracted driving* by:
  - Developing written policies and procedures, training programs and enforcement mechanisms designed to restrict cell phone use for individuals driving on company business. Many organizations have implemented "no cell phone usage when driving" policies for individuals who drive as part of their employment responsibilities.
  - Restricting use of hands-free headsets, as well as hand-held mobile phones.
  - Ensuring that employees read and sign the written policy regarding distracted driving, and placing the signed form in the employee's human resources file.

E-discovery

Increased use of electronic medical records (EMRs) has important potential ramifications for "e-discovery" in lawsuits. One issue is that EMRs capture and track far more information than is routinely visible to staff who are documenting resident services. In many cases, the printed version of an EMR does not resemble EMR screen views, which are the reference point for healthcare providers. This disconnect makes it potentially difficult and time-consuming to comply with subpoena requests. As a result, major challenges arise when the printed version of the EMR is used in depositions or at trial. Failure to provide information – even when the lapse is unintentional and due to EMR complications – can seriously damage credibility and compromise claim defensibility.

Suggested action:

Include both the virtual and printed EMR in orientation sessions and yearly staff education programs, in order to familiarize staff with resident information in both formats, demonstrate how their electronic entries will look in printed form and reduce e-discovery risk.

Arbitration Agreements

In some venues, the use of arbitration agreements is gaining traction, with many courts becoming more open to upholding these agreements. Overall, this may be good news for the healthcare industry. However, in order to draft enforceable arbitration agreements, it will be essential to remain up-to-date on relevant national and state statutes and regulations, as well as applicable case law.

Suggested actions:

- *Consult with legal counsel on an ongoing basis* regarding relevant case law and statutory developments.
- *Ensure that each arbitration agreement is signed by a resident or representative with power of attorney for healthcare,* and concurrently signed and dated by an authorized representative of the facility, in order to meet the standard of "mutual consent."
- *Anticipate cases where the power of attorney may be contested* as not appropriately representing the resident's wishes and/or best interests.

Security and Workplace Violence

It is crucial to ensure a safe environment for both residents and employees, which entails preparing for potential security breaches. Just as organizations prepare for fires and tornadoes, they also should be ready to manage verbal or physical violence and other potential threats. Recent events in which active shooters have entered healthcare facilities, schools and other public venues underscore the importance of planning ahead. Calm and reasoned discussions with employees regarding security may help allay fears, rather than magnify unspoken concerns.

Suggested actions:

- *Initiate meetings with the local police department to discuss options for responding to an intruder,* up to and including an "active shooter" scenario.
- *Establish policies and procedures for staff to follow in the event of a breach in facility security* or the presence of an armed or unarmed intruder or person threatening violence.
- *Provide training for all employees* on preventing and responding to workplace violence.

Conclusion

CNA and our aging services insureds do best when we collaborate to promote resident safety. We offer this analysis of the most common and costly areas of loss as a roadmap for allocating human and financial resources in the quest to effectively identify and mitigate major sources of risk. The following questions may help focus these risk control efforts:

1. Is your organization committed to providing a compassionate, resident-focused culture of safety?
2. Have sufficient human and technical resources been allocated to ensure quality and safety?
3. Are adequate numbers of appropriately skilled caregivers available to promptly attend to resident needs?
4. Are sound measures in place to protect confidential medical, personal, organizational and financial information?
5. Are you measuring progress toward achieving these goals? And if not now … when?

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Published 10/2014.