Aging Services 2012

DATA ANALYSIS SUPPORTING THE NEED FOR INDUSTRY CHANGE

Death 48.6%

Resident fall 42.1%

Unsafe environment $123,163

Elopement $444,051

Fracture(s) 25.7%

The objectives of this study are to facilitate a better understanding of the risks associated with providing care for the aging population and to provide options for change.

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INTRODUCTION

CNA is pleased to present its seventh study on aging services professional liability claims. This publication is based upon claims that closed between January 1, 2007 and December 31, 2011.

The findings indicate that the allegations with the highest percentage of claims have not significantly changed since the studies published in 2004, 2005, 2007 and 2009. The top allegations in all of these five studies were resident falls and improper care. In the 2007 study, pressure ulcers were introduced as an allegation, and now represent the third most frequent claim, behind resident falls and improper care. Although specific percentages and average payments cannot be compared due to changes in dataset inclusion criteria, it is undeniable that these types of claims are recurrent and ongoing.

Perhaps the more striking revelation is that, according to actuarial forecasts, the number of claims per 1,000 beds *has not decreased over the past 10 years.* The past and current studies demonstrate that resident safety remains an abiding challenge for aging services organizations. The objectives of this study are to facilitate a better understanding of the risks associated with providing care for the aging population and to provide options for change.

Analysis of the data reveals the following key findings:

General Trends (Figures 1, 2, 3)

- Actuarial projections indicate that the frequency of incurred claims has fluctuated between 2.6 and 4.0 claims per thousand beds between 2001 and 2010.
- While both indemnity and expense payments have fluctuated over time, ultimate severity of indemnity and expense payments has trended upward over the past 10 years.

Business Segments (Figure 4)

- Not-for-profit facilities have disproportionately fewer closed claims than for-profit facilities.
- For-profit facilities' higher average total paid reflects a higher average paid expense.

Type of Facility (Figures 9 and 10)

- Skilled nursing facilities have a higher proportion of closed claims relative to the percentage of skilled nursing facility beds in the CNA book of business.
- Skilled nursing facilities have the highest average severity, followed by assisted living facilities.

Allegations (Figure 11)

- The most frequent allegation is resident fall, comprising 42.1 percent of closed claims.
- In general, high-severity allegations – including elopement, failure to follow physician's orders, gross improper care and failure to inform the physician of a change in the resident's condition – are infrequent. The exception is pressure ulcer allegations, which are both frequent and costly.

Injuries (Figures 15, 22a, 22b, 23a, 23b)

- The most frequent injuries are death and fracture. Almost one-half of the closed claims – 48.6 percent – involve death.
- The injury with the highest average severity at not-for-profit skilled nursing facilities is a cerebral vascular accident, while at for-profit skilled nursing facilities, it is muscle and ligament reinjuries during short-term stays. However, in terms of the overall average total paid for injuries, death has the highest average severity.

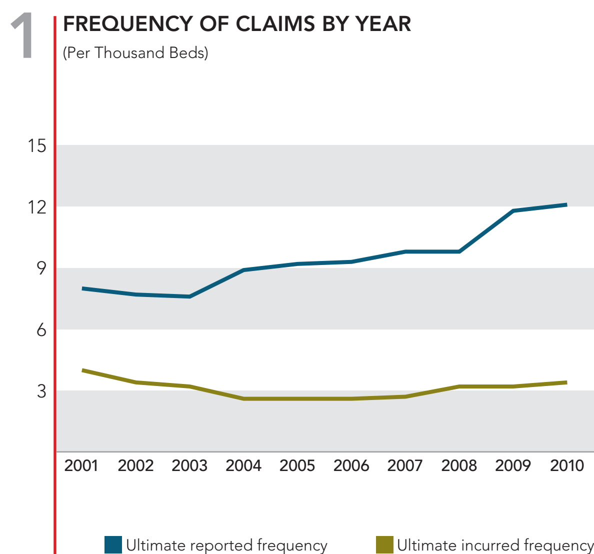
Severity of Closed Claims 2001 to 2010

Inclusion criteria for this study differ from the 2009 CNA aging services claims study. As a result of these changes, the findings from the two datasets do not lend themselves to an "apples to apples" comparison. Therefore this report, unlike past studies, does not contain a comparative analysis section.

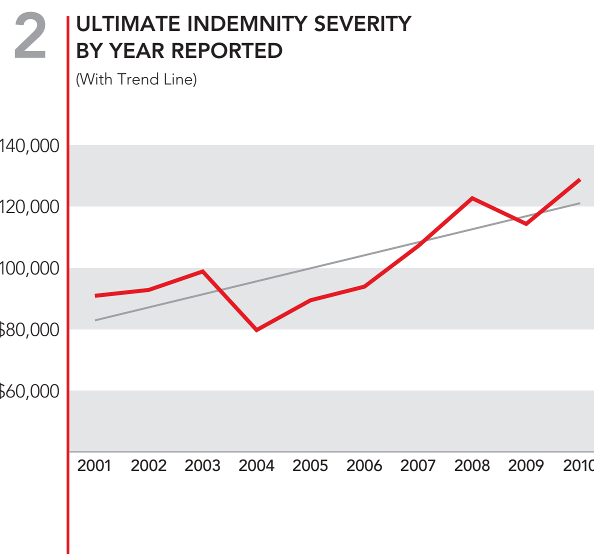
In order to more clearly capture trends in severity, this section uses a specific dataset, featuring a 10-year time frame and no minimum value for claims, which differs from the dataset used in other sections. It excludes clients who have atypical experience, unreliable data reporting or a non-traditional insurance structure. *Reported* claims are all claims reported to CNA, including those claims that result in no payment. *Incurred* claims are only those reported claims that resulted in an indemnity and/or expense payment. Ultimate claim counts and ultimate severity are projected using actuarial methods based upon historical development patterns.

- The ultimate *reported* frequency has increased over the past 10 years from 7.6 claims to 12.1 claims per thousand beds, while the ultimate *incurred* frequency has fluctuated between 2.6 and 4.0 claims. This difference reflects the fact that many reported incidents never develop into claims (see Figure 1).
- Both indemnity and expense payments have fluctuated in terms of ultimate severity. However, ultimate severity has trended upward over the past 10 years (see Figures 2 and 3).

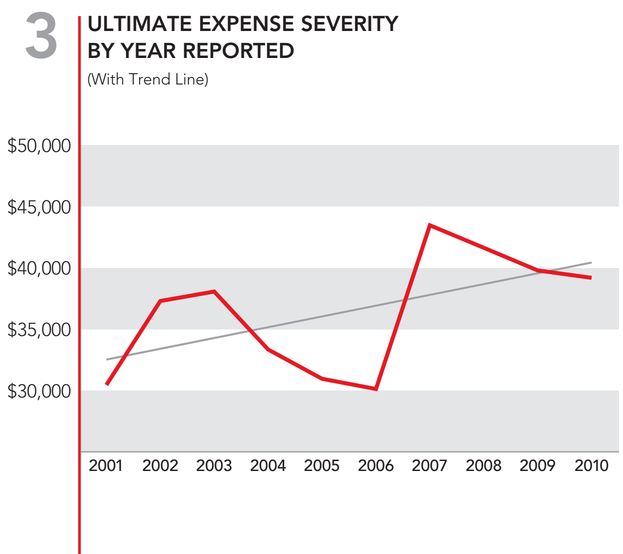
1 FREQUENCY OF CLAIMS BY YEAR
(Per Thousand Beds)



2 ULTIMATE INDEMNITY SEVERITY BY YEAR REPORTED
(With Trend Line)



3 ULTIMATE EXPENSE SEVERITY BY YEAR REPORTED
(With Trend Line)



Dataset and Methodology

The dataset described on page 6 for **Severity of Closed Claims 2001 to 2010** was used by actuaries to forecast reporting and severity trends. However, all remaining sections of this report are based upon a different dataset, consisting of 1,291 aging services claims that closed between January 1, 2007 and December 31, 2011. This second dataset excluded closed claims with an indemnity payment of less than $5,000, as well as claims from adult day care programs, home healthcare providers and accounts with atypical loss distributions. In addition to the 1,291 claims noted above, there were 1,048 aging services closed claims from this period with paid expense but no indemnity payment. Approximately $21.8 million was paid by CNA to defend these claims.

The following inherent limitations to the dataset should be noted:

- The dataset includes 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.
- Policies limit coverage for indemnity payments to $1 million, although judgments made against a defendant may be higher.
- Resolving a professional liability claim may take many years. Therefore, claims included in this report may have arisen from an event that occurred prior to 2007. If a claim closed during the period of the study and satisfied the inclusion criteria, it would be included in this dataset, irrespective of when the incident occurred.
- As previously noted, the inclusion criteria in this study differ from prior CNA aging services claims studies and reports from other sources. Therefore, readers should exercise caution when comparing findings.

The following terms used in the analysis are defined as noted below within the context of this report:

- **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.
- **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 failure to notify a physician of an injury for seven days, administration of wrong medications for 13 days or alteration of resident care records.
- **Improper care** refers to failure to follow established nursing care plan, reasonable standard of care, or organizational policy and procedure.
- **Indemnity payments** are monies paid for the settlement or judgment of a claim by CNA.
- **Expenses** are monies paid by CNA for the investigation, management and/or defense of a claim or lawsuit.
- **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).
- **Length of time to closure** is calculated as the number of months from the date the event was reported to CNA through the date when the claim closed.

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

Aggregated Data Review

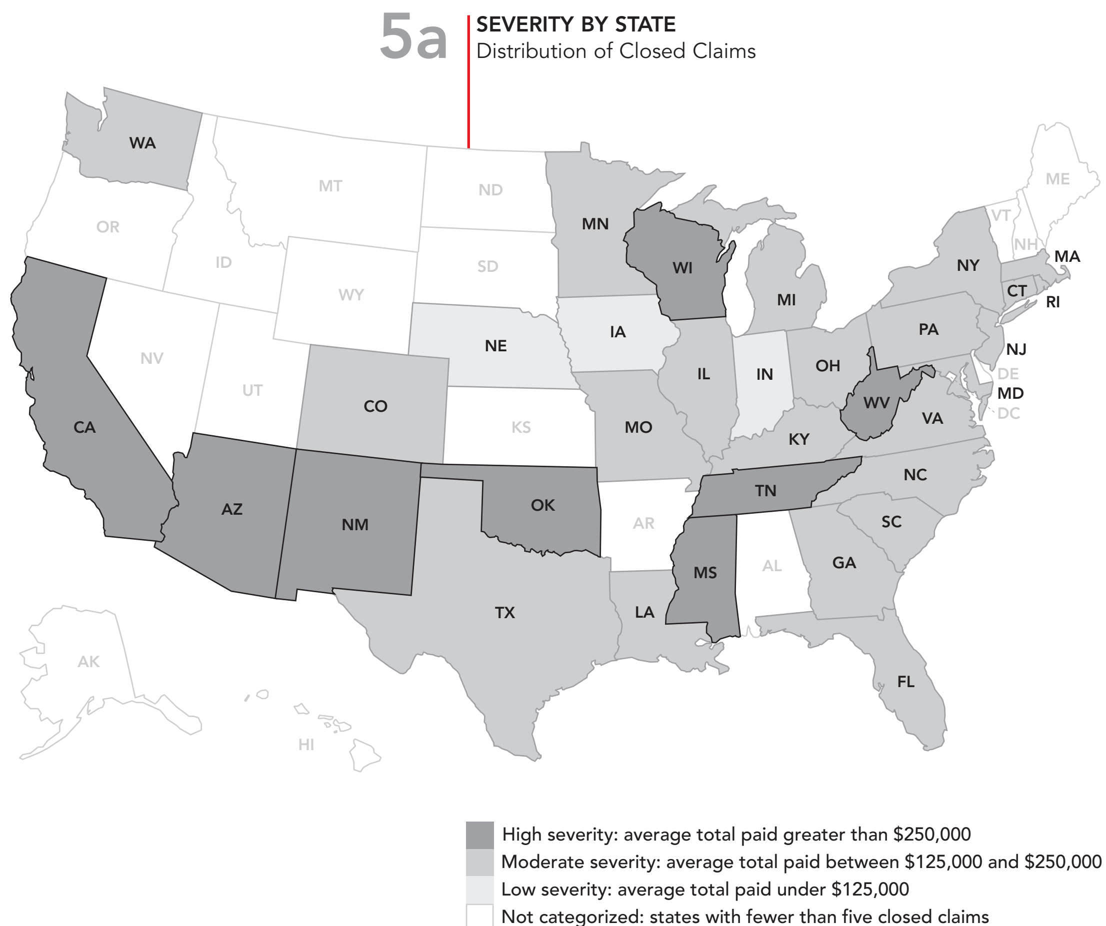
This section provides an overview of the data. Business segments are combined unless otherwise stated in the chart. More detailed information on closed claims associated with each type of facility follows.

Book of Business and Business Segments

- For-profit facilities have a disproportionately high number of closed claims relative to their share of the CNA book of business (see Figure 4).
- The higher average total paid by for-profit facilities primarily reflects higher average paid expenses.

Closed Claims by State

- The number of closed claims and severity in states with fewer closed claims may reflect the CNA book of business more than the litigation environment.
- Only states with five or more closed claims are included in Figure 5b.



4 CLOSED CLAIMS AND INSURED BEDS BY BUSINESS SEGMENT

Business segment	Total number of closed claims	Percentage of insured beds	Percentage of closed claims	Average paid indemnity	Average paid expense	Average total paid
Not-for-profit	409	48.1%	31.7%	$162,767	$38,188	$200,955
For-profit	882	51.9%	68.3%	$166,938	$50,318	$217,256
Total	1,291	100.0%	100.0%	$165,616	$46,475	$212,092

5b CLOSED CLAIMS BY STATE

State	Total number of closed claims	Percentage of closed claims	Percentage of beds	Average total paid	Ranking
NM	23	1.8%	0.6%	$343,479	High
MS	9	0.7%	<0.1%	$321,980	High
OK	11	0.9%	0.9%	$308,683	High
TN	61	4.7%	1.9%	$292,354	High
WV	7	0.5%	0.1%	$278,708	High
WI	17	1.3%	1.3%	$278,099	High
CA	80	6.2%	5.3%	$254,247	High
AZ	16	1.2%	1.1%	$250,634	High
WA	27	2.1%	6.1%	$248,861	Moderate
SC	18	1.4%	1.4%	$245,918	Moderate
IL	52	4.0%	3.1%	$245,889	Moderate
RI	13	1.0%	0.5%	$243,115	Moderate
KY	23	1.8%	1.1%	$243,009	Moderate
NY	148	11.5%	5.7%	$219,597	Moderate
CT	56	4.3%	3.8%	$217,343	Moderate
NJ	82	6.4%	5.6%	$210,558	Moderate
FL	32	2.5%	5.0%	$199,164	Moderate
NC	26	2.0%	2.4%	$199,045	Moderate
GA	57	4.4%	4.5%	$196,499	Moderate
VA	49	3.8%	3.5%	$196,312	Moderate
PA	129	10.0%	12.5%	$192,441	Moderate
MN	24	1.9%	3.2%	$186,373	Moderate
LA	5	0.4%	0.2%	$181,621	Moderate
MD	93	7.2%	5.1%	$174,203	Moderate
MA	82	6.4%	6.4%	$165,104	Moderate
MO	7	0.5%	1.5%	$153,231	Moderate
CO	9	0.7%	0.9%	$150,171	Moderate
OH	48	3.7%	4.7%	$146,305	Moderate
MI	14	1.1%	1.0%	$142,565	Moderate
TX	16	1.2%	2.3%	$134,958	Moderate
IA	9	0.7%	0.8%	$124,472	Low
NE	6	0.5%	0.6%	$105,060	Low
IN	15	1.2%	1.8%	$95,616	Low

Length of Time for Claims to Close (Date Reported to Closure)

- While a significant number of claims closed between one and two years after they were initially opened, 30 percent of the for-profit skilled nursing facility claims took more than three years to close (see Figure 6).
- Indemnity payments for assisted living facilities and continuing care retirement communities were more erratic, potentially due to the relatively small number of closed claims at these facilities (see Figure 7).
- Paid expenses increase with the duration of the claims (see Figure 8).

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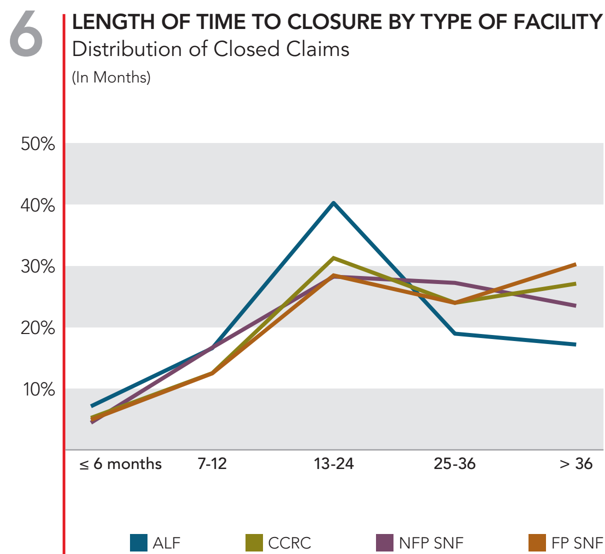
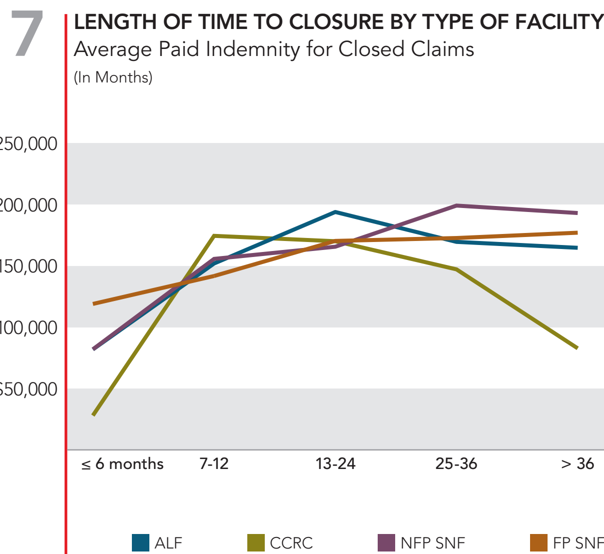
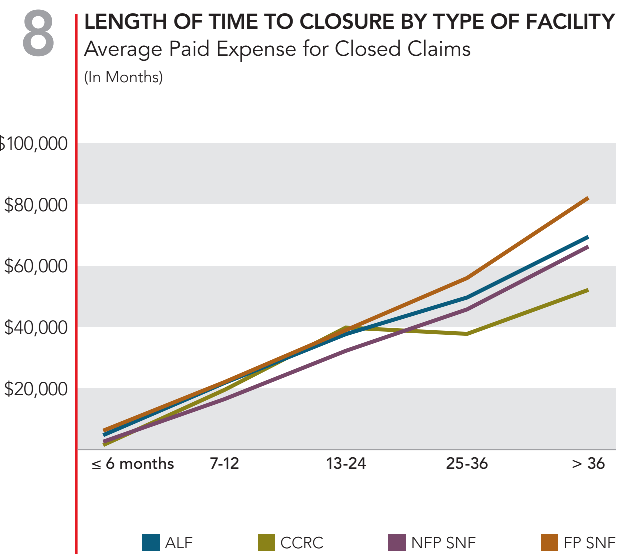


6 **LENGTH OF TIME TO CLOSURE BY TYPE OF FACILITY**
Distribution of Closed Claims
(In Months)



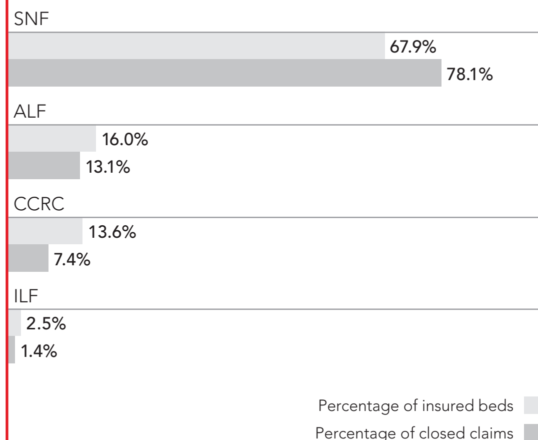
7 **LENGTH OF TIME TO CLOSURE BY TYPE OF FACILITY**
Average Paid Indemnity for Closed Claims
(In Months)

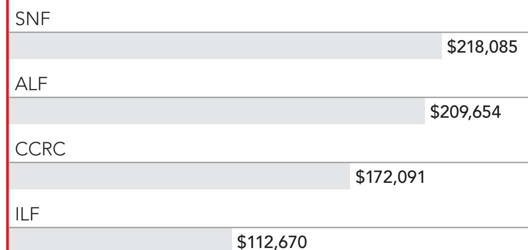


8 **LENGTH OF TIME TO CLOSURE BY TYPE OF FACILITY**
Average Paid Expense for Closed Claims
(In Months)

Type of Facility

- Independent living facilities experienced only 1.4 percent of the closed claims. However, this is less than their proportion of the CNA book of business (see Figure 9).
- Skilled nursing facilities represent a disproportionately high percentage of closed claims (see Figure 9).
- On average, skilled nursing facilities' closed claims are $8,431 higher per claim than those of assisted living facilities and $45,994 higher than those of continuing care retirement communities (see Figure 10).





Allegations

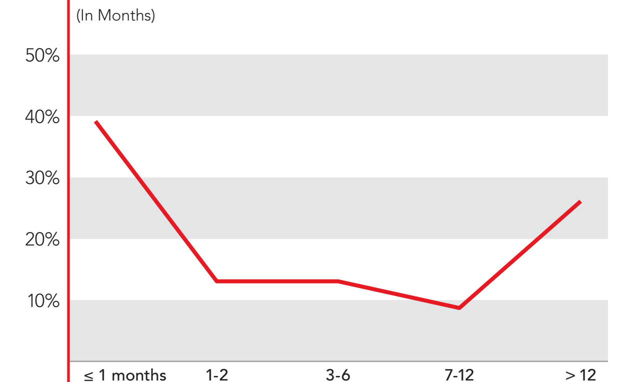
- Resident fall continues to be the most frequent allegation, with an average total paid of $171,960 (see Figure 11). In 38.7 percent of these cases, the fall was associated with a decline in the resident's medical condition that caused or contributed to the resident's death.
- Pressure ulcer, improper care and resident fall are the only allegations associated with at least 10 percent of the closed claims (see Figure 11).
- Elopement is the primary allegation in 23 claims. The high level of payments reflects the seriousness of injuries and the general expectation that elopement should never occur. The 23 elopements include 12 from assisted living facilities, nine from skilled nursing facilities and two from continuing care retirement communities. Elopements occur most frequently during the first month of residency and decrease in months two through 12, with another increase after the first year (see Figure 12).
- A significant percentage of the medication errors involve high-risk drugs or pharmaceuticals. These include insulin (14.2 percent); anticoagulants, such as Coumadin™ and Lovenox™ (27.0 percent); and narcotics, such as morphine and fentanyl (19.0 percent).

11 ALLEGATIONS
Average Total Paid for Closed Claims

Allegation class	Percentage of closed claims	Average total paid
Elopement	1.8%	$444,051
Failure to follow physician's order	1.3%	$368,114
Gross improper care	1.9%	$327,871
Pressure ulcer	16.1%	$281,345
Failure to inform physician	0.9%	$265,326
Improper care	14.5%	$238,954
Medication error	4.9%	$200,865
Failure to monitor	6.8%	$199,893
Abuse	4.2%	$185,171
Delay in seeking medical treatment	0.9%	$180,718
Resident fall	42.1%	$171,960
Other*	0.1%	$162,902
Failure to diagnose	0.7%	$145,018
Failure to treat	0.2%	$123,811
Unsafe environment	3.0%	$123,163
Improper placement for financial gain	0.2%	$120,705
Violation of resident rights	0.5%	$ 98,329
Total	100.0%	$212,092

*"Other" includes cremation of remains without the family's consent.

12 LENGTH OF TIME BETWEEN ADMISSION AND DATE OF ELOPEMENT
Distribution of Closed Claims
(In Months)



Injuries

- Death occurred in 65.1 percent of the closed claims alleging medication error (see Figure 13).
- Death and fractures are the only injuries associated with at least 10 percent of all closed claims. These two categories constitute 74.3 percent of the injuries (see Figure 15).
- Infection-related claims include residents with wounds and one who contracted Legionnaires' disease.
- Loss of organ function includes problems with vision and ability to void.
- Contusion/bruise occurs in a variety of allegations, including medication errors, falls and resident abuse.
- An injury involving teeth/dentures resulted from resident-on-resident abuse.

13 INJURIES RELATED TO MEDICATION ERROR
Highest Frequency Closed Claims

Injury	Percentage
Death	65.1%
Pain and suffering	12.7%
Loss of limb/amputation	4.8%
Cerebral vascular accident	4.8%
Fracture(s)	3.2%

Injuries

14 INJURIES RELATED TO MEDICATION ERROR
Highest Average Total Paid for Closed Claims

Injury	Average total paid
Loss of limb/amputation	$304,742
Cerebral vascular accident	$272,794
Contusion/bruise	$227,846
Death	$225,036
Loss of organ/organ function	$148,747

Injuries

15 INJURIES
Average Total Paid for Closed Claims

Injury	Percentage of closed claims	Average total paid
Death	48.6%	$262,728
Loss of limb/amputation	2.5%	$259,824
Pressure ulcer	7.2%	$245,926
Infection	1.3%	$225,909
Muscle and ligament reinjury	0.9%	$220,120
Cerebral vascular accident	0.5%	$211,522
Sexual assault	1.1%	$199,790
Contusion/bruise	1.8%	$180,774
Coma	0.2%	$171,908
Loss of organ/organ function	0.5%	$156,453
Head injury	1.2%	$151,194
Fracture(s)	25.7%	$145,200
Emotional distress	1.8%	$141,575
No injury*	0.3%	$135,106
Pain and suffering	1.9%	$110,789
Dehydration/lack of nutrition	0.2%	$110,483
Laceration	2.7%	$79,564
Burn	0.9%	$75,566
Back injury	0.1%	$64,968
Teeth/dentures	0.2%	$32,388
Sprain	0.2%	$22,875
Skin tear	0.2%	$10,304
Total	100.0%	$212,092

*"No injury" claims include resident falls with no resulting injury, as well as a counterclaim following eviction.

Analysis of Assisted Living Facility Closed Claims

Assisted living facilities comprise 13.1 percent of closed claims, compared with 16.0 percent of CNA-insured beds (see Figure 9).

Allegations

- Resident fall is the allegation in 46.2 percent of closed claims against assisted living facilities (see Figure 16a). The average total paid for resident fall is $183,125.
- Gross improper care has the highest average total paid at assisted living facilities. These claims include egregious deviations from the accepted quality of care, such as significant alterations of medical records and extensive lapses in communication with physicians.
- As noted earlier, 12 of the elopements occurred at assisted living facilities. The average total paid for elopement was $378,312 (see Figure 16b).
- A substantial difference ($109,351) exists between average total paid for the *allegation* of pressure ulcer ($251,370) and the *injury* of pressure ulcer ($142,019). Pressure ulcer as an *allegation* means that the primary reason for bringing legal action against the organization was failure to prevent development of a new pressure ulcer or deterioration of an existing one. As an *injury*, pressure ulcer reflects the outcome of care provided.

Injuries

- Death occurred in 37.2 percent of the closed claims associated with falls.
- Death is the most common injury (see Figure 17a).
- Emotional distress claims include allegations of inappropriate transfer and financial abuse.

16a Allegations

ALLEGATIONS AT ASSISTED LIVING FACILITIES
Highest Frequency Closed Claims
(Combined Business Segments)

Allegation	Percent
Resident fall	46.2%
Abuse	9.5%
Pressure ulcer	7.7%
Elopement	7.1%
Improper care	7.1%

17a Injuries

INJURIES AT ASSISTED LIVING FACILITIES
Highest Frequency Closed Claims
(Combined Business Segments)

Injury	Percent
Death	37.3%
Fracture(s)	32.5%
Pain and suffering	6.5%
Emotional distress	4.1%
Contusion/bruise	4.1%

16b Allegations

ALLEGATIONS AT ASSISTED LIVING FACILITIES
Highest Average Total Paid for Closed Claims
(Combined Business Segments)

Allegation	Average Total Paid
Gross improper care	$541,908
Elopement	$378,312
Failure to follow physician's order	$360,939
Delay in seeking medical treatment	$256,309
Pressure ulcer	$251,370

17b Injuries

INJURIES AT ASSISTED LIVING FACILITIES
Highest Average Total Paid for Closed Claims
(Combined Business Segments)

Injury	Average Total Paid
Death	$291,060
Emotional distress	$230,926
Contusion/bruise	$215,590
Loss of limb/amputation	$188,080
Fracture(s)	$174,469

Analysis of Continuing Care Retirement Community Closed Claims

Allegations

- The data reveal that 53.1 percent of allegations at continuing care retirement communities are related to resident fall, compared with 46.2 percent at assisted living facilities and 39.7 percent at skilled nursing facilities. The average total paid for resident fall is less at continuing care retirement communities than at other facilities.
- Two elopements occurred at continuing care retirement communities, each associated with a $1 million indemnity payment. One claim involved a resident with no history of wandering who died as a result of exposure to severe weather. In another claim, the resident eloped from the unsecured skilled unit and tumbled down a stairwell in a wheelchair.

Injuries

- Loss of organ function includes a claim of severe and untreated bowel obstruction, which resulted in resection and a colostomy.
- The severity of contusion/bruise claims is affected by one allegation of resident-on-resident abuse and another involving an anticoagulant medication error, which resulted in anemia and a large hematoma.
- One closed claim related to a resident's falls had no associated injuries, but did include significant expenses for managing the claim.

18a Allegations — ALLEGATIONS AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Frequency Closed Claims
(Combined Business Segments)

Allegation	Percent
Resident fall	53.1%
Improper care	10.4%
Failure to monitor	8.3%
Pressure ulcer	6.3%
Abuse	6.3%

18b Allegations — ALLEGATIONS AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Average Total Paid for Closed Claims
(Combined Business Segments)

Allegation	Average Total Paid
Elopement	$1,133,285
Gross improper care	$318,997
Delay in seeking medical treatment	$288,452
Medication error	$247,693
Failure to monitor	$195,798

19a Injuries — INJURIES AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Frequency Closed Claims
(Combined Business Segments)

Injury	Percent
Death	39.6%
Fracture(s)	34.4%
Laceration	6.3%
Pressure ulcer	4.2%
Emotional distress	4.2%

19b Injuries — INJURIES AT CONTINUING CARE RETIREMENT COMMUNITIES

Highest Average Total Paid for Closed Claims
(Combined Business Segments)

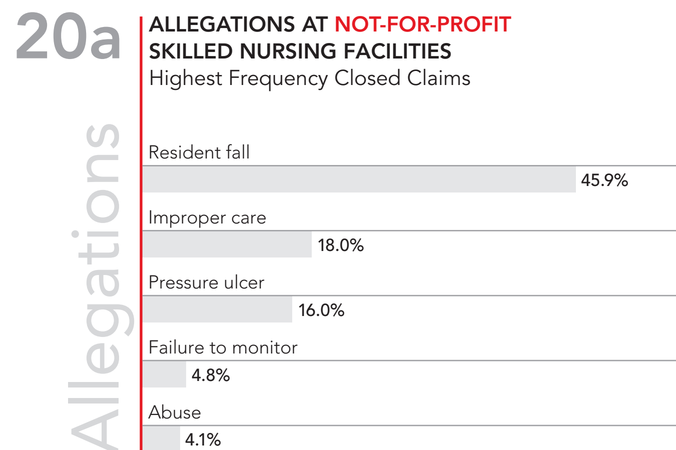
Injury	Average Total Paid
Death	$261,345
Loss of organ/organ function	$239,063
Contusion/bruise	$174,834
Fracture(s)	$149,149
No injury*	$90,830

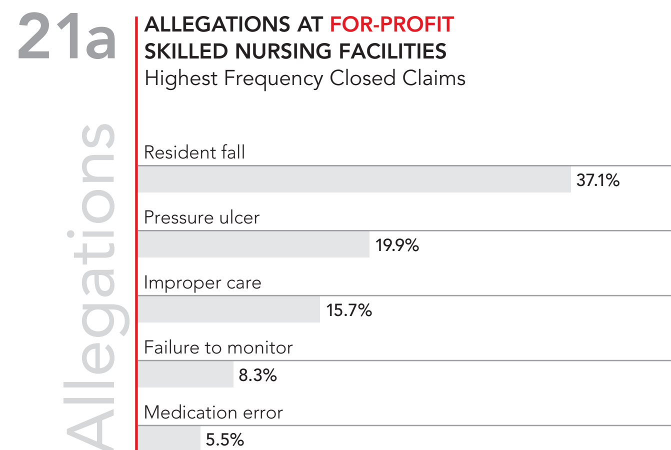
*This claim involved multiple falls by a resident with no associated injuries.

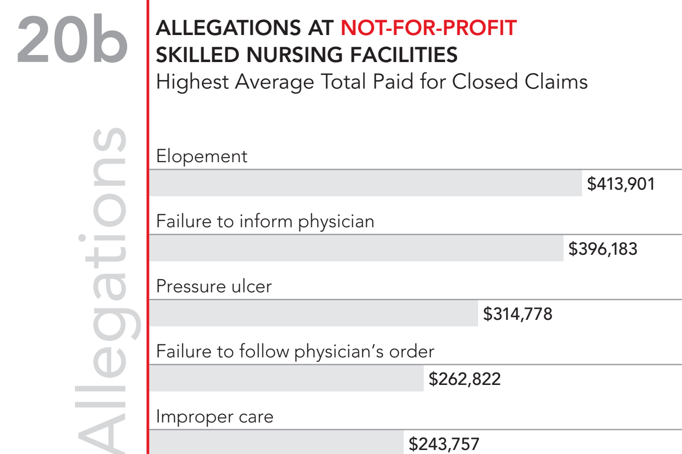
Analysis of Skilled Nursing Facility Closed Claims

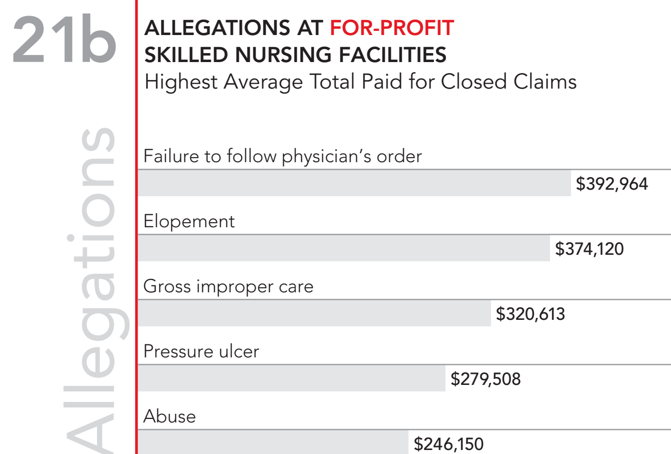
Allegations

- Allegations of abuse include resident-on-resident, employee-on-resident and visitor-on-resident.
- The average total paid for elopement and pressure ulcer is higher at not-for-profit facilities.
- The average total paid for failure to follow physician's order is higher at for-profit facilities. One claim had a paid indemnity of $1 million (see Figure 29).





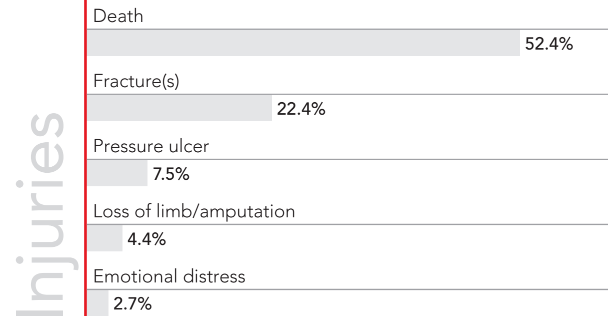




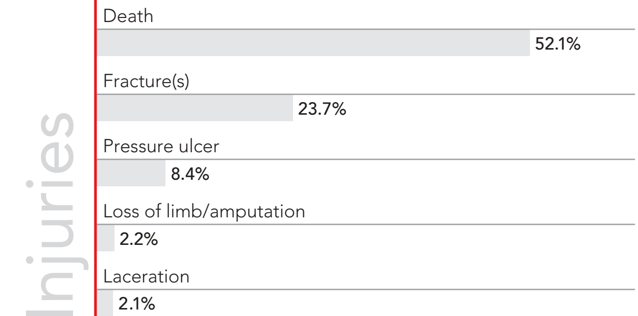
Injuries

- Severe nonfatal injuries tend to result in higher indemnity payments than do claims involving death. The higher indemnity is due to the ongoing medical expenses associated with disability.
- The highest-severity injury at a not-for-profit skilled nursing facility is a cerebral vascular accident suffered by a resident admitted for short-term rehabilitation. This injury allegedly resulted from failure to administer the prescribed anticoagulation medication.
- The highest-severity injuries at for-profit skilled nursing facilities include a traumatic medial collateral ligament rupture and a quadriceps tendon rupture. These injuries were sustained allegedly by residents who had been admitted for rehabilitation of a surgically repaired knee. One of the reinjuries involved a hyperflexion that occurred while the resident was being lowered onto the bed. The other reinjury occurred as a result of therapy inconsistent with the physician's orders.

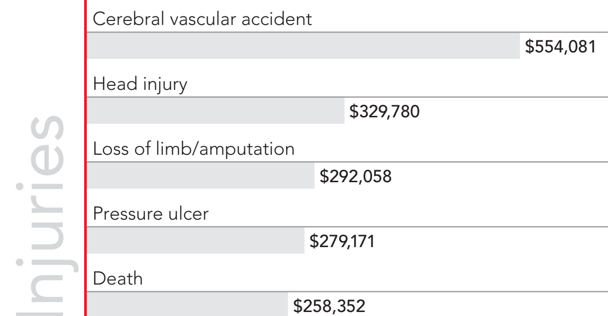
22a INJURIES AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES
Highest Frequency Closed Claims



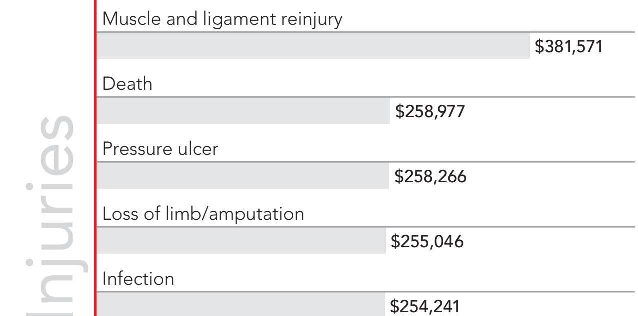
23a INJURIES AT FOR-PROFIT SKILLED NURSING FACILITIES
Highest Frequency Closed Claims



22b INJURIES AT NOT-FOR-PROFIT SKILLED NURSING FACILITIES
Highest Average Total Paid for Closed Claims



23b INJURIES AT FOR-PROFIT SKILLED NURSING FACILITIES
Highest Average Total Paid for Closed Claims



Analysis of Short-term-stay Closed Claims

Since the 2009 CNA aging services claim study, 350 additional closed claims were added into the 2012 dataset. Within this subset of 350 additional closed claims, the short-term-stay claims were identified and analyzed separately to better understand risks associated with shorter stays. For the purposes of this review, *short-term stay* is defined as an admission where the resident's intent was, in most cases, rehabilitation rather than extended care.

Short-term-stay Closed Claims

- Sixteen percent of the 350 closed claims involve short-term stays (see Figure 24).
- The average total paid for short-term-stay closed claims is $189,095, which is $1,341 more than the long-term average of $187,754 (see Figure 24).

Business Segment and Type of Facility

- The distribution of short-term-stay closed claims across business segments mirrors the distribution for all the closed claims in the dataset (see Figures 4 and 25).
- Skilled nursing facilities represent the highest proportion of short-term-stay admissions.
- Continuing care retirement communities experienced the highest average total paid for short-term-stay admissions.

Death occurred in 44.6 percent of the short-term-stay closed claims. This is only slightly lower than the percentage of fatalities among all the closed claims.

24 LENGTH OF STAY
(Combined Business Segments)

Length of stay	Percentage of closed claims	Average total paid
Short-term stay	16.0%	$189,095
Long-term stay	84.0 %	$187,754
Total	100.0%	$187,969

25 SHORT-TERM STAY BY BUSINESS SEGMENT

Business segment	Percentage of closed claims	Average total paid
Not-for-profit	32.1%	$185,025
For-profit	67.9%	$191,022
Total	100.0%	$189,095

26 SHORT-TERM STAY BY TYPE OF FACILITY
Average Total Paid for Closed Claims
(Combined Business Segments)

Allegations

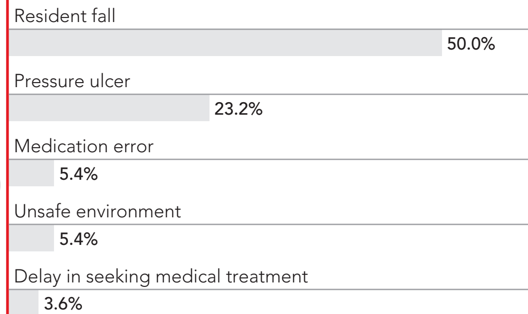
- The high severity of elopement in short-term-stay claims is due to a $1 million claim, involving a resident with no history of wandering who left the building and died of hypothermia.
- The high severity for medication error reflects a claim involving a significant overdose of pain medication, resulting in cardiac arrest and death.

Injuries

- Two-thirds of all muscle and ligament injuries are reinjuries that occurred during short-term stays.
- Death occurred in 44.6 percent of the short-term-stay closed claims (see Figure 28a). This is only slightly lower than the percentage of fatalities among all the closed claims.
- The two leading causes of death for short-term-stay residents are head injury and infection.

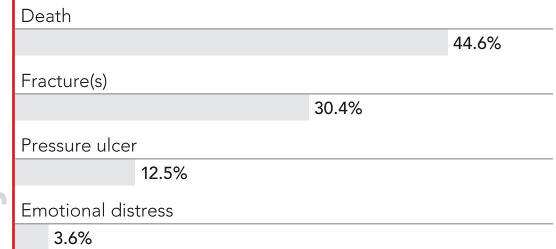
27a Allegations

ALLEGATIONS FOR SHORT-TERM STAY
Highest Frequency Closed Claims
(Combined Business Segments)



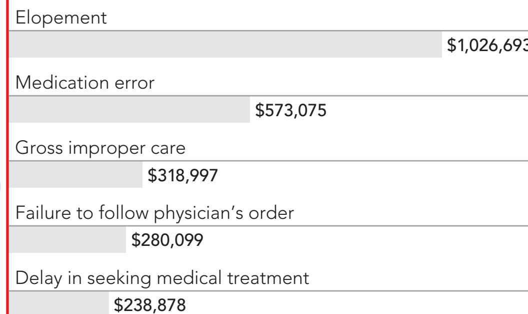
28a Injuries

INJURIES FOR SHORT-TERM STAY
Highest Frequency Closed Claims
(Combined Business Segments)



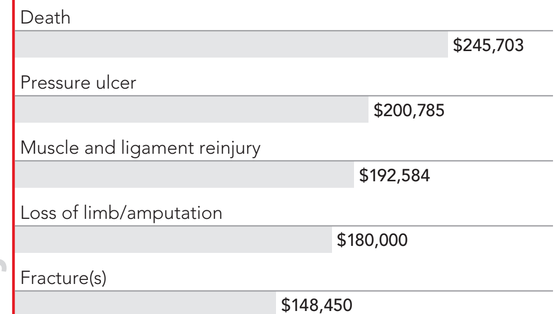
27b Allegations

ALLEGATIONS FOR SHORT-TERM STAY
Highest Average Total Paid for Closed Claims
(Combined Business Segments)



28b Injuries

INJURIES FOR SHORT-TERM STAY
Highest Average Total Paid for Closed Claims
(Combined Business Segments)



Analysis of Closed Claims with $1 Million Indemnity Payment

The average total payment by CNA on behalf of its aging services clients is $212,092. However, 29.2 percent of indemnity payments exceed $250,000, and a small subset of these claims is significantly higher. Figure 29 displays closed claims with indemnity payments of $1 million, the policy limit for each claim.

- Allegations include pressure ulcer, elopement, resident fall and failure to follow physician's order.
- Injuries include four deaths and two pressure ulcers.
- Four closed claims occurred at skilled nursing facilities and two at continuing care retirement communities.

29 CLOSED CLAIMS WITH $1 MILLION INDEMNITY PAYMENT

Allegation	Summary	Injury	Type of facility
Resident fall	A severely disabled resident was permitted to roam the facility without supervision. The resident fell down a laundry chute and was not located for several hours. Cause of death: asphyxiation.	Death	Skilled nursing facility
Elopement	The resident did not have a history of wandering while living in the assisted living unit. However, following admission to the skilled unit after surgery, she wandered outside. Cause of death: hypothermia.	Death	Continuing care retirement community
Failure to follow physician's order	The resident's wound progressed from Stage II to Stage IV, resulting from failure to follow physician's wound care orders. Subsequently, the state Department of Health Services issued its highest-severity citation to the facility.	Pressure ulcer	Skilled nursing facility
Pressure ulcer	Staff failed to prevent significant progression of a pressure ulcer during the resident's first 22 days of admission. The wound was noted to be necrotic, and it contained large amounts of dried stool. Documentation was lacking regarding wound care provided.	Pressure ulcer	Skilled nursing facility
Pressure ulcer	Staff failed to prevent significant progression of a pressure ulcer within nine days of admission. Cause of death: sepsis.	Death	Skilled nursing facility
Elopement	The resident wandered off an unsecured skilled care unit into the stairwell. She fell down the stairs, sustaining fractures to her femur and ribs. Cause of death: trauma.	Death	Continuing care retirement community

SUCCESS STORY

The following success story demonstrates how an aging services organization and staff significantly reduced the risk of resident falls:

The resident fall rate at Greek American Rehabilitation and Care Centre decreased by 17 percent, and the improvement was sustained over a four-year period. This remarkable result was due to the establishment of the following policies and procedures:

- functional evaluation immediately upon admission
- implementation of a muscle-strengthening and walking program
- enhancement of fall investigation procedures, using a 30-day grid that identifies patterns by tracking such elements as time of day, day of the week and identity of direct care providers
- prohibition of wheelchair use after admission, unless that was the resident's pre-admission means of mobility
- provision of one-on-one staffing for 72 hours for those residents identified as at high risk for falls
- development and implementation of a scoring system to track falls and any decline in activities of daily living within 30 days of admission
- utilization of investigative findings to educate employees in fall prevention

Another key to the program's success is related to organizational philosophy. Fall prevention became more important to the staff when the leadership team took visible action after a fall occurred. Direct involvement helped foster an environment where falls are taken seriously.

Fall prevention became more important to the staff when the leadership team took visible action after a fall occurred.

Resident falls: Focus on following resident service and care plans to minimize the risks of resident falls.

A common theme across the closed claims analysis is failure to follow the resident's care plan. Contrary to the plan of care, care providers left residents unattended, did not perform two-person transfers and/or utilized equipment improperly.

Action items to help reduce falls:

- **Empower a group of staff members to champion fall prevention,** including nursing, physical and/or occupational therapy, dietary, pharmacy, housekeeping and maintenance. Include certified nursing assistants in the group.
- **Report the findings** to the quality assurance committee.
- **Ensure that leadership participation is visible, meaningful and non-punitive.** Their primary responsibilities are to foster a systems approach to fall reduction while discouraging a "culture of blame" for resident falls, to strengthen fall reduction efforts by attending team meetings and to provide ongoing support for team initiatives.
- **Educate staff to monitor residents at potentially hazardous moments,** including toileting, bathing and other personal care activities.
- **Reinforce the need to supervise residents** as required by the care plan.
- **Develop staff members' critical decision-making skills.** Use of mock scenarios can help the direct care providers better manage and prioritize simultaneous requests.
- **Access and share published research and relevant Web sites** – including those of the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the National Institute for Occupational Safety and Health – to update fall prevention programs and enhance outcomes. For example, recently published research indicates that the narrow width of traditional beds (35 inches) utilized in nursing facilities may be a major factor contributing to residents falling from the bed.[1]
- **Implement the following strategies when formulating resident-specific fall prevention plans:**
  - Perform daily rounding.
  - Encourage residents, families and significant others to participate in creating the fall prevention plan.
  - Include certified nursing assistants and environmental services representatives in the planning process.
  - Aggressively evaluate the efficacy of interventions when a resident sustains multiple falls within a short period of time.

1 See Fragala, G. et al. "Examining Bed Width as a Contributor to Risk of Falls from Bed in Long-Term Care." *Annals of Long-Term Care*, June 2012. Available at **http:www.annalsoflongtermcare.com/article/examining-bed-width-contributor-risk-falls-bed-long-term-care?page=0,0&goback=%2Egde_134913_member_126485789**.

Elopement: Implement necessary measures to prevent these infrequent yet significant events.

Action items to minimize elopement risk:

- **Assess the resident's risk of elopement immediately upon admission and routinely thereafter,** as the resident's condition may change gradually and inconspicuously.
- **Regularly account for the whereabouts of all residents** by checking off each resident's name. Do not rely on counting the number of residents.
- **Require that all residents sign out when leaving the building** and sign in upon return.
- **Perform elopement drills** as frequently as fire drills.
- **Ensure that photographs of residents are readily available** and reflect their current appearance.

Pressure ulcers: Perform intensive monitoring to ensure compliance with care plans and protocols.

Many pressure ulcer-related claims alleged that staff had failed to follow wound care orders and/or the wound treatment plan, or to treat pressure ulcers in a timely manner. The data underscore the importance of notifying the resident's physician, family and significant others of the development or progression of pressure ulcers and distinguishing between pressure ulcers and other conditions, such as vascular wounds.

Action items for preventing and managing pressure ulcers:

- **Implement evidence-based intervention and treatment protocols,** ensuring compliance with professional standards.
- **Monitor compliance with wound care orders** and/or the wound treatment plan.

- **Complete and document a skin assessment upon admission** and at regular intervals thereafter.
- **Ensure timely communication among all individuals involved in providing care,** including the resident, family and significant others, certified nursing assistants, charge nurse/nursing management, the care plan team and any external consultants.
- **Distinguish non-pressure-related wounds from pressure ulcers,** in order to enhance treatment and accuracy of documentation.
- **Include certified nursing assistants as members of the skin care team,** and encourage them to participate in care planning.

Medication errors: Monitor administration of insulin, anti-coagulants and pain medications.

Action items for administration of high-risk medications:

- **Educate residents, families and significant others about the purpose of high-risk drugs,** as well as side effects and correct dosage.
- **Include residents, families and significant others** in routine medication safety checks.
- **Identify high-risk medications administered by the facility** and conduct monthly audits of these medications.
- **Track and trend errors** involving high-risk medications.
- **Establish special procedures for administering high-risk medications,** including double-checking the "five rights" (i.e., right patient, right time, right medication, right dose and right route) before drugs are given.
- **Review pertinent laboratory results** prior to administration of anticoagulants and insulin.
- **Perform a root cause analysis** following every high-risk medication error. (For further information on root cause analysis, see CNA's publication *inBrief®* 2010 – Issue 2, "Analyzing Errors: Improve Quality, Reduce Risk by Identifying Underlying Causes.")
- **Report audit results, root cause analyses and other findings involving high-risk medication errors** to the appropriate committee(s), leadership team and governing body.
- **Implement and audit performance improvement plans** developed by the appropriate committee(s).

The following risk control practices can help reduce errors when administering any medications:

- **Reconcile medication orders throughout all levels of care,** in order to maintain and communicate accurate information.
- **Work with pharmacy consultants,** in order to minimize medication errors.
- **Utilize two resident identifiers** when administering medications.
- **Read back and verify all telephonic medication orders** to ensure accuracy.
- **Continuously evaluate the risk of medication interactions due to polypharmacy,** as well as other drug-related hazards.
- **Assess staff competency to administer medications at least annually,** ensuring compliance with medication policies and protocols.

Quality improvement: Participate in initiatives related to improving resident care services and decreasing resident injuries.

Professional organizations within the aging services industry continue to work with their members to improve the quality of resident care. An example is the Nursing Home Quality Initiatives (**http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html**). Aging services leaders can reduce their own organization's exposures and strengthen the industry as a whole by joining initiatives dedicated to improving quality of care and decreasing resident injuries.

LOOKING FORWARD

The preceding claims analysis provides a current snapshot of professional liability risk exposures for the aging services industry. However, new theories of liability will emerge as factors in healthcare delivery models evolve. Long-range planning efforts should consider the following industry developments, among others:

Accountable care organizations (ACOs)[2]

ACOs are defined by the Centers for Medicare & Medicaid Services as "groups of doctors, hospitals and other healthcare providers who come together voluntarily to give coordinated high-quality care to their Medicare patients." ACOs will require strong post-acute care programs. Therefore, aging services organizations must consider participation in ACOs as part of their strategic planning. Competition for individual patients discharged from the hospital may evolve into a competitive environment for ACO affiliation. Winning a contract to become part of an ACO may require the ability to provide data on costs for resident services and quality of resident care.

Mergers and acquisitions (M&A)

M&A activity will continue to increase in the aging services industry, as facilities with narrower profit margins address the costs of complying with requirements of the Affordable Care Act (ACA). Losses may result from

- lapses in the due diligence process
- failure by new or previous owners to maintain the integrity and accessibility of health information records
- lack of clarity and accountability for services provided to residents
- inconsistent quality of care
- increased exposure to class action litigation

Information technology (IT)

IT is a component of strategic planning and should be addressed in capital budgets. Residents increasingly expect sophisticated IT applications for both service delivery and personal use. These applications potentially include telemedicine capabilities, remote monitoring, electronic health records, medication dispensing, wireless accessibility, Skype™ and social networking. Resident care applications must interface with other healthcare provider systems to enhance continuity of care. IT also enables families and service providers to remotely monitor the health status and well-being of seniors at home. As the use of IT increases in aging services organizations, risks to consider include

- inadequate backup processes, which cannot maintain provision of care in the event of system downtime
- data corruption
- intentional or unintentional breaches in security and confidentiality
- inappropriate information contained in e-mails or text messages
- lost or stolen portable equipment (e.g., laptops and hand-held devices)
- resident identity theft

Living environment and resident-directed care

In view of the increasing demand for a "non-institutional" environment, organizations are seeking new service delivery models – such as housing residents in multiple smaller buildings rather than one large complex – in the context of today's fiscal constraints. The following are examples of emerging service models:

- The Eden Alternative® (**http://www.edenalt.com/**) is an initiative designed to transform traditional nursing homes. According to the organization, targeted outcomes include increasing respect and eliminating loneliness, helplessness and boredom.
- The Green House® (**http://www.thegreenhouseproject.org/**) incorporates the Eden Alternative approach to services and provides a homelike structure with 10 to 12 resident rooms, dining room, kitchen and living areas.
- The Small House Alliance (**http://www.smallhousealliance.org/**) and other organizations focus on offering a richer life for the aging population in every setting.

Organizations providing services to healthier aging adults will encounter new theories of liability arising out of home health assistance. In addition, there may be liabilities based upon behaviors deemed unacceptable in a community living environment, such as use of illegal drugs or uninvited physical encounters.

2 See Fink, J. "Final Rules for Accountable Care Organizations – Impact on Nursing Homes," from BlumShapiro, at **http://blumshapiro.com/kbarticle/final-rules-for-accountable-care-organizations-impact-on-nursing-homes**. Also see "CMS Releases List of 27 ACOs," in *McKnight's Long-Term Care News & Assisted Living*, at **http://www.mcknights.com/cms-releases-list-of-27-acos/article/235941/?DCMP=EMC-MCK_Daily**.

Staffing shortage and burnout

The supply of healthcare employees is decreasing while the demand for services is increasing. One challenge is to control staff turnover related to burnout. High turnover rates and difficulties in hiring qualified staff affect consistency of care, and can lead to unintentional understaffing and use of under-qualified staff. Each of these factors diminishes quality, which in turn, may impact the organization's reputation and its vulnerability to professional liability claims.

Social media and Internet usage

Utilization of social media platforms and the Internet will exponentially increase consumers' access to information, including feedback posted by residents, their families, significant others and aging services employees. Quality reports posted on the Internet will increasingly be utilized to select providers. The ACA requires a quality assurance and performance improvement program with public access to detailed reports. Emerging risks associated with the Internet include

- an increase in *qui tam* whistleblower or other claims based upon government regulations
- legal actions stemming from marketing materials containing guarantees and promises, which are posted on the organization's Web site or distributed through social media
- claims of libel or slander
- breach of confidentiality of residents' protected health information and/or the organization's proprietary information

Changes in reimbursement

Medicare and Medicaid reimbursement rates will continue to decrease, and claims will be denied for certain preventable conditions and "never" events. Reduced availability and rising costs of long term care insurance may further decrease operating margins. Recent research indicates that in response to payment reductions, 36.8 percent of nursing facility operators expect to lay off direct care staff.[3] The primary risks associated with decreasing reimbursement are understaffing, as well as failure to maintain a safe environment and to replace equipment as needed. Staff reductions, despite increasing resident acuity levels, may result in legal actions that are difficult to defend. Greater attention to "never" events and Medicare "quality-driven" reimbursement methods are anticipated to contribute to a rise in the number and severity of lawsuits against aging services organizations.

Increasing complexity of risk exposures

As this section and the claims analysis demonstrate, risks in aging services continue to grow and evolve. Each development discussed in this section could potentially escalate into class action litigation. Aging services leaders, therefore, must become more knowledgeable and proactive in addressing emerging exposures and fostering the organization's ability to manage risks on an integrated, enterprise-wide basis. Leaders need to remain current with litigation trends, changing regulatory requirements, and most importantly, effective and evidence-based care and treatment approaches to resident health conditions.

In an era of greater transparency and "outcomes-linked reimbursement," organizational leadership must strive for enhanced resident safety and quality of care. A commitment to addressing the findings presented in the claims analysis, while anticipating future challenges, will serve as a solid foundation for achieving these important goals.

The following questions are designed to focus attention on your organization's strategic outlook:

- Is your governing body actively engaged in promoting a resident-focused culture of quality and safety?
- How are you making your organization attractive to ACOs?
- In the next two years, what strategic changes will you implement to differentiate your organization's culture and outcomes?
- Are you measuring progress for achieving these goals?
- And if not now, when?

Our publication documents issues in aging services, but it is important to remember the unsung heroes who are dedicated to improving residents' quality of life. Individuals who choose to move to an aging services community, or whose condition necessitates this life-changing transition, benefit from care provided by this important group of people.

3 See "Impact of Payment Reductions on Nursing Facilities." *Care Context*, Spring 2012. Available at http://www.aqnhc.org/pdfs/care-context-2012-03.pdf.

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