

 <b>HansonBridgett</b>		<h2>Responding to an Adverse Event</h2>	
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<h3>Responding to an Adverse Action</h3> <p>Considerations after an incident occurs in your community</p> <ul style="list-style-type: none"> <li>• Immediate actions</li> <li>• Reporting/documentation</li> <li>• Investigations</li> <li>• Media attention</li> <li>• Legal actions</li> <li>• Insurance</li> </ul>	

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<h3>Immediate Actions</h3> <ul style="list-style-type: none"> <li>• Securing health and safety of residents <ul style="list-style-type: none"> <li>– Attending to need for immediate medical attention</li> <li>– Arranging for appropriate level of monitoring, timely reassessment or reappraisal, and updating of care and service plan</li> <li>– Working with first responders</li> </ul> </li> <li>• Communications with treating physician</li> <li>• Communications with family or responsible party</li> <li>• Personnel actions <ul style="list-style-type: none"> <li>– Suspending employees</li> </ul> </li> </ul> <p><b>**Communications with the insurance company**</b></p>	

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### Incident Reports

- Do you have an internal process?
  - Who gets the incident report?
  - Where is it stored?
  - When is it required?
- Maximizing likelihood that attorney-client privilege will apply
  - Primary/dominant purpose of report: to prepare defense if litigation filed
  - Expectation of confidentiality: "Confidential" typed on report?
  - Distribution: Attorney, risk management, insurance adjuster
  - Who requested completion? Directive by attorney or risk management?

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### Reports to Regulatory Agencies and Others

- Mandated reporting of abuse: immediately report to local law enforcement; ombudsman; and regulatory agency all instances of reasonably suspected physical abuse, abandonment, abduction, isolation, financial abuse, or neglect. Written reports to follow.
- Unusual occurrence
- RCFE reporting

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### Internal Investigation

- Coordinating with legal counsel
- Identifying and interviewing key witnesses vs. witness statements
- Gathering, securing, and reviewing key documentation
- Determining what documentation to create and who should create it

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### Internal Investigation

- Considerations for those conducting the internal investigation
  - Who will do the interviews
  - Who will take notes
  - Who will receive the information
  - Where will it be saved
- Preparation for conducting the investigation
  - Review employee files, medical records, and other relevant documents
  - Prepare outline of questions
  - Determine who you need to interview

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### Documentation

**\*\*Will be scrutinized in the future by regulatory agencies, counsel, etc.\*\***

- Defensive documentation:
  - Good:
    - Facts
    - Based on personal observations
    - Fundamental information
    - Consistency
    - Relevant
  - Bad:
    - Conclusory language
    - Guessing/opinions
    - Admissions of fault or failure to follow protocols
    - Characterizations

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### Documentation

**\*\*Will be scrutinized in the future by regulatory agencies, counsel, etc.\*\***

- Types
  - Medical record
  - Incident reports
  - Reports to regulatory agency/law enforcement
  - Communications with family
  - Emails/text messages

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**Documentation -- Example**

Progress Notes:

- "Resident A has a dx of dementia and wanders. Resident A was involved in a peer to peer altercation. Resident B grabbed her upper arm. Resident A sustained a skin tear and bruising as a result."

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**Documentation -Example**

**Incident Report**

- "Resident A has a dx of dementia and wanders. She is territorial and combative with anyone who wanders into her room. Resident A had lived with Resident B for 2 months without incident. On the day she attacked Resident B she was irritated. CNA 1 heard a yell and entered the room. Resident A had her hand on Resident B's upper arm while sitting on her bed. Resident B was assessed for injuries. Resident B was found to have a skin tear because of this incident."

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**Documentation -- Example**

Nurse's Notes:

- "Resident A told this nurse that CNA 1 was rough when she was doing her care a few days ago."

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### Documentation

Maintaining relevant documents

- Medical record
- Non-clinical information
  - Staffing records/assignment sheets
  - 24-hour logs
  - Policies & procedures
  - Kardex
- May require changes to document retention protocol
- Process in place to maintain a copy of any investigation records for counsel's review

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### Documentation - Example

**SBAR**

- "Resident A stated that she was hit by a tall bald man yesterday afternoon in the common room. Resident assessed with no injuries noted. Denies any pain. When asked about additional information Resident stated, "that's all I know."

**SOC341:**

- "Resident A was hit by a tall bald man yesterday while in the common room."

**Follow-up Report to CDPH:**

- "Resident A was the victim in an altercation. Resident A reported she was attacked by a tall bald man in the common room. Head to toe assessment completed with no injuries noted. Resident A could not identify the attacker. Resident A had a confrontation with a male resident last month in the common room. Will monitor both residents for further incidents."

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### Follow-up

- Post-investigation
  - How to respond to what you've learned
    - Collect all investigation materials
  - Consider next steps
    - Internal changes required/ update care plans
    - Resident care
    - In-services
    - Check in with residents/ IDT assessments
  - Survey/Complaint/self-report binder

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### Media Attention

- **Maintain Resident privacy!**
  - Even confirming a resident was/is in your facility could be problematic
  - Follow your facility protocols
  - Inform counsel/management immediately
  - Possible response themes:
    - We do not respond to media inquiries/we only respond in writing
    - Care/safety of residents is our top priority
    - We are implementing measures to safeguard against similar incidents
    - We are conducting a thorough investigation to identify the facts or cause of the incident

Use of a PR firm may be an appropriate consideration in certain circumstances

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### Preparation for Investigation by Licensing Agency, Law Enforcement, Department of Justice, Ombudsman

- In-servicing staff on their rights during a licensing investigation
- Right of access to records
  - Quality assurance logs (by LTC ombudsman (H&S 1424.1))
  - Resident records (by state and federal licensing agencies; by ombudsman only with resident consent (42 CFR 483.10(h)(3); 42 CFR 483.70(i))
  - Internal investigations
  - Not to privileged communications or attorney work product
- Audits and assessments
- Considerations regarding legal representation of employees

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### Preparation for Investigation -- Example

- After a licensing investigation into an incident you learn that multiple staff members provided CDPH with written statements. They inform you that they were each told they were required to write and sign a statement.

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**Response to Deficiencies or Citations**

- Significance of appealing regulatory violations
- Procedures for challenging violations
  - Informal
  - Formal

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**Response to Requests for Records**

- Family/Resident
  - Authorization signed by appropriate person (resident, executor, etc.)
  - Recommend having attorney review and remove privileged and non-responsive documents
  - Bates numbering
- Pre-litigation dispute resolution efforts
- Notification
- Licensing Boards
  - Basis for request
  - Scope of request
  - Clarification
  - Pre-investigated?

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**“Special” Adverse Incidents**

- Ransomware issues
- Whistleblower
- Sexual Harassment
- Overpayments
- Reporting

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**Communication with Insurance Carrier**

- Consideration at all steps in the process

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**Case Study**

- Resident has dementia and is a high fall risk. Resident had history of falls. Each time resident fell, IDT met, recommended interventions, and updated the resident's care plan. Resident continued to fall despite new interventions. On May 1<sup>st</sup> CNA assisted resident to transfer from wheelchair to bed, but resident was ultimately assisted to the floor.
- Licensed nurse assessed resident and no injuries were noted. Several days passed and resident started to complain of pain in her right hip area. X-ray was taken of right hip with negative result for fracture. Tylenol was given for pain and was effective. Two days later, CNA reported swelling in the right leg with high pain levels. X-rays were ordered for right hip and leg. Results indicated a right femur fracture.
- What steps would you take as an Administrator or DON?

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**Case Study – More Information**

- As part of the investigation you learn that the resident required a two person assist. CNA tells you she pressed the call light, but nursing staff was giving endorsement to the next shift, and no one came to assist. She proceeded with the transfer because the resident needed help. During the transfer resident's legs buckled and lost balance. CNA was not able to lift resident onto bed and had to assist resident to the floor.
- What steps would you take as an Administrator or DON?

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## Recapitulation

Considerations after an incident occurs in your community

- Take immediate actions for safety of all
- Consider appropriate reporting and documentation
- **Notify Risk Management and/or Legal Counsel**
- Insurer

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## Questions?

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