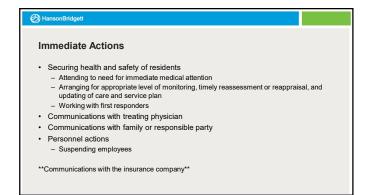


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Responding to an Adverse Action	
Considerations after an incident occurs in your community	
Immediate actions Reporting/documentation Investigations Media attention Legal actions Insurance	



(AnsonBridgett)	
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?	

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 	
Determining what decline header to declare and who should declare it	

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

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	

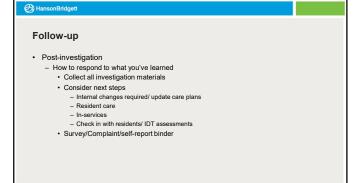


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Documentation Example	
Progress Notes:	
"Resident A has a dx of dementia and wanders. Resident A was involved in a peer to	
peer altercation. Resident B grabbed her upper arm. Resident A sustained a skin tear and bruising as a result."	
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Documentation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

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

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."

Documentation - Example



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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 incident 	i the
Use of a PR firm may be an appropriate consideration in certain circumsta	ances
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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 resident consent (42 CFR 483.10(h)(3); 42 CFR 483.70(i)) 	y with
 Internal investigations Not to privileged communications or attorney work product 	
Audits and assessmentsConsiderations 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 n	members
provided CDPH with written statements. They inform you that they were enthey 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 	е		
- 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 1st 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 	
Nouny Kisk management and/or Legal Counset Insurer	
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Questions?	