CNA

Aging Services Claim Report: 11th Edition

Foreword

CNA is pleased to collaborate with aging services providers in an effort to improve care outcomes for members of the senior population receiving care in our insured organizations. With more than 50 years of experience, CNA remains an industry leader in providing coverage for the professional liability exposures encountered by those who work in the aging services industry. We have again leveraged our experience in the industry and analyzed our closed claims data to raise awareness of those circumstances that occur most frequently and result in harm to residents. We recognize that even when excellent care is provided, resident comorbidities, system failures, and mismanaged customer expectations can result in adverse outcomes. CNA believes that understanding the conditions that lead to a claim will help care providers develop techniques to mitigate risk and minimize potential litigation. My sincere hope is that you share our passion for delivering quality experiences to seniors and are able to leverage the insight gained from this resource to assist you in doing so.

Blaine Thomas
CNA Vice President, Underwriting – Aging Services

CNA

Key Findings of the Aging Services Claim Report

There was a broad-based **increase in the average cost of claims** (average total incurred) across all care settings since the 2018 Aging Services Claim Report. (page 7)

The **average cost of claims in the assisted living setting** ($267,174) continues to **exceed** that of **skilled nursing facilities** ($245,559) in the 2021 dataset. (page 7)

Although **independent living claims** comprise only a small portion of the overall claim volume, large loss activity has driven an **increase in the average total incurred** ($254,606). (page 7)

Resident falls and **pressure injuries** remain persistent risks in aging services settings, representing **almost two-thirds of all claims** in the 2021 dataset. (page 8)

The average cost of **fall-related claims** remains the **highest in the assisted living setting**. (page 11)

The **average cost of fall-related claims** in the **skilled nursing setting** has shown a sharper **increase** compared to assisted living fall-related claims, driven in part by allegations of improper care. (page 12)

More than 59 percent of fall-related closed claim allegations in the skilled nursing and assisted living settings involved a **resident with a prior history of falls**. (page 16)

Claims in which there was a **history of a previous fall are more costly** than those with no prior history of falls. (page 16)

Dementia is a contributing factor in **72.9 percent** of all **assisted living fall-related closed claims**. (page 18)

The average total incurred for **pressure injury-related allegations** in the assisted living setting has **increased by more than 67 percent** (up to $282,358) since the 2018 dataset and has surpassed skilled nursing ($252,520). (page 19)

While **pressure injury claims** are less prevalent in the assisted living setting, approximately **two-thirds** of the pressure injury-related closed claims **involved the death of a resident**. (page 20)

Part 1: Report Overview

Introduction

With more than 50 years of providing insurance solutions for healthcare providers, CNA is recognized as a leader in the healthcare industry. Our dedicated and highly specialized aging services risk control, claim and underwriting professionals provide us with a unique perspective from which to identify exposures that continue to confront our insureds and the aging services industry.

Although the COVID-19 pandemic has presented the aging services industry with new challenges and loss potential, the ultimate effect of this pandemic upon litigation, claim frequency and severity remains uncertain.

The *Aging Services Claim Report: 11th Edition* will provide insight into challenges encountered by aging services organizations. The resource also includes claim scenarios to help raise awareness of potential risk factors, and provides practical risk management considerations to help mitigate sources of potential liability.

We hope that the information provided in this report will help organizations to identify areas of potential risk exposure. Aging services organizations should continue to evaluate and update their risk management processes, while implementing best practices to mitigate risk. Actions to consider and adapt to the individual aging services environment may include the following, amongst others:

- Develop a comprehensive pre-admission process, including accurate, sound and realistic marketing materials, to minimize potential liability associated with improper resident placement and retention decisions. Additional resources may be found in the CNA Healthcare *Alert Bulletin*® entitled "Pre-admission Screening: Key to Reducing Unsafe Retention Risks."
- Communicate realistic expectations and goals that engage families in safety initiatives and facilitate shared, informed decision making.
- Adhere to established transfer criteria and procedures to ensure timely intervention for those needing a higher level of care.
- Maintain comprehensive documentation of all discussions with residents and family members regarding resident admission, transfer, care planning and change in condition.

Executive Summary

In addition to the Key Findings outlined above, this report provides a focus on the development of realistic expectations with residents and their families while fostering relationship building through clear and transparent communications. **Part 4** of the report discusses expectation management and further explores the following topics:

- Aging services organizations create the foundation for an **open, trust-based relationship with residents and families** by fully disclosing service offerings, facility limitations and retention criteria at the outset of the engagement.
- A **sound pre-admission process and transfer/discharge protocols** are critical to minimizing liability associated with improper placement and retention decisions.
- **Placement suitability** of a potential resident should be determined by utilizing the pre-admission assessment to screen the resident's current and prior health status, as well as the probable path of geriatric conditions and potential complications related to the aging process.
- When negotiating parameters of care with residents and their families, **comprehensively describe the scope, frequency and duration of available resources** in relation to the resident's needs.
- During the admission process, and throughout the resident's stay, openly discuss the **likelihood of resident transfer** to a higher level of care based upon their changing care needs.
- Given the increasing age and acuity levels of assisted and independent living residents, it is imperative that organizations **candidly and comprehensively describe their service capabilities, as well as their limitations,** to prospective residents and families.
- As part of the pre-admission process, and as ongoing communications throughout their stay, residents and families should receive **education on the relationship between chronic conditions, the aging process and the occurrence of both falls and pressure injuries.**

Dataset and Methodology

The analysis in this report is based on 2,265 aging services professional liability claims that closed between January 1, 2018 and December 31, 2020. These claims will be referenced as the "2021 dataset" throughout the report. It should be noted that closed claims are historical by nature. As claims often take years to develop, this retroactive examination of closed claims does not reflect the value of current or future claims. Closed claims with an indemnity payment of less than $10,000 were excluded, as were claims from adult day care programs and home healthcare providers. Please note that percentages in charts or graphs may not add up to exactly 100 percent due to rounding or excluding categories that are immaterial to the analysis.

Limitations and Considerations

- **The data include only CNA-insured aging services organizations,** rather than the total universe of aging services organizations.
- **Indemnity and expense payments include only monies paid by CNA** on behalf of its insureds.
- **Deductibles are not included,** nor are other possible sources of payment in response to the claim.
- **The data reflect the $1 million per claim limit** typical of CNA primary professional liability insurance policies.
- **The data include those closed claims with a minimum indemnity payment of $10,000.**
- **Inclusion in this dataset is based upon the year a claim closed,** irrespective of when the incident occurred.
- **The data should not be directly compared with findings in previously published CNA claim reports** due to differing inclusion criteria.

Definitions

- **Average total incurred** or **average cost of a claim** refers to indemnity plus expense costs paid by CNA, divided by the number of related closed claims included in the dataset.
- **Bed type** refers to the level of service (e.g., independent living, assisted living or skilled nursing) provided at the time of the incident based upon the resident contract, as well as the policies and procedures or protocols established by the aging services 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 bed type, allegation or injury.
- **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, arbitration award or judgment of a claim.
- **Severity** refers to monies paid by CNA on behalf of CNA-insured clients resulting from the settlement of a claim, arbitration award or a jury verdict. It is expressed as the average paid per claim for indemnity and expense, or total paid (i.e., indemnity plus expense).

Abbreviations

Abbreviations used in this document include the following:

- AL/ALF: assisted living or assisted living facility
- IL/ILF: independent living or independent living facility
- SN/SNF: skilled nursing or skilled nursing facility
- ADLs: activities of daily living
- AIP: Aging in Place

Part 2: Closed Claim Analysis

Analysis of Claim Trends by Bed Type

Summary of Closed Claims by All Bed Types

Figure 1 demonstrates a shift in the distribution of claims occurring in the assisted living setting as compared to the 2018 dataset, with an increase from 18.7 percent to 21.6 percent. This is driven by multiple factors including changes to frequency and the portfolio mix.

Quantitative Findings

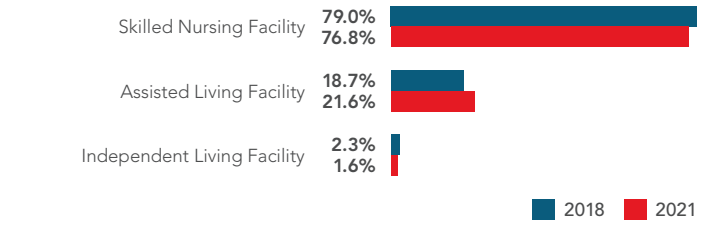
There was a broad-based **increase in the average cost of claims** (average total incurred) across all care settings since the 2018 Aging Services Claim Report, as indicated in **Figure 2**.

KEY FINDING

- In addition to the increase in severity of falls and pressure injuries in the 2021 dataset, there was also a noted increase in the severity of the following allegations:
  - Delays in seeking medical treatment
  - Medication errors
  - Resident abuse
  - Elopements
  - Improper care
  - Failure to monitor

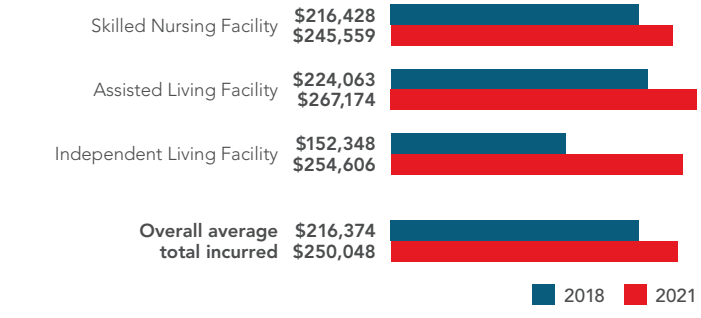
1 Distribution of Closed Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



2 Average Total Incurred by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



The **average cost of claims in the assisted living setting** ($267,174) continues to **exceed** that of **skilled nursing facilities** ($245,559) in the 2021 dataset.

KEY FINDING

- In assisted living settings, there was a notable increase in severity resulting from allegations involving failure to monitor.
- In skilled nursing facilities, the most notable increase in severity resulted from allegations involving delays in seeking medical treatment.

Although **independent living claims** comprise only a small portion of the overall claim volume, large loss activity has driven an **increase in the average total incurred** ($254,606).

KEY FINDING

Risk Insight

- The provision of services to higher acuity residents in the assisted living or independent living setting may increase potential risk exposures.
- While aging in place arrangements may be a beneficial marketing tool, retaining residents beyond the facility's capabilities increases the potential for unanticipated events and adverse claim outcomes.
- The lack of appropriate staffing may contribute to or exacerbate allegations of failure to monitor – and may lead to an increase in unwitnessed falls or delayed identification of pressure injuries.
- Aging services organizations may limit their risk exposures by establishing clear expectations regarding the service capabilities and limitations of their organization.
- A CNA analysis of customer engagements indicates that less than 25 percent of facility marketing materials convey realistic expectations regarding the ongoing risk of resident falls.
- The potential for severity emphasizes the need to set realistic expectations of services that may be delivered in aging services organizations. **Part 4** will provide additional insight.

Analysis of Claims by Allegation

Quantitative Findings

Resident falls and **pressure injuries** remain persistent risks in aging services settings, representing **almost two-thirds of all claims** in the 2021 dataset.

KEY FINDING

- Elopement-related claims comprise 1.8 percent of all closed claims, as seen in **Figure 3**. However, these claims continue to be some of the most expensive to close, with an overall average total incurred of $360,840 as noted in **Figure 4**. A review of the 2021 claim dataset shows that elopement-related claims occurred more frequently in the assisted living setting and had an average total incurred of more than $400,000.
- Allegations involving failure to monitor reflect one of the top five allegations in the assisted living setting, and also contribute to the higher average severity.
- Allegations involving sexual or physical abuse occur more often in and contribute to the higher severity in the assisted living setting.
- Allegations involving the failure to move residents to a higher level of care also contribute to the higher claim severity in the assisted living setting.

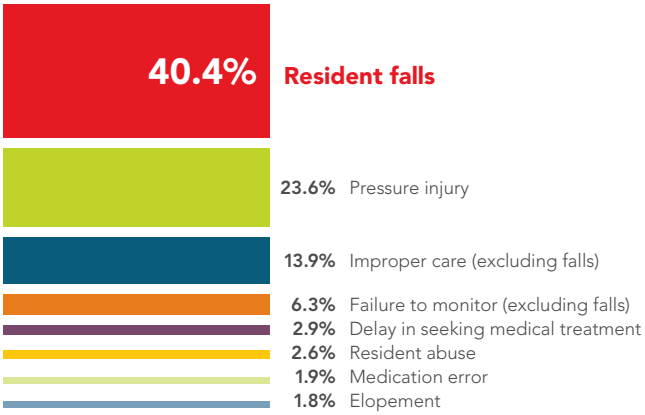
Risk Insight

- Analysis reveals that less than half of the insureds with whom we engage perform purposeful hourly rounding. Organizations should implement a rounding program to assist in risk mitigation related to elopements, falls, and resident abuse, amongst other exposures.
- To reduce the risk of resident falls, pressure injuries, resident abuse and elopements, organizations must be willing to engage nursing care and ancillary staff to:
  - Assist with resident observation
  - Pro-actively identify resident needs, and
  - Communicate resident needs to the care staff as appropriate.

For more information on pressure injury mitigation strategies, look for the upcoming CNA special resource on this topic in 2022. Subscribe to automatically receive this resource when it is released.

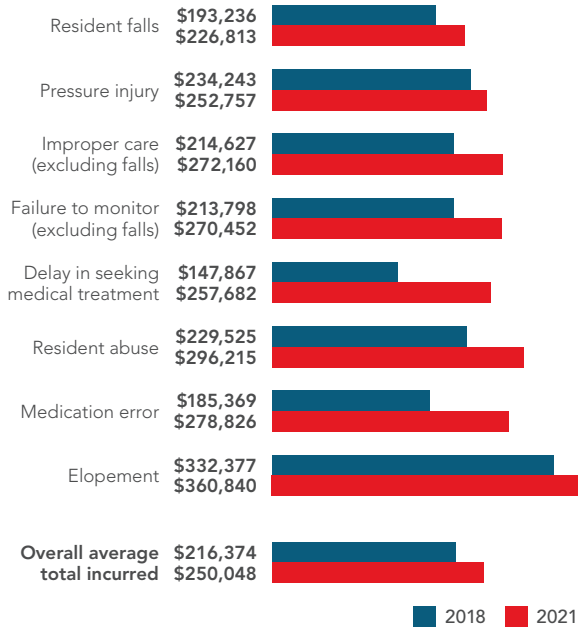
3 Distribution of Closed Claims by Top 8 Allegations

Closed Claims with Paid Indemnity of ≥ $10,000



4 Average Total Incurred of the Top 8 Allegations

Closed Claims with Paid Indemnity of ≥ $10,000



Analysis of Claims by Injury Type

Figure 5 demonstrates that 62.6 percent of closed claims involved a resident's death. These claims also represented the highest average total incurred in the 2021 dataset at $284,384 as noted in **Figure 6**.

Risk Insight

- While falls and pressure injuries are known occurrences and may result in serious injury or death, the failure to communicate or establish expectations with the family may be an aggravating factor contributing to the filing and severity of a claim.
- Facility acquired pressure injuries, as well as the delay in the initial identification of pressure injuries, may contribute to claim severity.

TOP 4 HIGHEST SEVERITY ALLEGATIONS

1 **$360,840**
Elopement

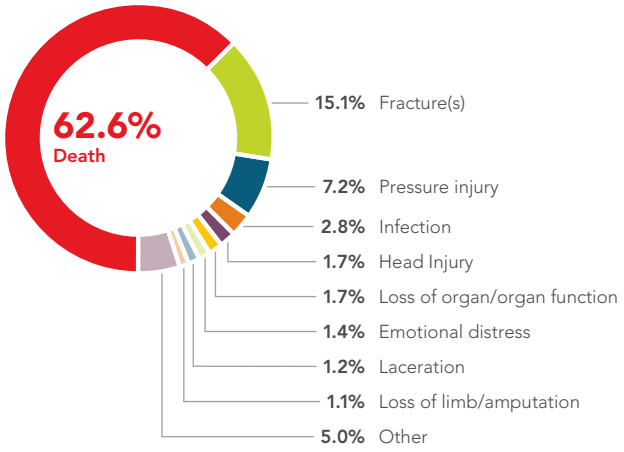
2 **$304,920**
Unsafe environment (excluding falls)

3 **$296,215**
Resident Abuse

4 **$287,415**
Failure to inform physician of change in/new condition

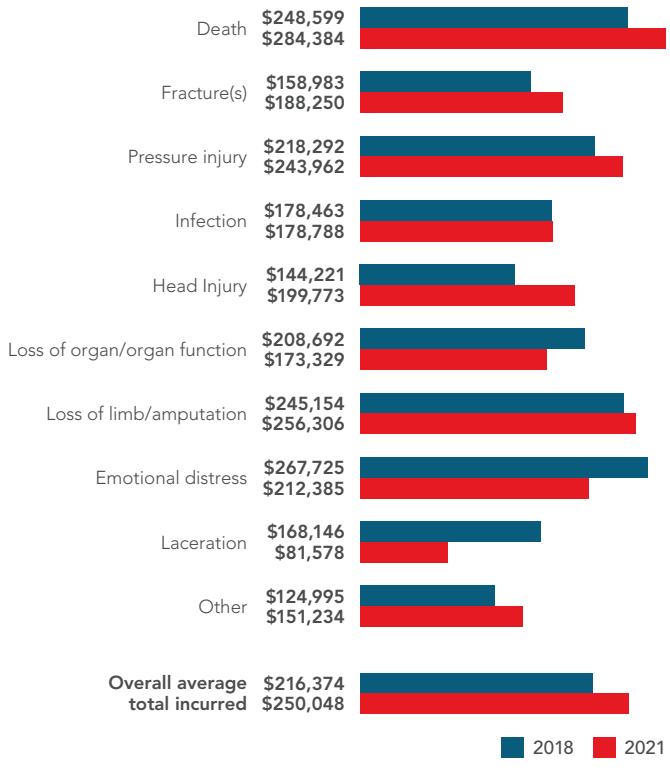
5 Distribution of Closed Claims by Injury Type

Closed Claims with Paid Indemnity of ≥ $10,000



6 Average Total Incurred by Injury Type

Closed Claims with Paid Indemnity of ≥ $10,000



Allegations by Setting

Assisted Living

Fall-related allegations continue to be the most common allegation in the assisted living setting, making up more than half (54.8 percent) of all claims. As shown in **Figure 7**, other than falls, the most common allegations include improper care, resident abuse, failure to monitor and pressure injuries. While pressure injury allegations are not prevalent in the assisted living setting, the severity of pressure injury claims has increased significantly. This will be discussed in more detail in **Part 3** of the report.

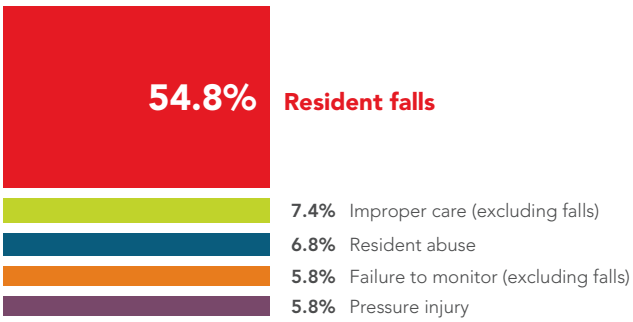
Skilled Nursing

Fall-related allegations continue to be the most common allegation in the skilled nursing setting, comprising 36.1 percent of all claims as seen in **Figure 8**. Pressure injury-related claims comprise 28.8 percent of the distribution. Combined, fall and pressure injury-related allegations account for approximately 65 percent of all claims in the skilled nursing setting, demonstrating that the industry continues to struggle with managing these sources of liability.

...the **failure to communicate** or establish expectations with the family may be an **aggravating factor** contributing to the **filing and severity of a claim**.

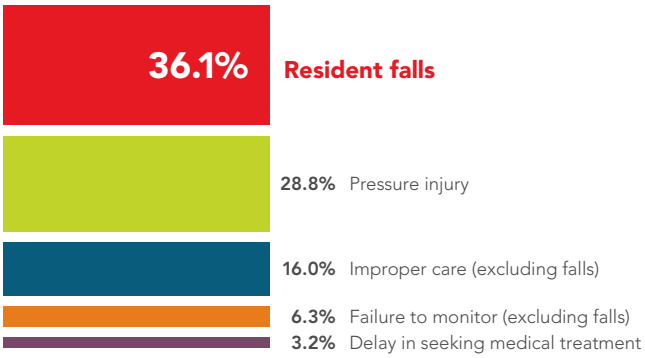
7 Most Frequent Allegations – Assisted Living

Percentage of 485 closed claims



8 Most Frequent Allegations – Skilled Nursing

Percentage of 1,728 closed claims



Risk Management Recommendations for Everyday Practice

- ☐ **Conduct comprehensive pre-admission screening to ensure placement of the resident in the appropriate care setting.**
- ☐ **Evaluate staffing practices and clinical protocols on an ongoing basis with a focus on providing a positive work environment that promotes resident safety and satisfaction.**
- ☐ **Document resident assessments, observations, communications, and actions in an objective, timely, accurate, complete, and appropriate manner.**
- ☐ **Encourage family involvement to cultivate realistic expectations, strengthen trust and help ensure that staff and family members share in the decision-making process.**

Part 3: A Focus on the Top Exposures

The remainder of the report will focus on the allegations related to falls and pressure injuries. These remain the top two allegations as seen in **Figure 9**.

Fall-related Closed Claims Data

There were 917 closed claims in the 2021 dataset that involved allegations related to a resident fall across all care settings. The average severity has continued to increase over the past several years, most notably in skilled nursing facilities as seen in **Figure 11**. The overall average total incurred for fall- related claims in all settings was $227,199.

KEY FINDING

The average cost of **fall-related claims** remains the **highest in the assisted living setting**.

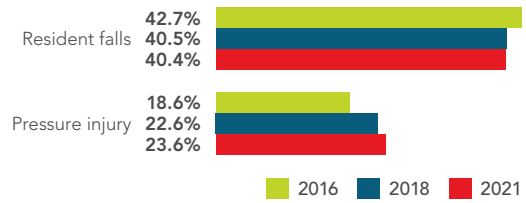
Distribution of Closed Fall Claims by Bed Type

A comparison of the fall-related closed claim distribution from prior reports demonstrates an increase in the percentage of claims occurring in the assisted living setting as shown in **Figure 10**. This is attributed to changes in claim frequency and the portfolio mix.

A comparison of the **fall-related closed claim** distribution from prior reports demonstrates an **increase** in the percentage of claims occurring in the **assisted living setting**.

9 Distribution of Closed Claims by Focus Allegations

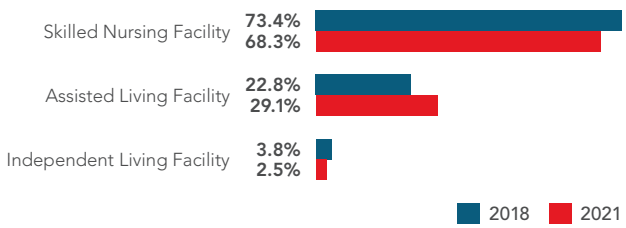
Closed Claims with Paid Indemnity of ≥ $10,000



To learn more about the risk factors that independent living organizations face, access the CNA Healthcare *Alert Bulletin*® on this topic.

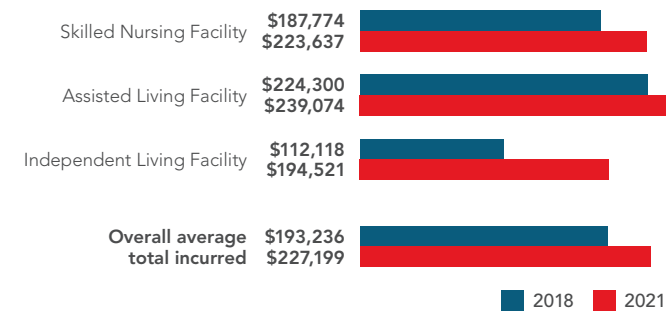
10 Distribution of Fall-related Closed Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



11 Average Total Incurred of Falls by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



Fall Claims by Top Allegations

The remainder of this section of the report is limited to falls that occurred in the assisted living or skilled nursing setting, which comprise 97.4 percent of all fall-related claims. Improper care represents the top allegation for fall-related closed claims at 51 percent as shown in **Figure 12**. Closed claims related to this allegation had an average total incurred of $229,934 as seen in **Figure 13**. Examples of fall-related improper care allegations include, but are not limited to:

1. Dropping a resident during transfer.
2. Failure to follow the resident's care plan, e.g. conducting a one person transfer when two individuals are required.
3. Failure to identify an individual as being at risk for falls.

An example of a case scenario involving an improper care allegation includes:

> A 74 year old male was admitted to an assisted living facility where he resided for more than two years. Two months prior to his fall, his service plan was updated to include a requirement for a two person transfer. A certified nursing assistant (CNA) who was new to the facility failed to review the service plan and attempted to transfer the resident to his bed independently, resulting in the resident falling to the floor. The resident was not transferred to the hospital until the following day, where he was diagnosed with a femur fracture as well as ulnar and radius fractures of both arms. The femur fracture was treated non-surgically with a leg-immobilizer, which caused wounds to develop on his lower extremity. In addition, Stage 4 wounds developed on his coccyx, requiring multiple debridements over the next six months. These issues eventually led to sepsis and contributed to his death.

KEY FINDING

The **average cost of fall-related claims** in the **skilled nursing setting** has shown a sharper **increase** compared to assisted living fall-related claims, driven in part by allegations of improper care.

Responding to Adverse Events

Adverse events should be reported to a clinical supervisor or risk manager per policy requirements, and an incident report should be completed promptly. Adverse events include incidents involving one or more of the following:

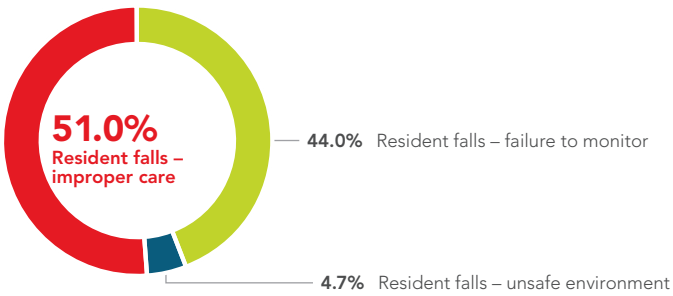
- ☐ **A resident is harmed or sustains an injury.**
- ☐ **An outcome has potential clinical significance.**
- ☐ **An outcome differs from anticipated results.**
- ☐ **An unexpected safety crisis.**

For more information on resident safety and responding to adverse events, we recommend consulting the following resources:

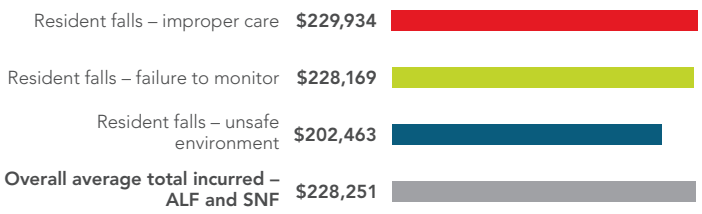
- CMS Adverse Events in Nursing Homes
- AHRQ: TeamSTEPPS® Training
- Institute for Safe Medication Practices (ISMP)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)

12 Distribution of Fall-related Closed Claims by Top Allegations (Limited to ALF and SNF)

Only top allegations were included and will not equal 100 percent.



13 Average Total Incurred of Fall-related Closed Claims by Top Allegations (Limited to ALF and SNF)



Risk management recommendations

- Conduct and document fall evaluations upon admission, post-fall, and upon change in condition.
- Determine if the resident experienced a change in condition and transfer to a higher level of care if indicated.
- Update service plans as appropriate and communicate to nursing staff.
- Comply with service plan directives.
- Continue to evaluate residents to confirm appropriateness for assisted living residency as permitted by state regulations, avoiding prohibited conditions.
- Promptly obtain medical examination and treatment post incident.

Failure to monitor was the allegation in 44 percent of resident falls as shown in **Figure 12**. This allegation had an average total incurred of $228,169 as noted in **Figure 13**. Lack of adherence with care plan monitoring requirements, such as when sitting in a wheelchair or left unattended on a commode, often lead to a resident fall. The following scenario is compounded by a resident with confusion and agitation:

> A 90 year old male was admitted to a skilled nursing facility following hospitalization for hyponatremia, a history of dementia and falls, and multiple other co-morbidities. Nursing documentation noted frequent agitation and a propensity to pace back and forth in the hallways. Staff continued to remind him to wear shoes or gripper socks when out of bed and walking. The resident showed signs of increasing agitation and confusion. Two years after his admission, the resident was in the dining room, unaccompanied by staff, when he attempted to sit in a chair that was already occupied by another resident. In trying to move to another chair, he fell, hitting his head. He was transferred to the hospital where a CT scan revealed a subdural hematoma. The resident died five days later. The lawsuit alleged failure to monitor. The case settled for $375,000.

Review the **admission screening** to **determine if the potential resident** fulfills the admission criteria and **may be safely cared for** and accommodated in accordance **with facility capabilities**.

Risk management recommendations

- Review the admission screening to determine if the potential resident fulfills the admission criteria and may be safely cared for and accommodated in accordance with facility capabilities.
- Provide additional supervision and precautions when a resident has a history of wandering or dementia.
- Implement the use of fall risk indicators to alert staff regarding residents at high risk for falls.
- Staff caring for residents with dementia should receive specific training on the disease process.
- Ensure that the care planning process denotes additional monitoring requirements for residents with a history of dementia and previous falls.
- Discuss the aging process with family and develop realistic expectations.

The Importance of Documentation

The resident healthcare information record is a legal document. A well documented record can:

1. **Provide an accurate reflection** of resident evaluation, change in condition, and care/service plan compliance.
2. **Guard against miscommunication and misunderstanding** among the interdisciplinary resident care team.
3. **Demonstrate the timeline** of care provided.
4. **Guard** against a lengthy litigation process.

Top 5 Fall-related Injuries

Death is the most frequent outcome associated with fall-related claims at 59.4 percent of the claim distribution, as shown in **Figure 14**. The average total incurred for fall-related death claims ($262,458) far surpasses other injuries as indicated in **Figure 15**. The frequency of fall claims resulting in death, coupled with the high severity associated with these claims, highlights the need for an ongoing focus on fall mitigation strategies as demonstrated in the case scenario below:

> An 85 year old male was admitted to an assisted living facility, ambulatory with the aid of a walker, and a history of Alzheimer's disease. The service plan included continence checks every 2 hours. The Resident Care Manager, who was covering the night shift, failed to provide the q2 incontinence checks for the resident, who was subsequently found on the floor of his room around 5:00 am. The resident's fall was not reported to family members or his physician. However, a post-lawsuit review of the record indicated a late entry reflecting that the family and physician were notified. After visiting the following day, the family became concerned upon observing bruising and increased confusion. They attempted to contact the Director of Nursing (DON) to coordinate a physician's visit. The DON failed to respond to messages, which resulted in a missed physician's appointment. Two weeks later, the resident was transferred to the hospital with symptoms of a stroke and was subsequently diagnosed with a subdural hematoma. He was discharged to a skilled nursing facility with documented loss of all functional capacity and inability to communicate. He resided there until his eventual death five months later. A lawsuit was filed and settled for an amount in the high six figures.

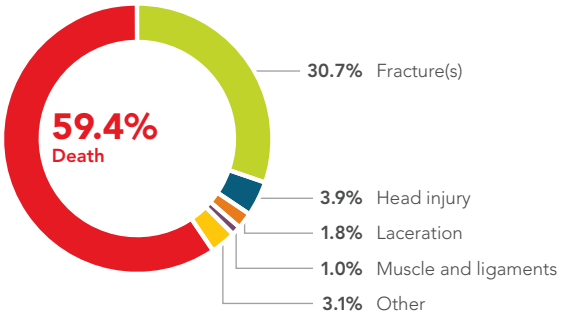
Risk management recommendations

- Provide additional supervision and precautions when a resident has a history of wandering or dementia.
- Comply with service plan directives.
- Report all falls, per policy, in a timely manner.
- Document actions taken that promote resident safety and service plan compliance in a timely manner.
- Conduct chart audits to assess the quality of documentation on a routine basis.
- Adopt a formal disclosure policy and procedure with documentation guidelines in order to consistently communicate facts pertaining to falls and changes in service plan, as well as effectively manage expectations of residents and families.
- Obtain a physician statement that the resident's status remains appropriate for assisted living residency if the resident is experiencing multiple falls.

Conduct and document thorough **fall assessments** upon admission **including a history of prior falls** and conditions that may increase a resident's propensity to fall.

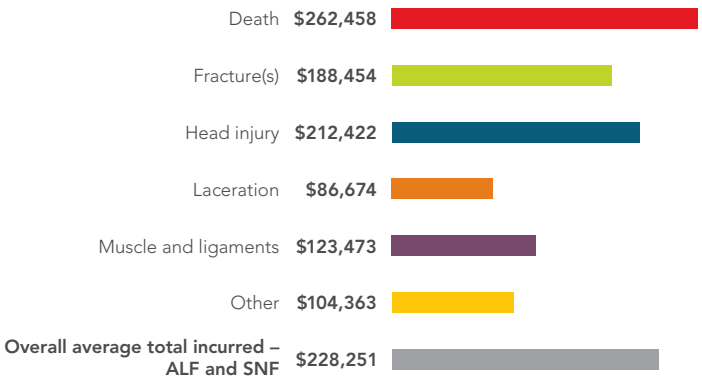
14 Top 5 Fall-related Injuries (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



15 Average Total Incurred of Top 5 Fall-related Injuries (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



Fall Claims by Witnessed Status

Figure 16 highlights that 64.8 percent of falls were unwitnessed. As **Figure 17** demonstrates, witnessed falls in the 2021 dataset were more costly than unwitnessed falls: $245,042 versus $220,923. The following two case scenarios provide examples of witnessed falls in which the ultimate outcome of the lawsuit was affected by a lack of compliance with the care plan directives, inadequate documentation and failure to provide timely care.

An 80 year old male was admitted to a skilled nursing facility. His care plan noted that he required a two-person transfer. A CNA was transferring the resident from his bed to his wheelchair when he began to slip. She lowered him to the floor. She made no notation in the resident healthcare information record until three days later, when the resident began to complain of pain. He was transferred to the hospital where he was diagnosed with a fractured hip and bilateral lower leg fractures. He underwent surgical repair, was discharged to hospice and died a month later. A lawsuit was filed against the facility. Lack of compliance with the care plan, as well as delayed documentation made it a difficult case to defend. The case settled for more than $800,000.

Risk management recommendations

- Comply with care plan directives.
- Ensure that staff obtain assistance for residents requiring a two-person transfer per their care plan.
- Report all falls, including near falls and lowering to the floor, in a timely manner.
- Timely document actions taken that promote resident safety and care plan compliance.
- Adopt a formal disclosure policy and procedure with documentation guidelines in order to consistently communicate fall facts and changes in care plan, as well as effectively manage expectations of residents and families.

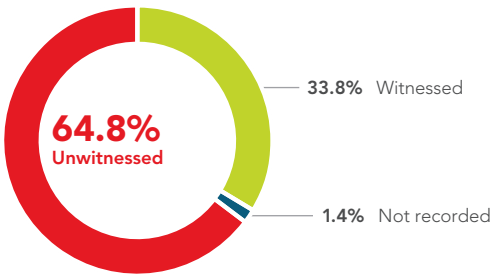
An 86 year old male was admitted to a skilled nursing facility with a history of deep vein thrombosis (DVT), anticoagulant therapy and a general decline in condition following a stroke. A week after admission, the resident fell out of his wheelchair while being transported by staff. The resident was admitted to the hospital where his condition continued to decline until his ultimate demise one month later. A lawsuit was filed against the facility. Defense of the case was hindered by a lack of assessment documentation upon admission, an incomplete care plan that failed to adequately address the resident's risk for falls and a 13 hour delay in transferring the resident to the hospital for a CT scan. The case settled for more than $500,000.

Risk management recommendations

- Conduct and document thorough fall assessments upon admission including a history of prior falls and conditions that may increase a resident's propensity to fall.
- Discuss the aging process with family and develop realistic expectations.
- Ensure that the care plan is comprehensive and addresses the resident's needs.
- Properly secure residents during transport.
- Promptly obtain medical examination and treatment post incident.

16 Distribution of Fall-related Closed Claims by Witnessed Status (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



17 Average Total Incurred of Fall-related Closed Claims by Witnessed Status (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000

Fall Claims by Previous Fall

As demonstrated in **Figure 18**, 59.7 percent of the fall-related closed claims involved a resident who had a history of a previous fall. Closed claims involving residents with a history of falls resulted in a higher average total incurred of $242,232 in the 2021 dataset, as noted in **Figure 19**. Knowledge of a previous history of falls may result in a higher expectation being placed upon the facility to implement additional measures in order to prevent recurrence. The following case scenario describes a closed claim in which the facility failed to follow the care plan and did not implement additional measures relative to the resident's propensity to fall.

> A 68 year old male, with a pre-admission history of multiple falls, fell several times during his two year residency at the skilled nursing facility. No injuries had previously been sustained during his falls. The CNA was attempting to transfer the resident from his bed to his wheelchair when she stepped into the hallway to ask another CNA for assistance. The second CNA responded that she could assist in a few minutes. When the second CNA came to help, the first CNA stated she was able to transfer the resident without a problem. However, when the daughter visited later that evening, she noted bruises on various areas of her father's body and head. The DON then assessed the resident and noted two bruised areas on the resident's shoulder, a bump on the right side of his head and a scrape to his lower leg. The resident was transferred to the local hospital emergency room for further evaluation. The hospital called later to advise that the resident was being admitted due to altered mental status and subdural bleeding. The resident was diagnosed with a subdural hematoma and a facial fracture. The facility initially stated the fall was of unknown etiology, but an investigation revealed that the CNA had dropped the resident during her attempt to transfer him independently. She failed to notify her supervisor of the incident and also failed to document anything in the resident healthcare information record. The resident died one year later. The case was settled for more than $650,000.

KEY FINDING

More than 59 percent of fall-related closed claim allegations in the skilled nursing and assisted living settings involved a **resident with a prior history of falls**.

Risk management recommendations

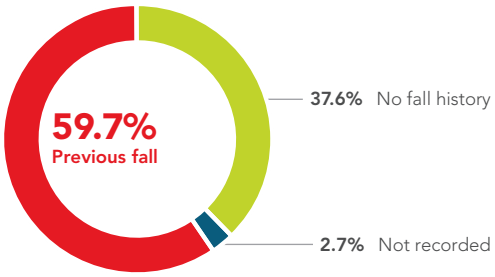
- Develop written admission criteria to determine if available services meet the needs of the resident.
- Conduct and document comprehensive fall assessments upon admission, including a history of prior falls and conditions that may increase a resident's propensity to fall.
- Include additional monitoring and transfer considerations in care planning requirements.
- Ensure appropriate staffing that permits two-person assists for those with additional needs for assistance.
- Orient staff to the importance of accurate and timely documentation.
- Adopt a formal disclosure policy and procedure with documentation guidelines in order to consistently communicate fall facts and changes in care plan, as well as manage expectations of residents and families.

KEY FINDING

Claims in which there was a **history of a previous fall are more costly** than those with no prior history of falls.

18 Distribution of Fall-related Closed Claims by Previous Fall (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



19 Average Total Incurred of Fall-related Closed Claims by Previous Fall (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000

Fall History – Additional Insight

Figure 20 reveals that, for fall-related claims resulting in death, 62.2 percent had a prior history of falls with an average total incurred of $277,247. This is compared to an average total incurred of $243,435 for those with no prior history of falls. Organizations should ensure that care or service planning takes into account a resident's prior history of falls and other co-morbidities that may contribute to the potential of falls.

> A 95 year old male was admitted to a skilled nursing facility with a well-documented history of dementia and multiple falls. The resident healthcare information record failed to reflect any fall precautions that should have been implemented at the time of his admission. After the resident's first fall, the family was notified that the resident was "fine." When the family arrived at the facility, they became aware that the resident was allowed to ambulate independently, with minimal monitoring. They also noted numerous facial bruises and a large lump on his head. One week later, the resident fell again resulting in a right subdural hematoma. He was airlifted to a local trauma center for treatment and died the same day. The case settled for more than $450,000.

Risk management recommendations

- Document fall evaluation and implementation of precautions in the resident healthcare information record.
- Ensure that the care plan establishes increased monitoring expectations for residents with a dementia diagnosis and prior history of falls.
- Evaluate residents after each fall.
- Implement the use of fall risk indicators to alert staff regarding residents at high risk for falls.
- Adopt a formal disclosure policy and procedure with documentation guidelines in order to consistently communicate fall facts and changes in the care plan.

Ensure that the **care or service plan** establishes **increased monitoring** expectations for **residents with a dementia diagnosis and prior history of falls**.

An effective fall-reduction program may help curb the rise in claim severity. For a summary of common fall-related allegations and preventive measures, download the *CareFully Speaking*® publication entitled "Resident Falls: A Collaborative Strategy for Risk Mitigation."

20 Average Total Incurred of Fall-related Closed Claims by Fall History (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000

	Death Claims		Non-Death Claims	
Fall History	Claim Distribution	Average Total Incurred	Claim Distribution	Average Total Incurred
Previous Fall	62.2%	$277,247	56.0%	$185,202
No Fall History	34.8%	$243,435	41.8%	$171,824
No Information Available	3.0%	$177,130	2.2%	$118,340

Dementia as a Contributing Factor in Fall-related Closed Claims

KEY FINDING

Dementia is a contributing factor in **72.9 percent** of all **assisted living fall-related closed claims** as indicated in **Figure 21.**

Figure 22 details the average total incurred for fall-related closed claims with dementia as a contributing factor as $242,269 for the assisted living setting and $226,390 for the skilled nursing setting. Facilities should ensure that all residents undergo pre-admission screening to verify that their condition is appropriate for the care setting. The following case scenario provides an example of a resident with advanced dementia and other co-morbidities who was admitted to an assisted living environment and experienced a fall with injury resulting in death.

> An 89 year old male with a history of advanced dementia and multiple underlying conditions was admitted to an assisted living facility for hospice care. He was in his room receiving assistance dressing when he lost his balance and began to fall. The aide lowered him to the floor. The resident denied injury but was noted to be more confused than normal. The daughter was informed of the fall and advised that there was no injury. Two days later, she visited her father and noticed that he was in pain and slumped over in his chair, with increased confusion. She requested that he be examined. He received an x-ray the following day which revealed a fracture of his right hip. He expired 5 days later. The death certificate listed cause of death as complications from fracture. The daughter filed a lawsuit alleging negligence. The lawsuit also included a request for a copy of the video from the hallway outside of her father's room, which the facility was unable to produce. A spoliation claim was then added to the lawsuit. The claim was settled for $250,000.

Risk management recommendations

- Develop written admission criteria to determine if available services meet the needs of the resident.
- Ensure the service plan establishes increased monitoring expectations for residents with a dementia diagnosis and prior history of falls.
- Evaluate residents after each fall.
- Adopt a formal disclosure policy and procedure with documentation guidelines in order to consistently communicate fall facts and changes in service plan.

Review these Risk Control Areas of Concern

- ☐ Pre-admission Screening
- ☐ Documentation
- ☐ Transfer to a Higher Level of Care
- ☐ Care/service Plan Compliance
- ☐ Expectation Management

A sound pre-admission screening process is critical to minimizing liability associated with improper resident placement and retention decisions. Access the CNA Healthcare *Alert Bulletin*® resource to learn more about the importance of this process.

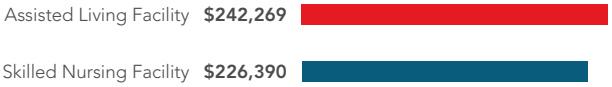
21 Dementia as a Contributing Factor in Fall-related Closed Claims

Closed Claims with Paid Indemnity of ≥ $10,000

Setting	Claim Distribution
Assisted Living Facility	72.9%
Skilled Nursing Facility	57.7%

22 Average Total Incurred of Dementia as a Contributing Factor in Fall-related Closed Claims

Closed Claims with Paid Indemnity of ≥ $10,000



Pressure Injury-related Closed Claims Data

This section of the report is limited to pressure injury claims that occurred in the assisted living or skilled nursing setting. For the 2021 dataset, there were 535 claims, with an average total incurred of $254,108.

Pressure Injury Closed Claims by Bed Type

Although pressure injuries are predominantly an issue for skilled nursing, they also occur in assisted and independent living facilities, especially as an increasing number of residents in those settings desire to "age in place." A review of the 2021 dataset will reflect that 94.7 percent of closed claims with a pressure injury-related allegation occurred in a skilled nursing facility, as detailed in **Figure 23**.

KEY FINDING

The average total incurred for **pressure injury-related allegations** in the assisted living setting has **increased by more than 67 percent** (up to $282,358) since the 2018 dataset and has surpassed skilled nursing ($252,520) as shown in **Figure 24**.

The following case scenario provides an example of a closed claim allegation involving a pressure injury in the assisted living setting. This case scenario also highlights the importance of proper documentation and coordination of care with contracted or external providers:

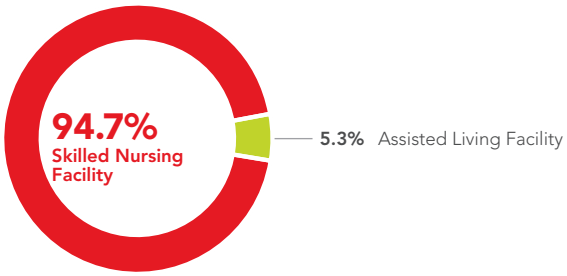
> An 80 year old non-ambulatory male with advanced dementia and a history of incontinence was admitted to an assisted living memory care unit. The initial skin observations noted dry, flaking skin. No additional documentation was noted for two weeks until an order was written for home health to evaluate and treat wounds. It was unclear in the resident healthcare information record if the home health care provider had previously evaluated the wounds. The next documentation was one week later in which a Stage 2 pressure injury was noted on the right buttock. There was no documentation of the potential need to transfer the resident to another facility until 10 days later when a hospital transfer was initiated. At the hospital, the resident was treated for multiple pressure injuries before ultimately being discharged to a rehabilitation facility. Two weeks later, he returned to the hospital where he was diagnosed with sepsis due to a sacral decubitus pressure injury. He died one month later. A lawsuit was asserted against the assisted living facility and ultimately settled for $340,000.

Risk management recommendations

- Perform skin evaluations on admission, upon readmission, on a regularly scheduled basis and when there is a significant change in the resident's condition.
- Document referral of residents with non-healing wounds to an appropriate specialist in a timely manner.
- Incorporate documentation of contracted providers, such as home health care, into the resident healthcare information record.
- Determine if the resident has a change in condition and transfer to a higher level of care if indicated.
- Continue to evaluate residents to confirm appropriateness for assisted living residency as allowed by state regulations, avoiding prohibited conditions.
- Provide educational programs for staff regarding the prevention of pressure injuries as part of the mandatory staff orientation and training.
- Adopt a formal policy to ensure consistent communication with family of changes in resident condition with a focus on managing the expectations of residents and families.

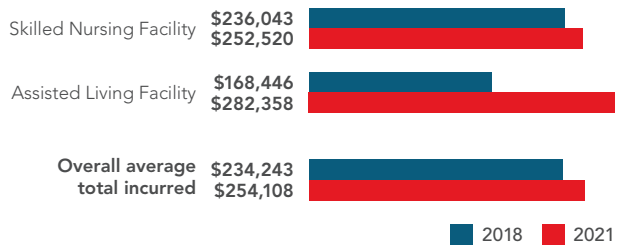
23 Distribution of Pressure Injury Closed Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



24 Average Total Incurred of Pressure Injury Closed Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



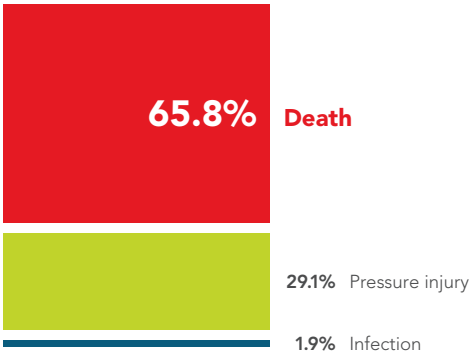
Pressure Injury Claims by Injury Type

Figures 25 and 26 note that, for both skilled and assisted living settings, approximately two-thirds of pressure injury closed claims resulted in death with an average total incurred loss of $261,828. The following claim scenario details an incident in which an assisted living resident's pressure injury progressed in severity, ultimately resulting in death:

> A 78 year old male was admitted to the assisted living facility after living independently at home. Six months following admission, he sustained a witnessed fall which resulted in a fractured hip. A couple of months later, the resident fell again, causing abrasions to both knees. The resident subsequently developed a small pressure injury on his left ankle, which was initially assessed as a Stage 2 – and later noted to actually be a Stage 4. The resident also developed a Stage 4 sacral wound that required surgical debridement. The resident died two weeks later. A lawsuit was filed against the assisted living facility which included allegations that the resident was not appropriate for continued assisted living residency as permitted by state regulations. The case settled for $600,000.

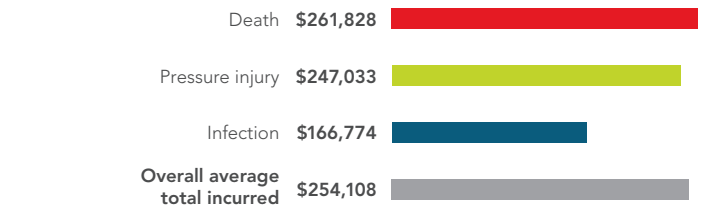
25 Distribution of Pressure Injury Closed Claims by Injury Type (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



26 Average Total Incurred of Pressure Injury Closed Claims by Injury Type (Limited to ALF and SNF)

Closed Claims with Paid Indemnity of ≥ $10,000



While **pressure injury claims** are less prevalent in the assisted living setting, approximately **two-thirds** of the pressure injury-related closed claims **involved the death of a resident**.

KEY FINDING

Risk management recommendations

- Develop written admission criteria to determine if available services meet the needs of the resident.
- Document referral of residents with non-healing wounds to an appropriate provider in a timely manner.
- Evaluate residents who are at risk of developing pressure injuries and implement interventions to maintain skin integrity.
- Ensure that documentation includes evaluation of wound and interventions in the resident healthcare information record.
- Determine if the resident has a change in condition and transfer to a higher level of care if indicated.
- Continue to evaluate residents to confirm appropriateness for assisted living residency as permitted by state regulations, avoiding prohibited conditions.
- Provide educational programs for staff regarding the prevention of pressure injuries that is part of the mandatory staff orientation and training.

Continue to **evaluate residents** to confirm **appropriateness for assisted living residency** as permitted by **state regulations**, avoiding prohibited conditions.

For more information on how to reduce risk and strengthen defensibility download the *CareFully Speaking*® entitled "Pressure Injuries: Sound Documentation is Key to Defensibility."

Pressure injuries are costly and may result in death, as seen in **Figures 27, 28, 29 and 30**. A review of the resident healthcare information record often reveals that the defensibility of claims is impeded by the lack of adherence to a facility's own policies and procedures as discussed in the following case scenario:

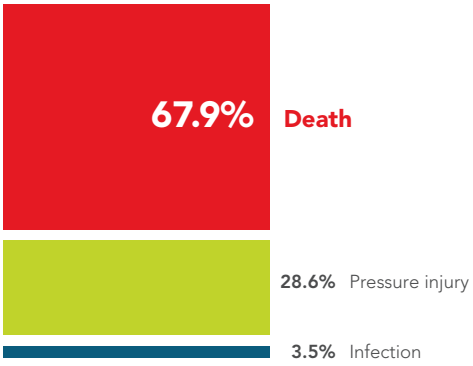
> A 75 year old female, who was totally dependent and required a two person transfer for all activities, was admitted to a skilled nursing facility. Upon admission, she was noted to have red, blotchy areas on both feet and ankles. Eight days later, open areas on both feet were noted in the resident healthcare information record. Physician orders included position changes every two hours. However, a review of the record revealed limited nursing documentation to support that the physician orders were followed. In addition, there was late documentation noted in the skin assessments conducted over the next several weeks. The skin breakdown continued to worsen over a six week period and progressed to include the groin, buttocks, coccyx and perineal area. The family initiated the request for transfer to a local hospital for additional wound care, where she underwent repeated debridement of her wounds. She was eventually admitted to hospice and died two months later. A lawsuit was initiated and settled for more than $1 million.

Risk management recommendations

- Evaluate residents who are at risk of developing pressure injuries and implement interventions to maintain skin integrity.
- Implement a process for weekly wound monitoring, assessment, intervention and documentation.
- Ensure consistent assessment procedures are conducted by qualified personnel, both upon admission and routinely thereafter.
- Establish an individualized care plan that includes the resident/family and multi-disciplinary team as appropriate.
- Document actions taken that promote resident safety and care plan compliance in a timely manner.
- Adhere to physician orders with associated documentation to verify compliance.
- Determine if the resident has a change in condition and transfer to a higher level of care if indicated.

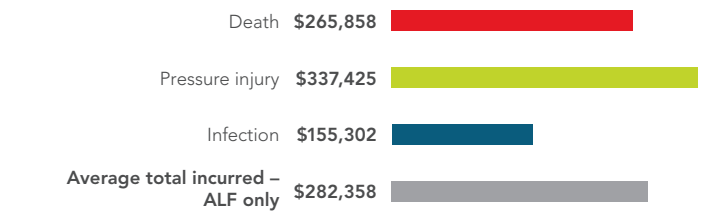
27 Distribution of Pressure Injury Closed Claims by Top Injury Type – Assisted Living Only

Closed Claims with Paid Indemnity of ≥ $10,000



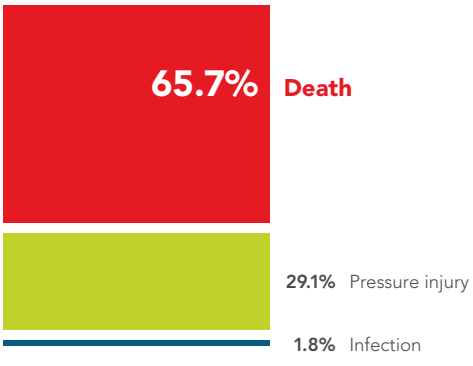
28 Average Total Incurred of Pressure Injury Closed Claims by Top Injury Type – Assisted Living Only

Closed Claims with Paid Indemnity of ≥ $10,000



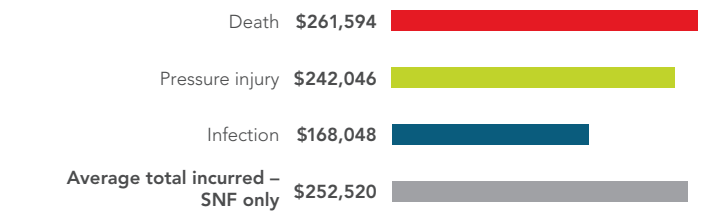
29 Distribution of Pressure Injury Closed Claims by Top Injury Type – Skilled Nursing Only

Closed Claims with Paid Indemnity of ≥ $10,000



30 Average Total Incurred of Pressure Injury Closed Claims by Top Injury Type – Skilled Nursing Only

Closed Claims with Paid Indemnity of ≥ $10,000



Part 4: Expectations Management

Aging in place (AIP) arrangements, which permit residents to reside in one location as their care needs evolve, represent a popular means of attracting prospective residents to aging services organizations. Families find AIP arrangements attractive because they help to promote continuity of care. Thus AIP tends to diminish concerns associated with having to transition a loved one to a higher level of care.

The willingness to accommodate AIP requests is not without risks for facilities, as underscored by many of the above case scenarios. Care should be taken to ensure that a facility maintains compliance with federal and state regulations in accordance with licensure status. Resident injury, allegations of unsafe resident retention and other unintended liability exposures may result when resident care needs exceed available resources.

Clear and transparent communication with residents and families regarding the realities of AIP arrangements may help reduce potential exposures. The following three actions are recommended to help facilities proactively manage expectations of residents and their family members:

1. Thoroughly screen prospective residents

A sound pre-admission screening process is critical to minimizing liability associated with improper resident placement and retention decisions. Routine review of rules and regulations help facility administrators to ensure that admission criteria comply with jurisdictional requirements applicable to the specific setting type. At a minimum, the pre-admission screening process should include the following:

Service disclosure

Aging services organizations create the foundation for an open, trust-based relationship with residents and families by fully disclosing service offerings, facility limitations and retention criteria at the outset of the engagement. If it is apparent during the pre-admission screening process that the capabilities of the facility do not correspond to the needs of the prospective resident, he or she should be directed to another source of care.

When accepting residents, admission agreements should expressly state that residents whose conditions and needs change will be transferred to another level of care. As an extra measure of defense, administrators should document the following in the agreement:

1. The capability of the facility to provide the level of care needed.
2. Available resources relative to the resident's functionality and cognitive status.
3. The resident's medical care and monitoring requirements.

In the event that an admitted resident later requires a higher level of care, the reason should be documented in the resident healthcare information record, and safe arrangements should be provided while facility administrators work with the family to find a more appropriate care setting.

Placement suitability

An important purpose of pre-admission assessment is to identify risk factors indicating that a potential resident is not a suitable candidate for a specified setting. With that goal in mind, the screening process requires an assessment of the resident's current health status, as well as the probable course of geriatric conditions and potential complications related to the aging process. Decisions regarding the suitability of placement should focus on areas such as:

- declining mobility
- eating/feeding difficulties
- incontinence
- skin breakdown
- confusion/cognitive impairment
- sleep disorders
- susceptibility to falls
- wandering/exit seeking behaviors
- need for ADL-related support
- ability to independently evacuate the facility in an emergency

Prospective residents and/or their families may be reluctant to fully disclose physical and mental deficits as these issues may "disqualify" them from admission to a desired location or increase the cost of care. To overcome this hesitancy, reiterate to residents and families that candid discussions of current capabilities help the organization to clarify resident needs, determine whether the care setting is appropriate, and create a realistic and responsive care plan.

The decision-making process regarding placement suitability presents an opportune time to begin the discussions of realistic expectations. If the facility lacks sufficient human or equipment resources to meet present or anticipated needs, communicate this concern to the prospective resident and their family members, while also noting the recommendation to seek another level of care in the screening report.

Needs identification

When negotiating parameters of care with residents and their families, comprehensively describe the scope, frequency and duration of available resources in relation to the resident's needs. Discussions should be based on the following basic areas of concern, among others:

- **Medical needs,** including degenerative conditions that affect a resident's ability to function independently, require frequent staff intervention or are associated with increased levels of monitoring.
- **Functional status,** including a resident's ability to perform ADLs, as well as whether the facility possesses the staffing levels, equipment and assistive devices necessary to meet the resident's current and emerging needs.
- **Behavioral issues,** such as wandering or exit seeking, aggression and impulsiveness, generally require placement within a secured, high-acuity facility.
- **Cognitive impairment** due to Alzheimer's disease or other forms of dementia and psychosis related to Parkinson's disease may signal the need for admission to a memory care facility or another setting offering a higher level of care.

Document all discussions regarding service needs with residents and family members – including questions asked and answers given – in resident selection records and admission agreements. Examples of communication strategies are provided below:

Sample Verbiage for Communicating Service Limitations

Regarding medical needs…

"As we discussed during the admissions process, our highest priority is to safely meet your service needs. Although your condition is now of moderate acuity, that level is expected to increase over the course of your stay. We want you to be aware that changes in health status may affect your care needs and overall safety, and at a certain point may necessitate alternate placement."

"Your current needs require staff members to be trained in [insert area(s), such as the appropriate use of equipment and assistive devices]. At present, not all of our staff members have the requisite skills to meet your known and anticipated medical needs. We thus have some reservations regarding the advisability of you remaining at this facility."

Regarding functional status…

"Do you have difficulty performing any specific tasks due to a health-related problem or condition, and do you anticipate requiring assistance with them in the near future?"

"Are you afraid of falling, and has your fear of falling diminished your willingness to go outside or participate in activities?"

"May we observe you completing a simple task, such as buttoning your shirt, picking up a pen and writing a sentence, putting on and taking off your shoes, or climbing some stairs?"

Regarding behavioral issues…

"Our organization has a written policy prohibiting use of physical and chemical restraints, and we cannot always prevent residents from wandering into unsafe areas. With that in mind, please tell us if you have ever felt the need to curtail your loved one's movements."

"We pledge to contact family members promptly about changes in resident behavior or mood. In turn, we expect family members to assist us in the transition of your loved one to another level of care, if that is deemed necessary. Do you understand and agree to our policy in this area?"

Regarding cognitive impairment…

"Based upon the findings of the pre-admission screening assessment and what you have told us, your loved one requires more interventions than our staff realistically can provide. If you wish, we can refer you to other residential options in this area that are better suited to her care needs."

"Given your loved one's growing risk of personal injury, wandering and elopement, as well as noncompliance with his medical regimen, we are recommending placement in a secured memory care facility, as our assisted living setting cannot ensure his safety."

2. Openly discuss the likelihood of resident transfer

Even when transfer to a higher level of care is clearly in the resident's best interest, some residents and family members may insist on their "right" to remain in a setting that is no longer appropriate. Such resistance may result in unmet resident needs, injurious falls, worsening medical conditions, unnecessary hospitalizations and other adverse consequences.

To avoid potential conflicts, transition-related protocols should be discussed with the resident and family during the selection process and throughout the resident's stay. The following measures may help enhance communication about resident transfer practices and prevent unrealistic expectations:

- **During pre-screening meetings, expressly state that residents eventually may require relocation due to evolving care needs,** and reiterate the potential need for relocation in written admission agreements.
- **Draft unambiguous written policies regarding transfer,** emphasizing that the facility will not provide prohibited, improper or impractical interventions simply because the resident and/or family may request them.
- **Educate residents and families during the admissions process,** and on a routine basis thereafter, regarding the obligation to transfer residents to a higher level of care when their condition changes. If applicable, note that state regulations impose a duty to transfer residents when necessary.
- **Exercise caution when discussing duration of stay,** carefully avoiding the implication that all residents are capable of aging in place even as their medical needs change.
- **Document all transfer-related communication between the organization and resident/family members** in the admission agreement and the resident healthcare information record.
- **Commit to reviewing the appropriateness of continued residency on a quarterly basis,** or more often as needed following a noticeable change in the resident's condition.
- **Ask the family to select a single spokesperson to serve as a liaison** between the facility and the family regarding major questions and concerns, including transfer recommendations.
- **In the event that a transfer is indicated, consider retaining the services of a long term care ombudsman** to communicate with family members about the resident's declining health and the necessity of transitioning to a higher level of care.
- **Provide a copy of the facility's transfer protocol to residents and family members** that provides for the transfer of vital resident health information and communication between care-givers at both locations during the transition.

To avoid potential conflicts, **transition-related protocols** should be **discussed** with the **resident and family** during the selection process and throughout the resident's stay.

Sound documentation is an essential risk management tool for aging services organizations, enhancing both quality of care and legal defensibility. Download the *CareFully Speaking*® resource for more on this topic.

3. Honestly describe facility limitations

Given the increasing age and acuity levels of residents, organizations should candidly and comprehensively describe their service capabilities as well as limitations to prospective residents and their families. The following actions may help promote transparency regarding realistic expectations, while avoiding subjects that may lead to misunderstandings, conflicts and subsequent litigation.

Foster transparency

The process of establishing expectations with residents and families should start early in the pre-admission process with a description of available services, safety measures, the level of care and supervision provided, and selection criteria. In addition to these communications, insert language into admission agreements, care or service plan summaries, and educational tools that reiterates the realities, including limitations, of the care environment.

Engage families

By encouraging family involvement and cooperation, facilities may cultivate realistic expectations, strengthen trust, and help ensure that staff and family members share in the decision-making process. The following actions may serve as a basis for enhancing collaboration:

- **Establish rapport and open lines of communication through a responsive complaint management program** and provide ample opportunity for all stakeholders to share in the care planning process.
- **Ensure that administrative staff is readily accessible to residents and their families,** maintaining visibility through means such as conducting safety rounds in residential areas and responding to resident/family complaints or inquiries within a designated time frame.
- **Highlight initiatives such as the fall management and skin integrity program in the resident handbook and/or admission packet,** and discuss the expectation that residents and families participate in risk mitigation efforts.
- **Promote social outreach for prospective residents and their families,** including resident/family orientation sessions, educational sessions on reducing falls and ongoing discussion of the aging process.
- **Ensure transparency and accountability after falls and other unanticipated events,** which helps strengthen credibility with residents and families.

Relay the likelihood of injury

Highly mobile and independent residents are typically regarded by family members as less vulnerable to falls and pressure injuries. This perception often results in the family attributing a resident's injury to staff inattentiveness, rather than the natural progression of underlying disease and/or aging. Therefore, if a resident presents with a history of falling in the home, facilities should clearly communicate that no safeguards can completely eliminate the risk of future falls.

Similarly, during the pre-admission process, residents and families should receive education on the relationship between chronic conditions, the aging process and the occurrence of both falls and pressure injuries. Educational efforts should continue throughout the residential stay, focusing on the extent of disease progression and presence of co-morbidities that may adversely affect a resident's fall risk or skin integrity. Document all discussions and family involvement in the resident healthcare information record.

To help organizations identify their strengths and weaknesses in terms of expectations management, a checklist is included on page 26.

The process of **establishing expectations** with residents and families should **start early** in the pre-admission process with a clear, simply stated **description of services, safety measures** in place, the **level of care and supervision** provided, and selection criteria.

Developing open and honest relationships with the residents and their families is key. The recent *CareFully Speaking*® publication entitled "Strengthening Facility-Family Relationships: Transparency is Key" focuses on four critical areas including accurate marketing representation, realistic resident selection criteria, clear billing/collection policies and consistent family interactions.

Establishing and Managing Resident/Family Expectations

Clear, honest and compassionate communication with residents and family members may help reduce the potential for misunderstandings, friction and grievances. After answering these questions, consider the steps that may be taken to address identified lapses, enhance transparency and minimize risk.

Measure	Yes/No	Action Needed
Culture of Safety		
Has the concept of "safety culture" been defined by the organization, and has a safety culture assessment been performed?		
Is every effort made to develop a culture conducive to resident safety and to ensure that staff members embrace this culture?		
Are needed changes championed by leadership, and are their efforts in this area visible to staff, families and residents?		
Are staff members made aware of why change may be necessary, and are they willing to support culture change efforts?		
Are respectful relationships formed with residents and families, and are these relationships cultivated over time?		
Transparency in Admissions		
Are selection criteria clearly defined, and do they relate to activities of daily living, ambulation, medication management, required supervision and mental status?		
Are marketing materials written with the goal of accurately describing organizational capabilities, available services and limitations, thereby cultivating realistic expectations?		
Are marketing/advertising materials and resident agreements reviewed by legal counsel to eliminate exaggerated or unrealistic descriptions, promises or guarantees?		
Are marketing and admissions staff trained to discuss service limitations and degree of supervision at each level of care?		
Are prospective residents carefully evaluated in terms of their overall functional level and their suitability for different levels of care?		
Are service offerings and expectations discussed with residents and families before and soon after admission, as well as throughout the resident's stay?		
Are both residents and families given a clear understanding of services that are *not* available at the chosen level of care (e.g., assisted living, independent living, etc.)?		
Are resident retention criteria included in admission agreements, so that residents and families have a clear understanding of occurrences and changes in condition that may result in transfer to another level of care?		
Are transfer criteria and protocols explained to residents and family members, and do they acknowledge in writing that they understand and agree to these policies?		

Measure	Yes/No	Action Needed
Transparency in Admissions (continued)		
Are residents and families informed that falls cannot always be averted, and that changes in health status are inherent to the aging process?		
Are residents assessed by clinical staff before rooms are assigned to ensure that they are being admitted to the appropriate level of care?		
Are facility policies regarding use of private nurses, nurse's aides and sitters communicated to residents and family members, and are available options presented during the admissions process?		
Are changing care and monitoring needs addressed in resident contracts as part of the facility's commitment to helping residents age in place safely?		
Resident/Family Education		
Are residents and families properly oriented to the fall management program, and is this orientation documented?		
Are residents and families educated by staff about fall management and related protocols, and is it explained to them that the possibility and harmfulness of falls can be reduced but not eliminated?		
Are barriers to communication assessed and documented in the resident healthcare information record, where applicable, including cognitive impairment, low general and/or health literacy, and limited English fluency?		
Are residents asked to restate in simple language the fall prevention/ management information they have been given, including the following:		
• **Common causes of falls,** as well as potential consequences?		
• **Recommended interventions,** as well as associated risks, benefits and alternatives?		
• **Resident and family responsibilities and expectations** related to fall prevention and mitigation?		
Are open-ended questions used to assess resident attitudes and better understand any perceived resistance to change?		
Are 10-point scales employed to identify resident priorities? (For example, "On a scale of 1 to 10, how important is it for you to walk outdoors on a daily basis …?")		
Are residents and families asked to repeat back critical instructions, and are their responses noted in the resident healthcare information record, where applicable?		
Are resident and family expectations discussed throughout the resident's stay in an ongoing, proactive and documented manner?		

Measure	Yes/No	Action Needed
Communication		
Are resident meetings held on a regular basis, and is there widespread participation?		
Are residents and families encouraged to articulate their own goals and preferences regarding ambulation and transfer, before staff members offer suggestions?		
Are questions and complaints elicited from residents and families, in order to avoid misunderstandings and prevent initially small problems from developing into major ones?		
Are residents and families taught how team-based care works and how it differs from private-duty nursing?		
Are staff members and providers trained to communicate proactively with residents and family, including …		
• **Initiating discussions with residents?** ("Take a moment to tell me if anything is bothering you right now.")		
• **Clearly articulating problems?** ("It seems to me your main concern is about fear of falling.")		
• **Encouraging feedback?** ("Are there other issues you wish to discuss or questions you want to ask?")		
• **Acknowledging emotions and unspoken concerns?** ("I know the topic of falling can cause worry.")		
• **Negotiating a practical course of action?** ("I have some ideas about how we can work together to help you stay on your feet.")		
• **Highlighting small accomplishments?** ("I see that you have been able to get around the facility safely by yourself.")		
• **Confronting noncompliance directly?** ("If you don't call for assistance when walking to the bathroom, the odds of falling and hurting yourself will significantly increase.")		
Is input solicited from residents about fall prevention, e.g., by asking "What else can we do to help you stay on your feet?"		
Are communications with residents and their family consistently documented?		

Measure	Yes/No	Action Needed
Family Councils		
Is a family council instituted and does it carry out important functions, such as …		
• **Addressing and resolving family and resident concerns** in a structured, documented and accountable manner?		
• **Offering ideas, suggestions and other constructive input** to organizational decision-makers?		
• **Educating families about internal policies, practices and new initiatives,** as well as state and federal laws and regulations?		
• **Welcoming and integrating new residents and their families to the facility**, via an ongoing peer support system?		
• **Fostering trust between families and administrators** by enhancing communication and participation?		
• **Supporting and strengthening the facility** through social activity programming, fundraising and community advocacy?		
Are new residents and their families informed about the role and benefits of the family council in preventing misunderstandings and facilitating positive change?		
Is information about the family council made available to new and prospective residents through a dedicated website, emails to residents/families and regular orientation sessions?		
Are clear and accurate minutes kept of every council meeting, including the full names of participants, issues discussed, and decisions and suggestions made?		
Are council member comments and inquiries responded to in a thoughtful and courteous manner within a designated time frame?		
Are council inquiries responded to in writing, thus showing that the council is taken seriously by leadership?		
Noncompliance with Fall Management Measures		
Are staff members trained to respond effectively to hostile, manipulative or otherwise difficult residents/families, using role-playing scenarios and "real-life" techniques?		
Is the effort made to develop a mutually acceptable plan of care with noncompliant residents, taking the time to explain and document the potential consequences of failing to adhere to fall-mitigation recommendations?		
Are formal procedures established and implemented for managing residents who do not follow agreed-upon safety rules, including documentation requirements for resident noncompliance and staff responses to it?		
Is staff proficiency in managing noncompliant residents monitored and are problems addressed, if necessary?		

Measure	Yes/No	Action Needed
Resident Transfer Management		
Has a formal policy been drafted that residents will be transferred to a higher level of care when necessary, i.e., when staff members observe that they are no longer safe in an independent or assisted living setting?		
Are residents and families educated regarding transfer policies and clinical criteria during the admissions process and periodically thereafter?		
Are residents continually monitored for signs that may indicate the need for transfer to a higher level of care, and is this monitoring included in the care/service plan?		
Are discussions regarding changing resident needs and safety considerations documented in the resident healthcare information record, and are summaries of these discussions conveyed in writing to residents and families?		
Prior to resident transfer, is a detailed fall management plan developed to facilitate a safe and orderly transition? If the answer is yes, does this plan:		
• **Reflect input from the resident** and/or family members?		
• **Include a comprehensive assessment of the resident's condition** and care requirements?		
• **Address all resident needs and deficits** identified in the initial Resident Assessment Protocols and Minimum Data Set, as prepared upon admission?		
• **Explain why the transfer is in the resident's best interest** (e.g., because the new facility has care capabilities that the current setting lacks)?		
Complaint Management		
Are residents and family members informed about reporting procedures in regard to care, treatment and resident safety issues?		
Has a formal complaint process been developed, and if the answer is yes, does the process include:		
• **Actively encouraging residents and their family members to share their concerns** with staff and leadership?		
• **Documenting complaints** and resolving them immediately, if possible?		
• **Designating a staff member to investigate any complaints** that cannot be resolved immediately?		
• **Compiling facts via interviews** with the resident and/or family members, as well as any staff members involved?		
• **Formulating a solution** to address the resident's/family member's concerns?		
• **Following up with the resident/family** to ensure that the complaint has been satisfactorily resolved?		

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