Self-Reporting Guidance for Nursing Homes: Ensuring Compliance While Avoiding Risk

Kyle René

Hancock, Daniel & Johnson, P.C.

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Background Noise: Senate Hearing and OIG Report

'83 years old, unable to speak, unable to fight back.' Daughters share heartbreaking stories of abuse in nursing homes – ABC News, March 6, 2019

Senators Ramp Up Outrage Over Nursing Home Abuse – AARP, March 6, 2019

Nursing homes will be in crosshairs of Senate hearing on abuse next week – McKnight's, March 1, 2019

Senate hearing examines 'devastating' nursing home abuse -CNN, March 6, 2019

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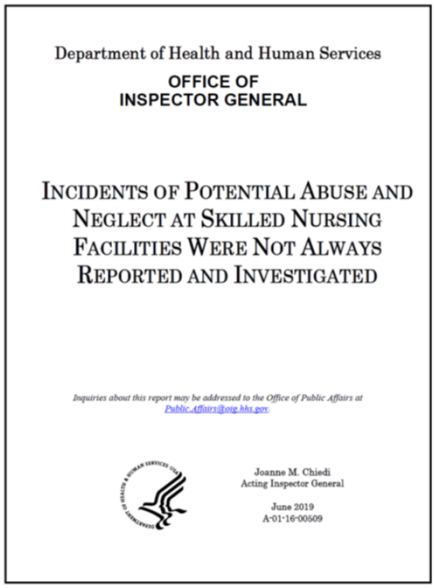

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INCIDENTS OF POTENTIAL ABUSE AND NEGLECT AT SKILLED NURSING FACILITIES WERE NOT ALWAYS REPORTED AND INVESTIGATED

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Joanne M. Chiedi
Acting Inspector General

June 2019
A-01-16-00509

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OIG Report Findings:

"an estimated one in five high-risk hospital ER Medicare claims for treatment provided in calendar year 2016 were the result of potential abuse or neglect, including injury of unknown source, of beneficiaries residing in a SNF"

"We recommend that CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported"

"**SKILLED NURSING FACILITIES FAILED TO REPORT MANY INCIDENTS OF POTENTIAL ABUSE OR NEGLECT TO THE SURVEY AGENCIES**"

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Back to Basics: What is a reportable incident?

Federal Origins: 42 C.F.R. § 483.13(c)

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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Reportable Incidents Continued…

Categories of Reportable Incidents:

1. Abuse
2. Neglect
3. Exploitation
4. Mistreatment

Injuries of unknown source and misappropriation of property are specifically identified

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"Immediately" Reportable?

A.S.A.P.

- All reportable incidents are categorized as being "immediately" reportable.
- The two-hour outer limit applies to situations in which the "events that cause the allegation involve abuse or result in serious bodily injury."

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Sources of Interpretation:

The Federal Register, 81 F.R. 88729

injury. We note that all allegations of abuse, with or without injury, fall into the immediate reporting category, as we believe it is imprudent to allow delay reporting of any abuse. Furthermore, we note that the 2-hour and 24-hour time frames represent maximums and we would expect that most reports would occur more quickly. In all cases, we would expect prompt action to protect individuals and address concerns, and delays in reporting, even within the allowable time frames, must be reasonable and not be related to attempts to obscure events or evade responsibility.

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"In accordance with State law…"

The State Operations Manual, Appendix PP, F609

The phrase "in accordance with State law" modifies the word "officials" only. State law may stipulate that alleged violations and the results of the investigations be reported to additional State officials beyond those specified in Federal regulations. This phrase does not modify what types of alleged violations must be reported or the time frames in which the reports are to be made.

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…however...

F609 guidance continued:

Some States may have different reporting requirements that could go beyond the Federal requirements or are more specific than the Federal requirements. For example, some States require that all falls be reported to the SA. The SA should continue to manage and investigate these cases under its state licensure authority. If the State determines that these occurrences do meet the definition of abuse, neglect, mistreatment, or injuries of unknown source, as outlined in this guidance, the SA must assess whether the nursing home has met the requirements for reporting and investigating these cases in accordance with 42 CFR §483.12(c).

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Reporting in Virginia: What is required?

Categories outlined in Virginia Facility Reported Incident Form ("FRI")

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Phone: 804-367-2122 FAX: 804-527-4503

Facility Reported Incident (FRI)

Use of this form is optional. Reporting as required is not optional. Failure to provide credible protective/preventive measures at the time of an initial report or failure to provide evidence of a thorough investigation with corrective measures in the final report may result in VDH conducting an on site investigation to determine if acceptable practices are in place to protect residents.

Facility Name: _____

Report date: _____ Incident date: _____

Resident involved: _____ _____

Injuries: ☐ Yes ☐ No If yes, describe:

Incident type:

☐ Allegation of abuse/mistreat
☐ Allegation of neglect
☐ Resident property misappropriated
☐ Suspicious death
☐ Injury of unknown origin
☐ Resident Elopement
☐ Communicable disease *(notify local health department pursuant to 12 VAC 5-90)*
☐ Life/safety affected
☐ Utility failure
☐ Fire
☐ Structural damage
☐ Other

Describe incident, including location, and action taken:

Name of employee(s) involved and their positions:

Employee action initiated or taken:

If applicable, date notification provided to:
- Responsible party _____
- Physician _____
- APS _____
- DBP _____
- Law Enforcement _____

Facility internal investigation:
Completed on _____ Is attached ☐ Yes ☐ No
Will be conducted/Report forward to VDH/OLC: _____
For 5 working day and final reports, include a summary of the investigation and corrective measures implemented to prevent recurrence.

Name & Title of Reporting Person: _____

Revised 03/2019

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FRI Categories of Reportable Incidents

Incident type:		
☐ Allegation of abuse/mistreat	☐ Injury of unknown origin	☐ Life/safety affected
☐ Allegation of neglect	☐ Resident Elopement	☐ Utility failure
☐ Resident property misappropriated	☐ Communicable disease *(notify local health department pursuant to 12 VAC 5-90)*	☐ Fire
☐ Suspicious death		☐ Structural damage
		☐ Other

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The nitty and gritty (and somewhat unpretty): What do we mean by "involving"… "suspected"…

Appendix PP, F609

"…if facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered to be reportable and require action under §483.12(c)."

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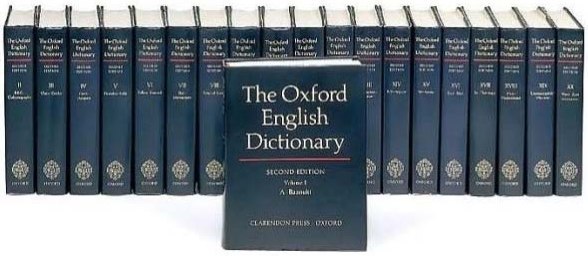

Key definitions: What is "abuse"? What is "neglect"? How broad is "potential" noncompliance?

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Federal Standards

42 C.F.R. § 483.5: "Abuse"

Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. *Willful*, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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Federal Standards continued

42 C.F.R. § 483.5: "Neglect"

Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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Standards of the Commonwealth (12VAC5-371-10 Definitions)

"Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This includes verbal, sexual, physical or mental abuse.

"Neglect" means a failure to provide timely and consistent services, treatment, or care to a resident necessary to obtain or maintain the resident's health, safety, or comfort or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness.

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Making a Judgment Call: Anecdotes and Examples

1. Resident fall with injury: Neglect?
2. A case of “clumsy”: Abuse?
3. Just “going for a walk”: Elopement?

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So we have to report….What now?

Easy, obvious, and too frequently overlooked:

1. Check that all FRI fields are complete and accurate (dates, facility and staff names etc.).
2. Avoid short-hand, acronyms, poor grammar and confusing, ambiguous, or contradictory language:
   - "Resident struck face during push"
   - "Resident d/c'd due to hx of non-comp as noted by ADOn and idt"
   - "Resident was acting funny before incident occurred"

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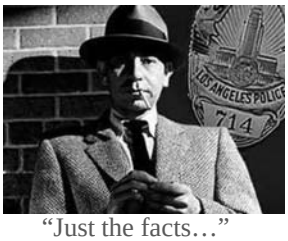
To include or not to include, that is the question…



"Just the facts…"

Sticking to the facts and avoiding speculation. Examples:

- The unwitnessed fall ("resident found on floor")
- The unwitnessed altercation ("resident reported/alleged…")
- Injuries of unknown origin

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Properly Framing the Initial Report

42 C.F.R. 483.12(c)(2)-(3) directs that facilities must:

(2) Have evidence that all alleged violations are thoroughly investigated.
(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

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The most important thing?

Answering the question: What has been done to ensure residents are safe and that a threat of harm is not ongoing?

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Common examples of potential risk mitigation efforts to include in self-reports:

Resident-to-resident abuse:

- *Have the residents been separated?*
- *Has any special monitoring been initiated, including 1-1 if necessary?*
- *Has an involuntary discharge occurred?*
- *Have psychological evaluations been ordered?*

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…Risk Mitigation Continued…

Allegations of staff/visitor abuse/neglect:

- *Has the staff member been moved off the floor during the investigation?*
- *Has monitoring of visitors/staff been initiated?*
- *Are we interviewing potential witnesses (staff, residents, other visitors to verify the allegation?*
- *If the identity of an alleged abuser is unknown, do we at least have a physical description that we can monitor? Have we initiated interviews of potential witnesses who may provide additional info?*

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…Risk Mitigation Continued…

All abuse allegations:

Have we contacted law enforcement? Adult Protective Services?

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…Risk Mitigation Continued…

Elopement:

- Has local law enforcement/search & rescue been contacted?

- Are staff members searching the area? Where specifically? Why? (i.e., do we know whether the resident may have attempted to visit a specific place?)

- If the resident has returned, have we implemented monitoring? Placement on a secure unit? Elopement assessment?

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…Risk Mitigation Continued…

Injuries of Unknown Origin:

- *Has the resident been evaluated for serious injury and cleared?*
- *Have we transferred the resident to the hospital?*
- *Have we initiated interviews of potential witnesses?*

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…Risk Mitigation Continued…

Misappropriation of Resident Property:

- *Has law enforcement been contacted?*
- *Have the resident's other valuables been secured?*
- *Has the resident been educated regarding the facility's policies on securing of valuables?*

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Special Situations:

Facility Emergencies (Floods, Fires, Power Outages, Etc.):

- *Have emergency agencies been contacted? If so, whom?*
- *Have residents been removed from an affected area (e.g., a unit or hallway)? Have they been safely relocated within the facility?*
- *All residents accounted for? No injuries?*
- *Have we given staff special assignments to monitor/aid residents? (e.g., providing water during utility failure, etc.)*

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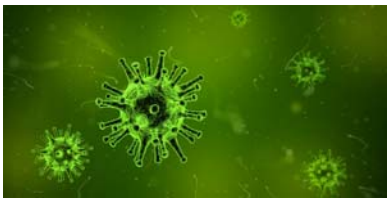
Special Situations Continued: Communicable Diseases



- 12VAC5-90-80 includes a list of communicable diseases which a facility must report to the local health department. Among these, facilities are required to report:

Outbreaks, all (including foodborne, health care-associated, occupational, toxic substance-related, waterborne, and any other outbreak)

- "Outbreaks" are in turn defined under 12VAC5-90-10 as:

the occurrence of more cases of a disease than expected

*12VAC5-90-80 also requires facilities to report confirmed cases of Influenza

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…Communicable Diseases continued…

Regarding the FRI Report:

- *What infection prevention/control measures have been implemented?*
- *Have affected residents been isolated?*
- *Have admissions to a facility wing or unit been suspended?*
- *Have staff and residents been informed?*

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Backstage: The Initial Report is in…Now what?

Mitigation Efforts:

-"Prophylactic" Plan of Correction

-Referral to QAPI

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"Prophylactic" Plan of Correction

-Facility need not draw up a formal "Plan of Correction" for every self report. A facility's approach will depend on the incident in question and any potential noncompliance.

-In principle, facilities should aim to have completed the elements of an otherwise successful plan of correction where a self-reported incident reveals the potential for noncompliance.

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Plan of Correction: The Five Elements

1. Corrective action for the residents affected.
2. Steps to identify other residents affected by deficiency/noncompliance.
3. Measures/systemic changes to prevent recurrence.
4. How corrective measures will be monitored.
5. Date of compliance and identification of those responsible for corrective action(s).

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Self Reporting and QAPI

Facility Self-Reporting data be integrated into the facility's QAPI program in order to:

1. Track trends tied to self reports.
2. Develop responsive Performance Improvement Projects (PIP's) as needed.
3. Evaluate the effectiveness of ongoing QAPI efforts.

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Initial v. Follow Up Report

Refresher: Purpose of the Initial Report?

- *Report the non-speculative facts, as known.*

- *Highlight immediate steps taken to prevent further risk of harm.*

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…Initial v. Follow Up Report continued...

Purpose of Follow Up Report?

42 C.F.R. § 483.12(c)(4):

Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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What to include in the final report? Two major items:

1. Investigative actions taken and their results.

   Example: Resident-to-Resident Abuse Allegation

   - Did we interview potential witnesses? What did they report?

   - Did we review residents' behavioral histories and diagnoses? What did we find?

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…Final Reports continued…

2. Corrective measures taken to address risks to health and safety, and to correct any deficiencies.

Resident-to-Resident example continued:

- Have we updated resident care plans?

- Have we educated residents? Staff?

- Have we implemented any monitoring/oversight to ensure corrective actions are being followed and further action isn't necessary?

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What matters the most in Virginia?

Among other areas, <u>care planning</u>.

How does this relate to self-reporting?

Care planning needs to be a central focus where an allegation of abuse is reported:

1. *Is the alleged abuse tied to any potential shortfall in the care planning process?*
2. *Have care plans been updated in response to alleged abuse?*
3. *Have facility staff been properly trained on developing and following care plans?*

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Slaying the Hydra:

What facilities should be doing when nobody is looking.

1. Staff education: Hands on approach > Screen time
2. Validation through observation: Oversight and one-on-one communication.
3. “Rinse and Repeat”: Once is not enough.

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Kyle René
Hancock, Daniel & Johnson, P.C.
krene@hancockdaniel.com
Hancockdaniel.com

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