

Mistakes Are Inevitable:

The Role of a Complaint and Grievance System and Other Similar Systems in Improving Care

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Some Preliminary Considerations

- Caring for LTC Population is Incredibly Challenging
- Nursing Homes One of Most Regulated Industries in the Country
- Both Caring for LTC Residents and Surveying LTC Facilities Are Daunting Jobs--
- Circumstances are Challenging
 - Quantity of Work is Significant
 - Nature of the Work is Challenging
 - Consequences for Errors are Severe

Optimal LTC Delivery:
Good Systems

Admission - Ongoing Care -
Resident Safety

Dietary - Activities, Social
Services, and Resident Rights

Abuse Prevention -
Administration

Physical Plant/Maintenance

Optimal LTC Delivery:
Good Systems

**Is it reasonable to
expect that systems
will always work
perfectly?**

Optimal LTC Delivery:
Good Systems

**Is it reasonable to
expect that facility
leadership will always
know right away when
systems problems arise?**

Optimal LTC Delivery:
Good Systems

**What methods
does leadership
commonly use to
detect problems?**

Optimal LTC Delivery:
Good Systems

**Morning Department Heads
meeting
Shift Change Report
Incident & Accident Reports
What else?**

Optimal LTC Delivery:
Good Systems

**Where are the
holes in these
methods?**

Optimal LTC Delivery:
Good Systems

Nights and Weekends

**Key Leadership Personnel
Absences**

**Culture Does not Encourage
Employees to Report Events
That May Reflect Adversely
on Facility or Staff**

Optimal LTC Delivery:
Good Systems

**Who Is Usually the
First to Know When
Systems Are Not
Working Optimally?**

Optimal LTC Delivery:
Good Systems

Residents

Direct Care Staff

Optimal LTC Delivery:
Good Systems

Proposal:

If a facility’s leadership does not encourage frank reporting of problems by residents and staff . . .

Optimal LTC Delivery:
Good Systems

Proposal:

And if it does not take those reports seriously when they are received. . .

Optimal LTC Delivery:
Good Systems

Proposal:

Sooner or later it will miss some serious problems!!

A Cautionary Tale

This really happened!
in a Facility with
A GOOD SURVEY
HISTORY

A Cautionary Tale

- Two incidents of abuse involving same employee:
- An LPN pulled a residents hair and shoved her. The resident allegedly hit the nurse in the face with a can of Ensure. The LPN was not suspended or sanctioned in any way. The LPN had the resident transferred to the Hospital for a psychiatric evaluation.

A Cautionary Tale

- Two days later the same LPN slapped a resident in the face, slammed her head on the wheelchair armrest (injuring her neck) and she pulled out the resident's hair (leaving her bald in one or two quarter inch size places on her head). 3 staff members had to pull the LPN off the resident. The Resident called the police. The family called the SA. The facility self-reported nine days later.

A Cautionary Tale

- A complaint investigation ensued . . .
- As part of their investigation, the surveyors interviewed 11 residents. 6 of 11 of the residents said they would feel uncomfortable reporting complaints about the direct care staff to the administration.
- 6 of 11 identified a particular CNA as being very loud and verbally abusive.

A Cautionary Tale

- A male resident was admitted to the facility with diagnoses to include Anxiety Disorder, Diabetes, Hypertension, Methadone Patient. This resident had no short or long term memory problems, modified independence cognitive skills for daily decision-making. There were no indicators of delirium-periodic disordered thinking/awareness coded on his most recent MDS.

A Cautionary Tale

–This resident told the surveyor that a CNA had exposed the genitals of two other residents to him.

–This was the same CNA identified by other residents as loud and verbally abusive

A Cautionary Tale

–This same resident tearfully informed the surveyor that this same CNA had forced him to have anal intercourse and oral sex with him. He gave a very detailed description and indicated that he was terrified of this CNA.

A Cautionary Tale

Did the resident report these allegations?

- The resident said that he had told a male nurse about the CNA exposing his roommate’s genitals to him but nothing was done about it.
- The nurse denied the resident had told him this.

A Cautionary Tale

- A female resident reported to surveyors that she had been told by the male resident about the CNA exposing residents’ genitals to other residents, **AND** about him roughly throwing a resident. She also said that she had observed this CNA throw a resident into his bed.
- This resident said that she told the Chief Director of Operations about “some of the things going on in the facility” who responded – “get a photo of it, because that is proof, otherwise, I don’t want to hear about it.”

A Cautionary Tale

- Another female resident reported to another CNA that she had been handled roughly by this same CNA and that on one occasion he had thrown her into her bed so hard that he almost broke her arm. That CNA reported the incident to the DON.

A Cautionary Tale

- The DON met with the resident and the CNA who brought this to her attention, and listened to the resident describe how this CNA had abused her.
- The DON confirmed with the reporting CNA that she was talking about the abusive CNA and then said he was going on PRN and wouldn't be here much. Then she walked out of the room.

A Cautionary Tale

- Facility was cited for violating tags F223 (abuse), F225 (failure to investigate/report abuse allegations), F226 (failure to implement policies to prevent abuse) and F490 (administration) – all at the immediate jeopardy level.
- IJ ran for 29 days.
- Facility settled and paid a total CMP of \$182,000 (original CMP was approximately \$240,000).
- **Prior to this survey, facility had a good survey history.**

A Cautionary Tale

Could these things have occurred without the knowledge of staff and residents?

Did the facility leadership create an environment where resident and staff grievances were encouraged?

A Cautionary Tale

Did facility leadership take resident grievances seriously?

Was the emergence of serious problems inevitable as a result?

A Cautionary Tale

Let's Discuss--

How could this have been prevented?

How Do Systems Fail?

The following case study is based on, but not identical to, an actual event that occurred in a nursing home recently.

How Do Systems Fail?

Case Study:
Surveyor determines resident failed to receive Lasix for two days after admission, those Lasix was on discharge orders from hospital attending and order was not d/c'd by facility medical director. LPN taking down discharge orders into facility system admitted that she missed the order for Lasix for this resident.

How Do Systems Fail?

Case Study:
Resident developed pitting edema; was eventually transferred back to hospital with breathing difficulty, elevated heart rate. Hospital restored Lasix to medication regimen and resident recovered and returned to facility.

How Do Systems Fail?

Case Study:
Facility cited for F 271 Admission Orders, F 281 Professional Standards, and F 385 Physician Services, all at "G" s/s level, all having the single example of resident not receiving Lasix.

How Do Systems Fail?

Case Study:
Facility did not dispute tag at IDR. In its POC the facility corrected the orders for example resident, confirmed in writing with his physician that his orders were correct, monitored q/day for four weeks that he received his ordered meds, and in-serviced all licensed staff on procedures for taking down orders.

How Do Systems Fail?

Case Study:
Survey agency accepted the POC and confirmed on revisit that it had been implemented, placed facility back in compliance within 90 day window. This was not a "double G" situation, so facility had no remedies imposed.

How Do Systems Fail?

Case Study:

No root cause analysis or systems review was undertaken by the facility or surveyors. If this had been done, we would have learned:

How Do Systems Fail?

Case Study:

Single LPN in facility assigned responsibility for transcribing orders for all newly admitted residents into facility's EHR system. She had other duties as well. She had recently been counseled about excessive overtime, and she had a disabled child at home.

How Do Systems Fail?

Case Study:

On the day she omitted the Lasix order, there were a total of 6 residents admitted, each with an average of 11 medications, plus labs and treatment orders. The discharge orders were handwritten by the physician and faxed to the facility.

How Do Systems Fail?

Case Study:

The reason six residents were admitted is that the facility admissions coordinator (who had a bachelor's degree in business) received a call from the hospital's discharge planner (a social worker) at about noon on Friday, desperately looking for placement for six patients the insurance company utilization review company had told the hospital they needed to discharge.

How Do Systems Fail?

Case Study:

Four of the six patients to be discharged were on Medicare and needed rehabilitation. The hospital was the nursing home's most important referral source, and the nursing competed with three other facilities for referrals from this source.

How Do Systems Fail?

Case Study:

All newly admitted residents and all new orders for existing residents were, per facility P&P, required to be reviewed by the resident's charge nurse on the next 11-7 shift and again at a clinical meeting with the DON and all unit supervisors the following morning after the 7-3 shift report.

How Do Systems Fail?

Case Study:

The normal 11-7 charge nurse called off that afternoon and was replaced by an agency PRN nurse who had worked at the facility before on the day shift, but had not been instructed on the proper procedure for checking orders.

How Do Systems Fail?

Case Study:

The following day was a Saturday. The DON was not on duty. The new orders were reviewed by the weekend manager (the assistant administrator), the weekend supervisor (an RN), and another RN who was supervising the therapy wing. All had other demands on their time. Because there were six new residents and three others with new orders, the review was done hurriedly and they also missed the Lasix order.

How Do Systems Fail?

Case Study:

On Sunday night the resident was discovered to have pitting edema and breathing difficulties and was sent out. On Monday morning, the DON reviewed the orders for the resident, discovered the missed Lasix order, and counseled and provided one on one in-service to the LPN.

How Do Systems Fail?

Case Study:

LPN had repeatedly complained to administrator and DON about work load and warned them it was difficult for her to get work done accurately in time allowed.

LPN had called corporate employee grievance line with same complaint– complaint had been forwarded to administrator.

How Do Systems Fail?

Case Study:

Knowing these additional factors, was the facility’s POC likely to have been effective in preventing future errors?

How Do Systems Fail?

Discussion questions:

What were the systems failures in this facility?

Who knew about them?

Why weren’t they addressed?

How Do Systems Fail?

Discussion questions:

What are the characteristics of a robust resident and employee complaint/ grievance system?

How Do Systems Fail?

Discussion questions:

Do the federal regulations provide any guidance?

Could they help us even in non-federally regulated facilities?

Federal Regulatory Requirements- Self-Investigations

F225

42 CFR §483.13(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

Would this include employee or resident complaints?

Federal Regulatory Requirements-
Self-Investigations

F225

42 CFR §483.13(c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

Federal Regulatory Requirements-
Self-Investigations

F225

42 CFR §483.13(c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Regulatory Requirements-
Self-Investigations

Do the staff know who to report to?

What if we treated all resident or staff complaints in the way we are required to treat abuse or neglect allegations?

A robust internal complaints and grievances system is a key element for detecting problems within facilities—

half-hearted efforts are not good enough!

Questions or Comments—

NOW IS THE TIME!
