

**MOMENTUM** 2022 Annual Conference and Trade Show August 30 - September 1, 2022 *LeadingAge Ohio*

**Preventing & Managing Adverse Events to Reduce Regulatory Risk**

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**What is an Adverse Event?**

\$483.5 - An untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

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**Examples of Adverse Events**

- Elopement
- Fall with serious injury
- Resident abuse, neglect
- Adverse medication reaction
- Death from acute illness
- Development of pressure sores
- Major medication error
- Burns
- Suicide attempt

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### Requirements Related to Adverse Events (F866)

- **§483.75(c)(4)**
  - Monitoring
  - System for identifying, reporting, tracking
  - System for *investigating* and analyzing
  - Use of data and information to develop processes to prevent
- **Phase 3 ROP implementation**

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Adverse Events do not automatically = Noncompliance

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Adverse Events that are the result of noncompliance often = Immediate Jeopardy

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Citations = Survey Points



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### Special Focus Facility (SFF) Designation

### Low 5 Star Rating

- Managed Care Contracts
- Referrals (preferred provider)
- Public Relations/Advertising

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### 5 Star Health Survey Score

\* An IJ cited at Past Noncompliance receives 20 Pts.  
 \* Deficiencies cited at SQC are assigned the higher number of points as designated in parentheses.

| Severity  | Isolated            | Pattern               | Widespread            |
|---|---------------------|-----------------------|-----------------------|
| Immediate Jeopardy  | J - 50 pts*<br>(75) | K - 100 pts*<br>(125) | L - 150 pts*<br>(175) |
| Actual Harm that is not IJ  | G - 20 pts          | H - 35 pts<br>(40)    | I - 45 pts (50 pts)   |
| No actual harm with potential for more than minimal harm that is not IJ | D - 4 pts           | E - 8 pts             | F - 16 pts (20)       |
| No actual harm and potential for no more than minimal harm              | A - 0 pts           | B - 0 pts             | C - 0 pts             |

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### Red Hand Icon

- “G” or ↑ level deficiency on any abuse/neglect/misappropriation deficiency (F600, F602 and F603) cited on last annual or in last 12 months
- D – F level deficiencies at F600, F602 or F603 on the last annual or complaint and the previous annual or complaint (2 consecutive)
- Health Score for 5 Star is capped at **2 stars**

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### Other Effects of Citations

- Substandard Quality of Care
- AG Investigations and criminal prosecutions for abuse/neglect
- Lawsuits
- Certificate of Need Implications
- Insurance Rates
- Future Transactions
- Impact on Future Enforcement (e.g., double Gs, enhanced enforcement and fines for successive Infection Control

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### Top Immediate Jeopardy Deficiencies 2021

- Infection Control (F880) – 17
- Accident Hazards (F689) – 16
- Abuse/Neglect (F600-F610) – 16
- CPR / Advance Directives (F678) – 13
- Quality of Care (F684) – 7
- Significant Medication Error (F760) - 6
- Respiratory Care (F695) – 5
- COVID Testing (F886) - 1

\*Source: Data.CMS.gov, Calendar Year 2021, excludes tags currently subject to IDR as of 4/13/2022

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**Avoiding Citations and/or Points r/t Adverse Events**

- Identify the "root cause" of the incident/event & address
- Identifying the "root cause" requires a thorough investigation
- Ideally, no "surprises" identified by survey team

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**Investigation Objectives**

- Demonstrate Compliance
- Correct Noncompliance/ Performance Improvement
- Demonstrate Past Noncompliance

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**Inadequate Investigations**

- Problem not addressed or corrected
- Residents remain at risk
- Ongoing Immediate Jeopardy Citations
- Ongoing noncompliance

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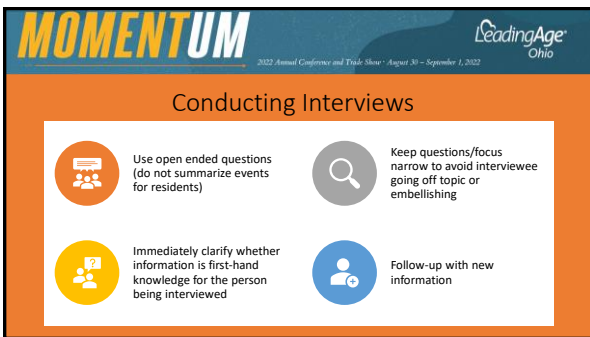
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### Statements

- From individuals relevant to the investigation
- Scope will be different for every situation/incident.
- Statement should address root cause of the incident, even if interviewee can provide no relevant information on topic.
- No opinions or speculation



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### Technique

- Interview Witness
- Summarize Verbally
- Write & Review
- Sign and date

**Note:** Ideally, witnesses should not write a statement without an interview.

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### Additional Investigative Measures

|                      |                         |                                    |                      |                         |                               |
|----------------------|-------------------------|------------------------------------|----------------------|-------------------------|-------------------------------|
| 01<br>MEDICAL RECORD | 02<br>EXAMINE THE SCENE | 03<br>SECURE AND EVALUATE EVIDENCE | 04<br>CAMERA FOOTAGE | 05<br>OUTSIDE RESOURCES | 06<br>EMS or HOSPITAL RECORDS |
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### Investigative Summary

- ✎ Background or pertinent resident history/information
- ✎ Summarize information obtained (e.g., statements, record review, etc.)
- ✎ Note actions taken that were good (e.g., resident was assessed, care plan developed, etc.)
- ✎ Make sure the evidence (statements, etc.) supports the conclusion (e.g., staff followed the plan of care, so the fall was unavoidable)

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### Internal Action Plan

- ✓ Correct for involved resident(s)
- ✓ Address all residents at risk
- ✓ Correct any systems issues
- ✓ Inservice / educate Staff
- ✓ Develop and implement quality audits
- ✓ QAPI Meeting

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