



*Abuse & Incident Investigations:
Is Your Facility CSI Team In Place?*

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*Michele A. Conroy, Esq.
Rolf Goffman Martin Lang LLP
Dustin Ellinger, BSN, MHA, RN
Rolf Consulting*



Why Investigate Incidents?

- ☉ **Prevention**
- ☉ **Improve Systems and Quality**
- ☉ **Correction – Minimize enforcement actions**
- ☉ **Compliance**



Required Investigations

- ☉ Abuse Regulations – F225
- ☉ Quality Assurance – F520
- ☉ Quality Assurance Program Improvement (“QAPI”) Requirements
- ☉ Ohio Law - § 5165.69 – Plan of Correction Requirements



Common Thread

- ☹ Need to identify the “root cause” of the incident, allegation or problem in order to fix it.
- ☹ Identifying the “root cause” requires a thorough investigation
- ☹ A thorough investigation requires a CSI team:
Care Scene Investigation Team



What Should be Investigated?

- ☹ All allegations of Abuse, Neglect, Misappropriation of Resident Property & Injuries of Unknown Source
- ☹ Any incident that caused or has the potential to cause significant negative outcome, such as:
 - Development of pressure sores
 - Elopement
 - Falls
 - Major medication error
 - Burns
 - Suicide attempts
 - Deaths

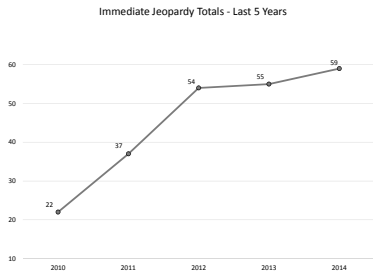


Inadequate Investigations

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



Immediate Jeopardy Trends



How Do You Conduct a Thorough Investigation?



Elements of an Investigation

- ☉ Determine the Who, What, Where, When & How:
 - Who is involved?
 - What happened or did it happen?
 - Where did it happen?
 - When did it happen?
 - How did it happen?



Elements of an Investigation

- ☉ Determine **Why** it happened
- ☉ Why = Root Cause Analysis
- ☉ If you don't know why it happened, you may not be able to determine what needs to be done to prevent the incident from happening again.



What is a “Root Cause Analysis”

- ☉ Tool used to identify why something when wrong
- ☉ Understanding the problem behind the problem
- ☉ Investigation Technique – Step-by-Step Process that asks “why” at each juncture until the “root cause” is uncovered.

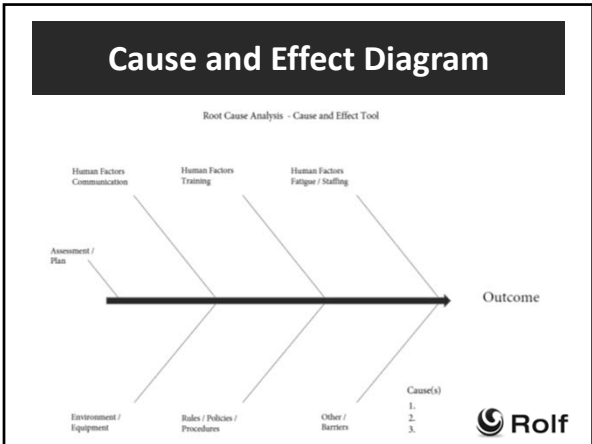


The “5 Whys Tool”

Problem statement	One sentence description of event or problem
Why? →	
Why? →	
Why? →	
Why? →	
Why? →	
Root Cause(s)	1. 2. 3. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GAP/downloads/5Whys.pdf>





Starting the Investigation

- ☞ Start as soon as possible after the incident
- ☞ Interviews!
 - Involved resident(s)
 - Direct witnesses (Staff, residents or visitors)
 - Staff working at time of incident

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Common Problems with Interviews

- ☞ Involved resident(s) not interviewed
- ☞ Interview with involved resident(s) not thorough
- ☞ Written witness statements vague or very difficult to understand and no follow-up
- ☞ Other pertinent individuals not interviewed (e.g., resident's roommate, other staff members)

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Conducting Interviews

- ☛ Use open ended questions
- ☛ Do not summarize events
- ☛ Keep questions/focus narrow to avoid interviewee going off topic or embellishing
- ☛ Immediately clarify whether information is first hand knowledge for the person being interviewed
- ☛ Follow-up with new information



Case #1

Although the Immediate Jeopardy was removed, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) because the facility did not assess all potential victims, **did not interview staff to determine if sexual activity could be suspected between RT #33 and any other residents** and did not complete abuse training for all staff.



Case #2

- ☛ Alleged Resident-to-Resident Abuse
- ☛ Witness statement referred to an unrelated incident (alleged) involving two other residents
- ☛ Witness statement and nursing notes referred to primary incident as a 'sexual assault'
- ☛ Surveyors capitalized



Statements

- ☞ Obtain statements from individuals relevant to the investigation (**Note:** Scope will be different for every situation/incident).
- ☞ Do not forget to obtain a statement from the alleged perpetrator before they leave the building.
- ☞ Statement should address root cause of the incident even if interviewee can provide no relevant information on topic.



Written Statements

- ☞ Technique
 - Interview
 - Summarize verbally
 - Write & Review
 - Sign and date
- ☞ Do not allow a witness to write a statement without an interview.
- ☞ Do Not Speculate!



Include Forensics!

- ☞ Review the medical record.
- ☞ Examine the room or area where incident took place.
- ☞ Talk to physician and family.
- ☞ Secure evidence - Have equipment (alarms, doors, lifts, etc.) evaluated by the appropriate persons.
- ☞ Review camera footage.
- ☞ Utilize outside resources (e.g., pharmacy, police, therapy company).



Tips

- ☞ Follow-up with additional information brought to light during investigation, including new allegations.
- ☞ Rule out all potential perpetrators.
- ☞ Make sure residents are protected during the investigation process.
- ☞ Leave no stone uncovered!



Investigation Summary

- ☞ Summarize information obtained (e.g., statements, pertinent information from the record, etc.)
- ☞ May not ultimately figure out the why – **Don't guess!**
- ☞ Make sure the evidence supports the conclusion



QA Protection

- ☞ Investigation summary should remain as part of QA or QAPI
- ☞ Identify documents as part of QA
- ☞ Do not use for anything but QA
- ☞ Only share investigation and summary results with member of the QA Committee
- ☞ Keep separate from medical record



Internal Corrective Action Plan

- ☉ Plan should address the root cause (**Note: Identifying a root cause ≠ Noncompliance**)
- ☉ Correction can be and usually is more than just inservicing (e.g., revise plan of care, changes in protocols, etc.)
- ☉ Need to have a system in place to care for and manage residents with behaviors – focus on prevention of behaviors & not reactive



Action Plan Elements

- ☉ Be prepared – expect survey scrutiny
- ☉ Address all residents at risk
- ☉ Common survey pitfalls
 - Incomplete staff education
 - Incomplete quality monitoring plan
- ☉ When training is necessary, make sure 100% of the staff is educated
- ☉ Develop and implement quality audits – ‘early and often’



Elements of Past Non-Compliance

- ☉ Surveyor must find during the survey that:
 - The facility was not in compliance with the tag at the time the situation occurred
 - The noncompliance occurred after the exit date of the last standard survey and before the survey currently being conducted
 - Facility corrected the noncompliance and is in substantial compliance at the time of the current survey with the tag in questions
 - All elements are implemented prior to the START of the survey



Case #3

Although the Immediate Jeopardy was removed on 07/18/14 at 7:30 P.M., the facility remained out of compliance at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as **all staff members (RN #55 and STNA #54) had not been in-serviced on the abuse policies and procedures** and the supervised visits for Visitor #1



Cases #4 and #5

- “...not enough time had elapsed to evaluate whether the facilities corrective action was being monitored for on-going compliance.”
- “Although the Immediate Jeopardy was removed on 12/11/14, the facility remained out of compliance at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility started conducting ongoing weekly audits on 12/15/14 and **was in the process of verifying the corrective action taken was effective.**”



Questions?



Conroy@RolfLaw.com
(216) 682-2131

Ellinger@RolfConsulting.com
(614) 943-0210

www.RolfLaw.com