i Advance Senior Care
information. insight. innovation.

BEST PRACTICES FOR RESIDENT SAFETY:

Staying Alert for the Residents' Benefit

Sponsored by

Omnicare®
a CVSHealth company

i Advance Senior Care
information. insight. innovation.

Table of Contents

Avoiding legal claims in assisted living

Nancy Reynolds, Esq.

The recently published 2016 Claim Report from CNA Insurance Companies' Aging Services division identified the highest quantity of claims to occur in skilled care facilities, but the highest payments on claims were for assisted living facilities. This finding should not be unexpected.

Many assisted living facilities tend to depart from the maximum levels of care they are authorized to provide and are held accountable for failing to satisfy the higher level of care they have voluntarily assumed. Because assisted living residents are typically healthier than skilled care residents, serious injury is considered to demand a higher payout on the claim because of fewer comorbidities. In other words, the only factor contributing to the injury is the malpractice.

Further, because assisted living residents tend to be younger than skilled care residents, they will either live longer with their injuries or their deaths will be considered more untimely and tragic than those of skilled care residents. Both result in higher verdicts or settlements.

Assisted living facilities should:

- Be mindful of the limitations on levels of care they are required to provide to avoid claims of negligence for providing a higher level of care.
- Probe deeply into resident functionality during the admission process to uncover those who are attempting to slide in under the line to qualify for the lower cost of assisted living.
- Evaluate residents regularly for changes in condition that would disqualify them for assisted living and require skilled care.

Assisted living facilities and their management companies are well aware of the requirements governing when residents should be moved to skilled care. These limitations should be strictly enforced because providing skilled care is an excellent set up for a negligence claim.

Skilled care is almost always required when residents:

- need regular-to-constant skilled nursing or medical care
- have infectious diseases
- are a danger to themselves or others
- have Stage III or higher pressure ulcers
- require more than the minimal assistance with activities of daily living (ADLs)
- cannot evacuate the building by themselves
- require restraints.
- When caring too much can get you in trouble

Many states do not recognize assisted living facilities as providers of medical care. Conversely, most states do recognize skilled care facilities as providing medical care. That distinction is critical when defining what the negligence duty is. If the assisted living facility exceeds its regulated standards and provides medical care, it will be held to the higher standards of a medical provider. Blurring the lines invites trouble for the assisted living facilities on a regular basis. The scenarios below are offered as illustrations of when the assisted living facilities may or may not be considered to exceed the scope of their practice.

Consider this hypothetical scenario: A relatively independent resident who uses a walker falls in her room behind closed doors. As long as the facility did not create a fall hazard in the room—by, say, leaving the floor wet or leaving her walker where she cannot get to it—a finding of negligence is unlikely. The assisted-living facility is not required to provide constant nursing care, which includes, contrary to a common plaintiff's argument, remaining in line-of-sight supervision.

In another scenario, a cane-wielding resident of a memory care unit uses his cane to threaten residents and staff. He poses no danger so long as he stays on psychotropic medications administered by a doctor as part of a treatment plan for dementia. However, his condition changes after his family, citing the side effects of his medications, demands that the medications be stopped. Unfortunately, the man threatens a resident, resulting in an injury-causing altercation. Arguably, this resident should never have been admitted to assisted living because of a medical problem that could easily render him a danger to himself and others and which required close monitoring by medical staff.

Suppose an assisted living facility resident, who had only mild dementia and had never shown signs of poor judgment or elopement risk, is hit by a train and survives the accident. She had told the nurse that she was going to the local convenience store to buy cigarettes. As an assisted living resident with no prior concerning behaviors, she had the right to come and go at will. In this scenario, the facility was not on notice of this poor judgment and had no duty to protect the resident from the events that occurred.

And, consider the case of an assisted living resident who uses a motorized wheelchair and rolls herself into a reflecting pool while on a facility-sponsored outing to a local monument. This was an organized outing of adults who had no cognitive deficits or medical conditions that would give notice of a foreseeable danger. The standard common law negligence duty, with its standard defenses of contributory negligence and assumption of the risk, would apply, not a heightened duty for medical providers.

Defining negligence in such cases depends on what obligations and accompanying care levels the facilities assume. Medical standards do tend to apply when facilities are engaged in medical acts, such as distributing medications. But courts in several states—including New York, Virginia, Tennessee, Ohio, New Jersey and Illinois—have issued rulings that reinforce the separate regulations governing skilled nursing facilities and assisted living facilities.

For example, the Supreme Court of Virginia held that an assisted living facility only had a duty of ordinary care to its residents while they were on the property. When a resident left his facility and threw himself off a bridge to his death, the facility was not considered to have been negligent. A New Jersey federal district court held that assisted living facilities were not covered by the state's nursing home regulations and dismissed any claims of malpractice under those rules.

An Ohio veterans' assisted living home was not held liable when a resident fell off a second-floor balcony to his death. The veteran was mentally competent, with only mild ambulatory impairment and mild memory deficits, and so the court applied a standard premises liability analysis.

Finally, a New York assisted living facility resident, who ambulated independently, broke his hip while bowling with the activities director and other residents. The common-law negligence claim against the facility was dismissed. The facility was not negligent, the court ruled, because it was not an insurer of the safety of the resident, a competent adult.

For laymen, assisted living facility liability can be confusing and complex. Some states do consider assisted-living services to be medical in nature, with duties defined by medical experts. Elsewhere, courts resort to the lower, common-law standards. In California and Arizona, elder abuse claims can be successfully lodged when assisted living facilities fail to provide services for activities of daily living that residents require. Thus, it's critical to understand and comply with the rules in your state.

If medical care is the issue being litigated, the assisted living facility may have been providing care beyond its regulatory mandate. When you assume a higher burden, you will be required to provide care that comports with that higher standard. The moral of the story? Stay true to the well-defined limitations for assisted living facility admission—or be prepared to suffer the consequences of failing to provide a higher level of care. And for assisted living, those consequences can be very expensive because the residents' injuries, from which they may suffer for many years, cannot be discounted by co-morbidities.

i Advance Senior Care
information. insight. innovation.

Enhancing Medication Management Programs: A look at high alert medications

Nancy Losben R.Ph. CCP, FASCP, CG
Chief Quality Officer
Omnicare, a CVS Health company

Medication Management is one of the hallmark services provided by senior living communities. A well-designed and dependable medication management program evokes the trust and confidence of residents and their families.

To ensure residents have access to their medications when they need them, staff training programs should focus on the ordering, receiving, storage and monitoring of medications. Often staff is required to know which pharmacy a resident uses, when a refill of a medication is needed, and how a resident's medications will be delivered to the community. This is a complex set of rituals that is time-consuming for staff and is often underestimated and underappreciated by residents and families.

But isn't a medication management program so much more than the drugs handled? Indeed, it is about the safety of the resident. In addition to all of the operational activities associated with the acquisition of medications, monitoring residents for side effects, drug-related adverse events, such as falls, adherence to medication therapy, and residents' responses to the medications they are prescribed. Monitoring programs require some knowledge of medication safety and the tenacity to intervene when a medication-related change is observed in a resident. Training should focus on "High-Alert Medications".

As described by the U.S. Food and Drug Administration, "High-Alert Medications" are those most likely to cause significant harm to patients of any age, even when used as intended by the prescriber. While errors in these medications are not more common than in others, "High-Alert Medications" more commonly cause harm and their adverse reactions are usually more serious, especially in the senior population.

Some classes of medications often used in senior care designated as high-alert include:

- antipsychotics, antibiotics, anticoagulants, insulins and highly concentrated insulins (U 200, U 300 and U 500 insulins), other oral and injectable antidiabetic agents, opioids, and drugs of narrow therapeutic index such as levothyroxine, digoxin, and methotrexate.

i Advance Senior Care
information. insight. innovation.

High Alert Medications

amiodarone	metoprolol
carbamazepine	methadone
clonidine	morphine sulfate
digoxin	oxycodone
insulin	phenytoin
levothyroxine	quinidine
lithium	valproic acid
methotrexate	warfarin
High doses of digoxin, levothyroxine, methotrexate ordered to be taken daily, warfarin prescribe > 7.5 mg daily, morphine sulfate prescribed at a total daily dose > 30 mg	Medications with 10-fold differences between low and high doses (example warfarin 1mg and warfarin 10 mg; haloperidol 0.5 mg and haloperidol 5 mg; Vitamin D 5,000 units and Vitamin D 50,000 units)
Sliding scale insulin	Medication available as liquids
Look-alike, sound-alike medications such as: tramadol and trazadone; hydralazine and hydroxyzine; MS Contin® and Oxycontin®	When more than one tablet or capsule is needed to make a single dose

Source: The Institute for Safe Medication Practices, www.ismp.org

Preventing harm from high-alert medications is not just dependent on prescriber order and dispensing accuracy. Improved medication management and rapid identification of adverse drug events is necessary to minimize serious temporary or permanent patient harm. Monitoring is the key, but staff should become familiar with "High-Alert Medication" names, review them in training and orientation, and maintain the list in the wellness center or wherever medications are managed and know who is taking them.

What action can Senior Living Communities take to bring a new dimension of patient safety to their medication management program? Beyond policies and procedural activities, add high alert medications to curriculum for nurses and medication assistants. Assure staff understands that medication misadventures involving "High-Alert Medications" as a result of error or mismanagement can result in patient harm. Recognize residents taking "High-Alert Medications" and closely monitor for medication adverse effects. Provide appropriate care planning or support as needed. When a prescription is identified as a "High-Alert Medication", clarify the order with the resident and the prescriber and ask a pharmacist if there are any special monitoring parameters. Always consider the medication the resident takes as a possible cause of change in mental or physical condition.

While medication management programs can help to build and retain census, adverse drug misadventure can just as easily drive it down. Senior Living Communities can keep residents safe in the community by enhancing training and vigilance by regarding "High-Alert Medications" for what they are: the potential to cause harm to a patient at any age. Proper management of "High-Alert Medications" not only enhances medication management programs, but also helps to minimize the risk associated with medications.

Vaccines, vigilance making for a moderate flu season

Pamela Tabar, Editor-in-Chief

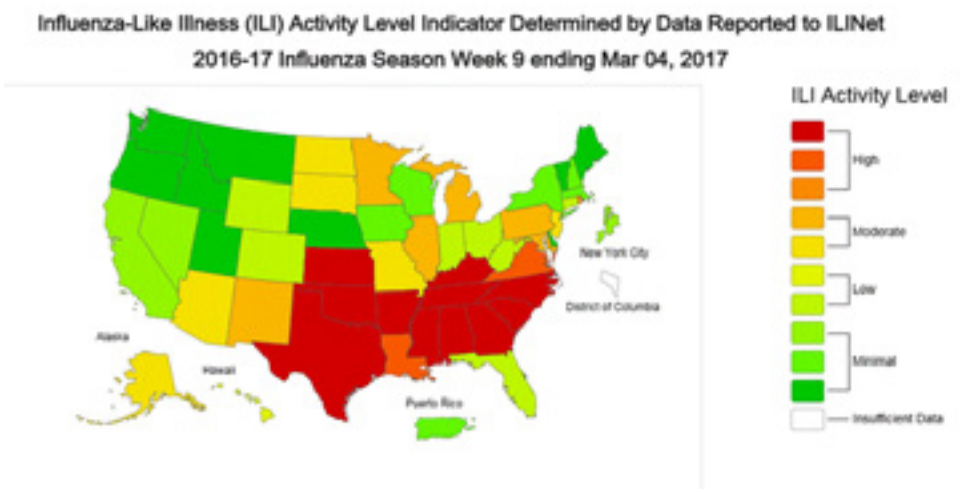
While the U.S. influenza activity remains elevated, the 2016-17 flu season appears to have peaked. Fewer cases were reported nationwide during the first week of March than in the previous two weeks, but flu-like activity is still showing vigor in the Southeast and South regions.

Several states are still above the national baseline for flu-related outpatient visits, the Centers for Disease Control and Prevention (CDC) notes in its weekly surveillance report. The most common flu type by far this year has been the Influenza A (H3) virus. No influenza virus type has shown unusual resistance or rogue characteristics this season.

As in previous years, senior over age 65 represent the most hospitalizations by age group—more than four times higher than any younger age bracket. Reported deaths (all ages) due to pneumonia and influenza are lower than in the past five years during the same month, yet are still above the national epidemic threshold.

Which states have the best rates?

During last year's flu season, Maryland, Iowa Connecticut, Rhode Island and South Dakota had the highest vaccination rates—more than 51 percent of their state populations. four times higher than any younger age bracket. Reported deaths (all ages) due to pneumonia and influenza are lower than in the past five years during the same month, yet are still above the national epidemic threshold.



It's not too late to get a flu vaccine, the CDC adds. This year, the CDC recommends the use of injectable vaccines only, putting the nasal spray version on hold amid questions about its effectiveness. Several versions of the flu shot are available, including two versions designed specifically for older people.

For more information and resources, visit the CDC's Flu Site.

Count on Omnicare.

Your pharmacy partner in expert service and care.

24/7/365 access

Pharmacist support when you need it

Suite of cost containment programs

Provide appropriate therapy and medication cost-effectiveness

Medication reviews

Consultant pharmacists utilize deep expertise in geriatric medication management to ensure optimal health outcomes

Advanced digital tools

Easy-to-use tools allow your staff to track medication orders and billing

Compliance management

Guidance through the ever-changing state and federal regulations

Medication availability

Superior medication availability through daily and emergency deliveries backed by our 125 Long Term Care Pharmacies and 9,600 CVS Pharmacy retail locations

To see how our customized expertise and exceptional services can benefit you, visit omnicare.com.

888-545-OMNI
results@omnicare.com
omnicare.com

Omnicare®
a CVSHealth company

©2017 Omnicare

Re-evaluating vision and gait

Pamela Tabar, Editor-in-Chief

Poor vision is a well-known contributor to falls risk, but Irish researchers say the reason why may not be what we thought. Functional acuity was thought to be the main culprit in gait changes, hesitant stride length and other walking issues. But contrast sensitivity may play a larger role that first believed, says a study published in the Journal of Gerontology A.

More than 4,600 adults age 50+ took part in the study as part of The Irish Longitudinal Study on Ageing.

The study measured gait speed, cadence, stride length and analyzed the participants' visual acuity and contrast sensitivity. While researchers found no evidence of a relationship between gait and visual acuity alone, they did find decreased stride length among those with poorer contrast sensitivity and lower spatial frequency.

"This evidence suggests that it may be necessary to consider refocus of the assessment of vision to include the most appropriate measures," the study authors write.

The study results also reinforce the importance of contrasting colors and patterns in senior living environments for wayfinding and safety.

Elder falls prevention

Tom DiCarlo

Are elder falls preventable? Long-term care has made positive strides in the identification of fall risk factors, the evidence-based assessments of fall probability and in addressing and reducing risk factors. Some studies indicate elder falls and injuries are reaching epidemic proportions, so how do we keep this epidemic from growing?

Falls, especially frequent falls, should not be ignored. Studies have shown a person who has fallen once is two to three times more likely to fall again within a year. It is not unusual that an underlying heath-related issue or medication may be increasing a person's risk of falling. Mitigate intrinsic risk factors through proper nutrition, strengthening/balance exercises, pain management, vision care and proper footwear. Take action to reduce extrinsic risk factors, too: Remove or tack down throw rugs, repair loose banisters, remove clutter and secure trip hazards.

Fall-related deaths among U.S. seniors have risen steadily in the past 13 years. Death rates among those age 65+ were 41 per 100,000 in 2004, but have increased to 58 per 100,000 by 2013, according to the Centers for Disease Control and Prevention.

Senior Fall Facts

One-third of Americans aged 65+ falls each year.

Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall.

Falls are the leading cause of fatal injury and the most common cause of nonfatal trauma-related hospital admissions among older adults.

In 2013, the total cost of fall injuries was $34 billion.

The financial toll for older adult falls is expected to increase as the population ages and may reach $67.7 billion by 2020.

Source: Centers for Disease Control and Prevention

Advancements for elder fall injury protection

Hip protectors: Various products, soft or hard shell, worn under or over clothing covering hips. Compliance of application is key. Some studies conclude hip protectors offer little to no protection from a hip fracture while others support use.

"Smart" clothing: A flexible, energy-absorbent material called Armourgel has been adapted to help mitigate the impact of falls that often leave elderly people with broken bones. Armourgel›s British designer says the material can be incorporated into conventional clothes, providing protection for fragile bodies falling on to hard surfaces.

Wearable airbag: A wearable airbag that incorporates a fall-detection system that uses both acceleration and angular velocity signals to trigger inflation of the airbag. The fall-detection algorithm was devised using a thresholding technique with an accelerometer and gyro sensor.

Helmet for elders: A head covering with a hard or soft shell and various shock-absorbing materials. Proper fit and compliance are required for the protection to be effective. The bulkiness and social stigma of head gear are major complaints.

Floor mats: Bedside floor mats range in thickness from 1-3 inches and are designed to absorb impact and reduce risk of injury from a fall. Floor mats have a durable vinyl cover, a slip-resistant bottom, and some are outfitted with pressure sensors. However, some studies show that floor mats can have risk factors of their own. The mat itself can be a stumbling risk, especially if a person has poor balance or poor vision, uses a walker or uses a portable IV pole.

Partner for prevention

Partnerships and care coordination are strategies to help elders reduce their fall risks. According to the American College of Surgeons Committee on Trauma's Committee on Injury Prevention and Control suggests these four strategies in its 2014 Statement on Older Adult Falls and Fall Prevention:

1. Older adult care providers to implement comprehensive fall prevention programming including:

- Developing community partnerships with community-based centers, such as YMCAs, churches, senior centers, and older adult living centers.
- Incorporating an evidence-based exercise/physical therapy fall prevention program.
- Partnering with home-based visiting programs to complete multi-factorial risk assessments, including: medication review, including the use of opioids; assessment of vision, home safety, and balance and gait; and consideration of vitamin D supplementation.

2. Assessment of the risk/benefit of anticoagulation and anti-platelet therapies in older adult patients.

3. Risk assessment of falls in regular practice. Examples are included in the STEADI (Stopping Elderly Accidents, Deaths, and Injuries) tool kit.

4. Collaboration with regional and statewide fall prevention coalitions for local networking/resources.

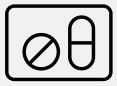
In summary, identifying and addressing specific intrinsic and extrinsic factors can reduce the risk of elder falls. Advancements in injury-protection devices can reduce fall-related injuries when used properly. Is it then possible to theorize with a greater emphasis on advancements in Elder falls injury protection would also impact the rising death rate in seniors caused by unintentional falls? Root cause analysis and advancements in technology will play a major role.

Omnicare, a CVS Health company

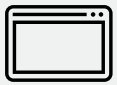
A Consultative Approach to Care

With more than three decades of experience, Omnicare works to deliver practical and innovative pharmacy solutions to address your needs both now and in the future.

Omnicare's responsive, consultative approach demonstrates our commitment to you and your residents. Together, we'll build a solution designed to fit your needs, choosing from a wide range of offerings that includes:



Specialized medication packaging using state-of-the-art automation to ensure accuracy and compliance for your residents.



Omniview, our easy-to-use online worksite for key functions such as eRefill, pre-admission assessment, order tracking, billing, and Med D claims management. Using Omniview, physicians can ePrescribe for controlled substances*, authorize refills and reconcile consultant recommendations.

Practical electronic tools that support your desire to spend time with patients, not paper. An industry-leading eMAR solution and Computerized Physician Order Entry (CPOE) offering are designed to streamline your workflow, allowing more time for resident care.

Consultant pharmacist services to ensure the safety and appropriateness of each residents' medication regimen and deliver heightened quality and compliance for your facility.

Complete product line, education and support for infusion therapy to enhance in-house capabilities while meeting acute care needs and elevating staff expertise.

In-services for nursing staff to deepen their understanding and awareness of senior health issues.

Contact us today, and working together, we'll deliver an innovative solution to encompass your needs in ways that best suit you.

888-545-OMNI
results@omnicare.com
omnicare.com

Omnicare®
a CVSHealth company

omnicare.com

*where allowed by regulation

©2016 Omnicare