MED-NET CONCEPTS LETTER ©

Where Compliance and Ethics, Risk Management/Safety, Quality Assurance and Performance Improvement, Reimbursement and Law Come Together.

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Dear Colleague,

Awareness is the first step toward an effective Compliance, Risk Management, Quality Assurance, Performance Improvement, and Law program. The following true reports are intended to broaden your understanding and awareness of potential exposures of liability throughout healthcare settings with the expectation that, as a starting point, forewarned is forearmed.

We believe a first-hand opinion of our sector of healthcare provides invaluable insight into the daily challenges facing our community.

Remember, it is important to immediately report any abuse of residents/patients, no matter the circumstances.

Please contact us for additional information as well as to discuss potential proactive programs to detect, prevent, and mitigate potential exposures and damages.

ALERTS

LEIE Database Video Tutorial

The Office of the Inspector General (OIG) posted a new video tutorial on how to use the Exclusions database to better guide the public through the verification process. Watch the video here.

For more information on the HHS OIG Exclusions Program, visit their website.

Snapchat Post Leads to Connecticut Nursing Home's Fine

A Connecticut nursing home was fined $1,320 by the state Department of Public Health (DPH) after a nurse aide posted a video on Snapchat of a resident in a wheelchair asking for a cheese sandwich. In the video, the resident was seated in a wheelchair, wearing a white helmet, and repeatedly asking for a grilled cheese sandwich. The video had been edited with the caption, "All I want is a grilled cheese sandwich." The aide had just attended training a day earlier in which staff were reminded that cell phone use is prohibited in resident care areas, the DPH citation said.

Compliance and Ethics Perspective:

Taking pictures and videos of residents (often in compromising or demeaning situations) without their consent or the consent of their representative and posting them on social media is a violation of residents' right to privacy. Failure to comply with the facility's rules prohibiting the use of cell phones in residents' care areas—especially after attending training on those rules—may be considered grounds for dismissal and cause the facility to receive deficiency citations fines. Theft of resident property is considered provision of substandard quality of care, in violation of state and federal regulations. According to F-Tag 600 Freedom from Abuse, Neglect, and Exploitation in the CMS State Operations Manual, Appendix PP, mental abuse can occur through the use of smartphones and other personal electronic devices. It includes keeping or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. A photograph or recording of a resident, or the manner in which it is used, that demeans or humiliates a resident, regardless of whether the resident gave consent and regardless of the resident's cognitive status, is abuse.

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OCR Settles Second Case in HIPAA Right of Access Initiative

The Office for Civil Rights (OCR) at the US Department of Health and Human Services announced its second enforcement action and settlement under its HIPAA Right of Access Initiative, promising to vigorously enforce the rights of patients to get access to their medical records promptly, without being overcharged, and in the readily producible format of their choice. A Florida medical center agreed to take corrective actions and pay $85,000 to settle a potential violation of HIPAA's right of access provision. In March of 2019, OCR received a complaint concerning a patient alleging that, despite repeatedly asking, the medical center failed to forward a patient's medical records in electronic format to a third party. Not only did they fail to timely provide the records to the third party, but they also failed to provide them in the requested electronic format, and charged more than the reasonably cost-based fees allowed under HIPAA. OCR provided the medical center with technical assistance on how to correct these matters and closed the complaint. Despite OCR's assistance, the medical center continued to fail to provide the requested records, resulting in another complaint to OCR. As a result of OCR's second intervention, the requested records were provided for free in May 2019, and in the format requested. In addition to the monetary settlement, the medical center will undertake a corrective action plan that includes one year of monitoring.

Risk Management Perspective:

A healthcare provider is required, under the Office for Civil Rights' (OCR) HIPAA Right of Access Initiative, to allow patients timely access to copies of their medical records at a reasonable cost, and in the easily producible format of their choice. To avoid violations and possible costly fines, a healthcare provider should ensure that staff members responsible for responding to medical record release requests are trained in the protocols to follow regarding timeliness, format selection, and reasonable cost. Periodically auditing staff responses to requests to determine that document release complies with the HIPAA Right of Access Initiative may reduce the risk of fines and other sanctions.

Tennessee Imposter Nurse Pleads Guilty to Wire Fraud, Healthcare Fraud, and Identity Theft

A Tennessee woman, 44, posed as a registered nurse, despite having neither a nursing degree nor a nursing license from the Tennessee Department of Health, and no nursing experience. Through this fraudulent scheme, she was hired by at least eight healthcare providers between September 2012 and November 2018. Over the six-year period, she worked in a variety of medical settings, including nursing homes, rehabilitation and assisted living facilities, a doctor's office, and home health agencies. The imposter had access and rendered medical care to numerous patients, dispensing medications, obtaining invasive access to patient's bodies, and gaining access to patients' sensitive and private medical information. Additionally, as a purported registered nurse, she made numerous false entries in patients' medical records and submitted false claims to public and private healthcare benefit programs. Upon learning of her imposter status, two of her employers voluntarily repaid healthcare benefit programs a combined sum of over $500,000 for claims submitted.

Compliance and Ethics Perspective:

State and federal laws require Medicare and Medicaid approved long-term care facilities to employ adequate nursing staff. Registered nurses must have the required level of training and skills "to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" (§483.35 Nursing Services). All staff members working in Medicare and Medicaid-approved facilities whose positions require that they be licensed and/or certified should have those licenses and certifications verified

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prior to being hired. Employers should require the employee to present an original license or certificate so the employer can make a file copy, and should not accept a copy. State licensure databases should be checked, with the results printed and saved in each employee's HR folder. Conducting periodic audits can help to ensure that staff are maintaining certifications, continuing education requirements, and have not committed any violations which would exclude them from working for a Medicare or Medicaid participating healthcare provider.

$357K Awarded to Family of 92-year-old Man Who Died after Florida Nursing Home Fall

A Florida nursing home must pay $356,700 to the family of a 92-year-old man who fell and injured his head but was not taken to the hospital. The man had Alzheimer's disease and a history of falls and had been admitted to the facility for rehabilitation. After he was transferred two weeks later into the skilled care nursing section, he fell and hit his head. Workers performed an X-ray and deemed him clear to return to his room, rather than sending him to the hospital for treatment. According to the family's attorney, he then developed a hematoma on his brain and died eight days later. An arbitration panel that took over the family's 2018 lawsuit found the nursing home negligent and in violation of residents' rights. The panel awarded the family $6,700 for funeral costs and $350,000 for pain and suffering.

Compliance and Ethics Perspective:

A comprehensive care plan with specific intervention and prevention strategies should be developed for residents with a history of falling, to include more frequent monitoring. A resident who has fallen and possibly hit his or her head should be transferred to a hospital for evaluation to ensure there is no serious head trauma that might not be evident in x-rays. Staff should receive training on protocols for responding to resident falls with possible head trauma, and should also receive in-service training on care planning for residents with a history of falling and how to assess residents after a fall.

Florida Nursing Home Worker Arrested after Pawning Rings Stolen from Resident's Finger

A former Florida nursing home employee is facing felony charges after police say she stole rings off the fingers of a resident and sold them to a pawn shop. Police said the resident told them a worker came into her room to take a breakfast tray and volunteered to clean her rings. The woman said the worker slid the rings off her fingers and walked away, but she became worried as time passed. According to an affidavit, the resident later identified the worker, who denied taking the jewelry. As the investigation continued, officers searched a pawn shop database and found the worker had pawned two rings. Officers said they met with the owner, who showed surveillance video of the transaction. The gold wedding band and another gold band with a gemstone attached were later confirmed to be the same rings that belonged to the resident.

Compliance and Ethics Perspective:

A nursing home has a fiduciary responsibility to protect the personal property that residents have, e.g., jewelry worn or kept in their possession. An employee who steals valuables belonging to residents by deception, as in this case, or simply taking valuables that might not be stored in a locked drawer, disregards the rights of residents, which is considered abuse, neglect, misappropriation, and exploitation. Such acts may be considered provision of substandard quality of care in violation of state and federal regulations.

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Kansas Man Dies after Nursing Home Fire

A 64-year-old resident injured in a fire at a Kansas nursing home died. When fire crews arrived at the building, they found smoke in the hallways. Nursing staff led firefighters to the man, who was taken to a hospital. The blaze was contained to the room where it started and was extinguished when firefighters arrived. A preliminary investigation indicated the fire was accidental and likely caused by careless use of smoking materials. The building was not damaged. The fire marshal said smoke detectors in the building worked as designed.

Risk Management Perspective:

Although the smoke detectors in the facility were reported to have worked as designed, the Centers for Medicare & Medicaid Services (CMS) requires that a nursing home develop an Emergency Preparedness Plan based on a risk assessment that uses an "all-hazards" approach. CMS defines an all-hazards approach as "… an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters, including internal emergencies and man-made emergencies (or both), and natural disasters." The facility may have failed to adequately assess residents' risk potential for smoking unsupervised in their rooms. A review of the facility's smoking or non-smoking policy may indicate the need for changes. Staff training may be needed regarding performing the smoking risk assessments of residents, the need for adequate supervision while residents smoke, and any changes in policies and procedures regarding the facility's smoking policy and resident access to smoking materials. Staff should audit to determine if the smoking risk assessments for all residents who smoke are up-to-date and if the smoking policy is being followed.

Yours truly,

David S. Barmak, JD, CEO.

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EMERGENCY PREPAREDNESS: WILL YOU MEET CMS STANDARDS?

Will your facility be able to meet the demands and guidelines specified by CMS to deal with an emergency?

Following the easy-to-use checklist provided by Med-Net Academy will ensure that you meet the minimum guidelines and provide maximum resident safety.

The emergency preparedness checklist is available under the Med-Net Academy Condensed CMS Policies and Procedures category.

When using the checklist, each facility's leadership team can determine their level of compliance with CMS emergency preparedness requirements by selecting their specific category of readiness for each item listed.

Information gathered can then be used to strengthen existing emergency plans and guide staff in preparing for, managing, and recovering from identified potential hazards, using an all-hazards approach.

This checklist, developed for use in nursing homes, includes CMS emergency preparedness requirements as detailed in the State Operations Manual Appendix Z Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance.

The checklist can be accessed by clicking here.

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