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

The US Department of Health and Human Services' Office of the Assistant Secretary for Health has provided Guidance for PREP Act coverage for COVID-19 screening tests at nursing homes, assisted-living facilities, long-term-care facilities, and other congregate facilities.You can access it here: https://www.hhs.gov/sites/default/files/prep-act-coverage-for-screening-in-congregate-settings.pdf.

Paraplegic Nursing Home Resident Charged in Fatal Shooting at Illinois Long-Term Care Facility

A thirty-two-year-old resident of a long-term care facility in Illinois, who is paralyzed from the waist down and uses a wheelchair, was charged in the shooting death of another resident, who was seventy-seven. The victim was taken to a nearby hospital, where he died a short time later. The suspect was taken into custody at the rehabilitation center following the shooting and charged the next day.

Risk Management Perspective:

Compliance with the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule requires long-term care facilities to conduct a risk assessment to identify facility-level risk factors (e.g. active shooter, equipment failure, cyberattack, medical surge, and more) that could cause the greatest disruption to facility operations. Following completion of the risk assessment, the facility should develop an Emergency Preparedness Plan with strategies for addressing such events. Facilities should periodically review their policies and procedures regarding prohibition of weapons by staff, visitors, and residents. Train staff in their Emergency Response Plan's protocols for responding to an active shooter situation or an incident involving weapons. Training should include periodic mock drills to ensure that staff are adept at responding. The policy regarding prohibiting the possession of any kind of weapon while on the facility's premises should be regularly communicated to residents and visitors.

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Michigan Nursing Home Resident Beaten, Wedding Ring Stolen off Her Finger

A male orderly was arrested for beating and stealing from a sixty-nine-year-old Alzheimer's resident inside a Michigan nursing home. The attack allegedly happened just days after the woman moved into the facility. The victim's husband said the nursing home told him his wife's injuries were due to a fall. He also said her wedding ring was stolen. The suspect was charged with armed robbery, a felony, and elder abuse, a misdemeanor.

Compliance and Ethics Perspective:

Under the US Code of Federal Regulations 42 CFR § 483.12, Freedom from Abuse, Neglect, and Exploitation, when a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. A facility cannot disown the acts of its staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must do the following:

- Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported on a timely basis per established procedures to the administrator of the facility and to other officials, such as the State Survey Agency, law enforcement, and adult protective services when they have jurisdiction in long-term care facilities.
- Have evidence that all alleged violations are thoroughly investigated.
- Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress by immediately removing the alleged perpetrator from the environment and providing adequate supervision of residents.
- Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency within 5 working days of the incident. If the alleged violation is verified, appropriate corrective actions must be taken.

Washington State Suspends Certifications of Two Women Who Accepted Gifts from Patients

A Washington state occupational therapy assistant had her credentials suspended for three months after she accepted about $8,000 from a patient and did not return the money when asked to do so. A Washington state certified nursing assistant (CNA) had her credential indefinitely suspended. The Department of Health received a complaint alleging that while working at an assisted living facility, the CNA accepted a $10,000 check and an uncirculated 1800 silver dollar from a patient and had possession of the patient's vehicle.

Compliance and Ethics Perspective:

Misappropriation of resident property, as defined under the US Code of Federal Regulations 42 CFR § §483.5 - Definitions, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

The facility's policies and procedures regarding the prohibiting of giving gifts of any kind to staff should periodically be communicated to staff through training, and to residents, families,

and representatives through the residents' council. Also, any incident involving such gifting from residents, families, and representatives to staff members should be reported. Placing posters regarding the facility's gift policy around the facility may help to be a constant reminder to staff, residents, families, and visitors. Examples of misappropriation of resident property include, but are not limited to:

- Identity theft
- Theft of money from bank accounts
- Unauthorized or coerced purchases on a resident's credit card
- Unauthorized or coerced purchases from a resident's funds
- A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion
- A resident who provides monetary assistance to staff, after staff had made the resident believe that the staff member was in a financial crisis

Missing Resident at Ohio Nursing Home Sparks State Investigation, Apology

A seventy-three-year-old Ohio nursing home resident with dementia was taken to a local Starbucks by her son and daughter. When her son took her back to the facility around 4:30 p.m., he was not allowed inside to escort his mother to the right floor due to Coronavirus concerns. He said he was told that a nurse would meet her. But his mother got off the elevator on the wrong floor where construction was underway, and she could not get the elevator to come back. The facility did not contact her children to say she was missing until 1:30 a.m. Staff found her soon thereafter. The family says someone should have met their mother at the elevator and checked in on her routinely throughout the day.

Risk Management Perspective:

Failure to ensure that residents with dementia returning from outings are properly checked-in and escorted to their rooms may result in residents being placed in immediate jeopardy for injury or other harm due to their potential to wander or to exit the facility unsupervised, a breach of state and federal regulations requiring adequate supervision at all times. Policies and procedures should include protocols to follow when residents go on outings with family and are later checked back into the facility. Additional safeguards must be followed when situations such as COVID-19-related visitor restrictions prevent family members from entering the facility with returning residents, especially for those who are diagnosed with dementia or need other assistance in reaching their rooms. Train staff to anticipate the return of residents who have gone on family outings to ensure that they are assisted as needed. Conduct periodic audits to determine if protocols for checking residents in and out for outings are being followed.

Man in Armed Standoff at Florida Hospital Was Former Cop, Nurse at Hospital

An armed, suicidal former police officer, who was also a former previously licensed registered nurse, spent several hours in a standoff with law enforcement at a Florida hospital before being disarmed and taken into custody. The fifty-five-year-old was employed in the 1990s as a sheriff's deputy and police officer and was also a twenty-on-year military veteran. Additionally, he was a partner in a local gun manufacturing company. The county sheriff said the man had at least five firearms in his possession, including a high-powered rifle. He was eventually talked into surrendering.

Risk Management Perspective:

Compliance with the Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule requires hospitals and other healthcare organizations to conduct a risk assessment and develop a related Emergency Preparedness Plan with strategies for addressing such events. In recent years, active shooter situations have become all too common. Each healthcare provider is responsible for development of an adequate active shooter prevention and response plan and for training staff in the protocols to follow should an active shooter situation or an incident involving other weapons occur. Training should include periodic mock drills conducted in collaboration with local law enforcement to ensure that staff are adept at responding, and that law enforcement personnel are familiar with the facility's environment. All staff should understand how crucial it is to identify and immediately report any suspicious behavior that may potentially lead to violence. Obtain guidance in five active shooter response models for healthcare settings by visiting https://www.fbi.gov/file-repository/active_shooter_planning_and_response_in_a_healthcare_setting.pdf/view. It is also vital to enhance security by having a thorough check-in process, and not allowing anyone unauthorized to enter secure areas.

Mobile X-Ray Company to Pay $49,759 to Settle False Claims Liability

The United States Attorney's Office for the Middle District of Pennsylvania announced that Physician's Mobile X-Ray has agreed to pay the United States $49,759 to resolve potential liability under the False Claims Act. Physician's Mobile X-Ray is based in Harrisburg, Pennsylvania and provides mobile imaging services, including x-rays, ultrasounds, and cardiac services. According to US Attorney David J. Freed, Physician Mobile X-Ray improperly billed Medicare for the transportation component of X-Ray equipment when x-ray services were provided to more than one Medicare beneficiary at the same location during the same trip. While Medicare will reimburse providers for a transportation component associated with mobile imaging services, that transportation component should be apportioned when more than one patient at the same location receives an x-ray during the same visit. The United States alleged that Physician's Mobile X-Ray failed to apportion its charges between 2014 and 2019, leading to overcharges to Medicare.

Compliance and Ethics Perspective:

Knowingly submitting claims over a long period of time that include a transportation fee for each of the x-ray services provided to multiple patients/residents at a single location during a single trip may be considered submission of false claims, in violation of the federal False Claims Act, jeopardizing the eligibility of the healthcare provider to participate in Medicare and Medicaid reimbursement programs. Regulations allow reimbursement of only one transportation fee which should be prorated among all patients/residents receiving x-ray services during that one trip to the one location. A provider should review policies and procedures regarding the process for submission of claims to ensure that claims submitted comply with Medicare and Medicaid regulations, particularly claims that include transportation fees that should be prorated across more than one individual receiving those services. Train staff members involved in claims submissions regarding prorating of transportation or other services (e.g., group therapy vs individual therapy sessions) shared by more than one individual.

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Texas Assisted Living Facility Facing Lawsuit after Family Claims Employee Died from COVID-19

A Texas woman is suing an assisted living facility after two members of her family, a daughter and a granddaughter, claimed they contracted COVID-19 while working there. According to the lawsuit, the daughter tested positive for the virus after coming into contact with a resident at the facility. The family claims she was never told the resident was infected, and that management sent her to help the resident without adequate protection. The daughter later died from complications of the virus. The granddaughter was pregnant at the time she tested positive and has since recovered.

Compliance and Ethics Perspective:

Facilities should review policies and procedures to ensure implementation and compliance with the Centers for Medicare & Medicaid Services (CMS) reporting requirements and timely communication to employees, residents, families, and responsible parties regarding confirmed or suspected COVID-19 cases. Also, facilities should ensure that there are adequate supplies of PPE available, and that employees are trained regarding the facility's Infection Control Program for preventing the spread of COVID-19, including protocols for individual practice regarding hand hygiene and proper wearing of PPE when providing care to COVID-19 positive residents.

Yours truly,

David S. Barmak, JD, CEO.

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AFFILIATES

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COMPLIANCE OFFICER-QUALIFIED CERTIFICATE PROGRAM

Med-Net Compliance, LLC has introduced its Compliance Officer-Qualified Certificate Program to assist in preparing candidates to lead an effective Compliance and Ethics Program according to Centers for Medicare and Medicaid Services (CMS) Phase 3 compliance and ethics requirements.

Upon successful completion of the program's curriculum and examination, Med-Net Compliance will award the Compliance Officer-Qualified (CO-Q) designation to participants. Candidates who successfully complete the NAB approved seven element program, will earn a total of 8.75 CEs.

Candidates for the CO-Q designation are those who include compliance practices as an integral component of current or future professional responsibilities including compliance officers, quality and risk management professionals, healthcare executives, and healthcare professionals with the requisite background.

Candidates must possess academic and professional experience by having a Baccalaureate degree or related education and experience in a healthcare setting or with a provider of services to the healthcare sector.

For more information on the Compliance Officer-Qualified (CO-Q) Program, please go to the Med-Net Compliance website at: https://www.mednetcompliance.com/co-q-program/.

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