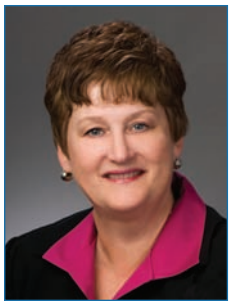

LEGAL ISSUES

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Regulatory and Litigation Risks of Elopement

Elopements place nursing homes and assisted living facilities at great risk. When a resident exits the building undetected and the individual is unsafe to be out of the facility environment without supervision, it is very dangerous for the resident. The resident is alone in an uncontrolled environment and he or she lacks the skills and/or mental capacity for self-protection. Elopements have resulted in resident deaths, significant injuries and exposure to extreme heat and cold. Facilities can be the subject of negative national new stories related to resident elopements, be the subject of malpractice lawsuits and receive significant regulatory citations with large monetary sanctions.

Unfortunately, elopements can and do occur throughout the country. In 2017, news media reported that a Pennsylvania nursing home's license was revoked for "gross incompetence" related to an elopement. The resident's body was found in a roadside ditch nearly a month after eloping from a Pennsylvania facility. This resident had a history of exit-seeking and had previously exited from a secure unit. A delay in reporting the missing resident complicated the facility's response. Regulatory actions and litigation were both experienced by the facility as a result of this unfortunate elopement (https://bit.ly/2Mxsen0).

A $5,000,000 verdict was rendered against assisted living community in California related to a resident's death when a 90-year-old resident exited from the building into a courtyard. While in the courtyard, she fell, fractured multiple bones and sustained head injuries. She was discovered about 45 minutes after leaving the building. The lawsuit alleged that the facility staff were not well-trained and not capable of caring for individuals with her complex dementia-related needs. (https://bit.ly/2NfOwWH).

Common Allegations

Understanding some of the common allegations in elopement malpractice litigation can alert management to areas for focus and improvement in a facility. Common allegations in elopement litigation can include:

- Failure to properly train staff on assessment and monitoring for residents at increased elopement risk.
- Failure to recognize, assess, and address a resident's wandering behavior to prevent elopement.
- Inadequate numbers of staff or inadequate staff mix such as too few licensed nurses.
- Inadequate documentation regarding resident assessment, interventions, and care plans relating to wandering or increased elopement risk.
- Failure to properly monitor residents at increased elopement risk.
- Having incomplete or inadequate policies and procedures for elopement prevention or for timely locating a resident following an elopement.
- Failing to have adequate interventions consistently in place (i.e., door alarms, locked doors, security cameras, wander guards, etc.).
- Failure of staff to timely respond to interventions (alarms, etc.) to prevent or promptly identify an elopement.

Nursing homes often experience complex regulatory ramifications from situations such as elopements. The state and/or federal regulators often impose a variety of sanctions as directed by specific state and federal statutes and regulations. The State Operations Manual (SOM) from the Centers for Medicare and Medicaid Services provides the regulations and the interpretive guidance for providers and surveyors for Medicare and Medicaid certified facilities. The discussion in the SOM related to elopement can be found in the regulatory tag for accidents and safe environment (F689). The regulatory discussion includes that

". . . elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. A resident who leaves a safe area without supervision may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Various accidents and incidents have occurred with residents eloping from buildings including numerous situations that involved serious injury and/or death." (SOM, Appendix PP, Data Tag F689)

This regulatory discussion should place all certified facility providers on notice that risks for elopement are present and must be addressed on an ongoing basis. Elopements without injury have been cited by regulators, sometimes at the immediate jeopardy (IJ) level. Citations with or without injury at an IJ level create imposition of regulatory sanctions that may include civil money penalties, required directed in-service training, mandatory or discretionary denials of payment for new admissions and mandatory or discretionary termination of the Medicare and/or Medicaid certification. State regulatory action may be independently taken by the state licensing agency based upon the licensing state's statutes and regulations. These regulatory situations can have a multi-year impact on the facility as the lookback period for imposition of sanctions at the federal level includes three standard survey cycles that may be in excess of three calendar years. The regulatory guidance provides that Certified Facilities can be at risk for increased sanctions based upon the citations issued during the past three standard survey cycles, including standard surveys and any intervening complaint surveys.

Reduce Elopement Risk

Facilities should take proactive steps to reduce the potential for elopements. Identification of residents at increased risk for elopement should start at admission. Screening and assessment tools can assist facilities to identify residents at potential increased risk for wandering behaviors and/or elopement. With an initial assessment, care plan interventions should be developed and promptly implemented to reduce each resident's specific elopement risks. Interventions might include one or more the of following: admission to a secure unit; use of an electronic device to alarm and/or secure doors when the resident attempts to exit; increased monitoring by staff such as placement in a room near the nurses' station; or identification of the frequency of visual monitoring of the resident.

Facilities are also required to implement facility-wide security and safety measures. Security and safety risks must be assessed for the entire facility and should be included in the facility assessment process required by the regulation and interpretive guidance found in the SOM at F838. Each facility is required to conduct a comprehensive facility assessment. Assessing needs such as types and placement of security monitoring devices can include video cameras installed at exits and in other common spaces to increase overall facility security and assist in elopement prevention. Alarmed doors and other electronic monitoring devices should be designed and installed in a manner to maximize security oversight and to enhance safety. Monitoring of the security devices and door alarms should occur on an ongoing and defined basis with thorough documentation of such monitoring. Documentation of routine rounds and monitoring by clinical and maintenance personnel can assure that the equipment is continuously in good and effective working order.

Staff training also is essential to ensure that the facility is prepared to prevent elopements and to investigate situations in which a resident may be missing from the resident's unit and/or the facility. Training at hire and periodically is important for all facility staff, not just the clinical staff. Staff must be aware of the residents at increased elopement risk. Knowledgeable and well-trained staff can often safely redirect a resident when observed in potentially unsafe areas or when seen alone in an area such as the activity room. Also, periodic elopement drills will prepare the staff to fully implement the facility's policies and procedures to locate a resident in a timely and efficient manner when a resident is identified as missing.

Facility policies that clearly define the mechanisms and procedures for managing residents with increased elopement risks require policies to be tailored to the facility population and the facility's unique physical plant. Additionally, residents identified with increased elopement risk must have the individualized care plan interventions consistently implemented and periodically reassessed with resident changes or during routine care plan reassessment. Cooperation and communication with the family and physician are also important elements in a total plan for reduce elopement risk. Family members and other facility visitors should be aware that only non-residents are to exit from a secure wing or exterior door to prevent elopements.

Residents with previous elopements place the facility at increased risk of a higher citation level because the facility had notice that the resident needed additional and appropriate interventions to prevent future elopement. The facility should also utilize its Quality Assurance and Performance (QAPI) program to review and discuss all elopements to identify root causes. Such analysis allows the root cause of such incidents to be identified and allows risks to be reduced in the future. The facility's counsel can assist in developing and reviewing the QAPI policies and procedures to assure appropriate protection of such important quality improvement documentation.

Consistent individualized interventions can prevent elopement tragedies for facility residents and assist in positive outcomes for those in post-acute residential settings.

This column is not to be substituted for legal advice. Ms. Feldkamp is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, OH.