Senior Care

Data Insight

2026

MedPro Group

a Berkshire Hathaway company

Report Scope

This report details stories and data arising out of MedPro's senior care cases which closed with an indemnity payment. Even though well-meaning staff act on behalf of facility residents, failures in the process of care do occur, and can result in a long-lasting impact on both residents and their caregivers.

We trust you'll read our data and associated case stories with an eye on both clinical risk management and on how these events might have been prevented, for the benefit of residents, their caregivers, and staff members.

Throughout this report, we'll answer the following questions, among others, and support the answers with data:

What do recent actuarial financial severity trends look like?

Which case types are most common?

Who is most likely to be responsible for the resident's injury, and how serious are the injuries?

Where, and in which facility type do most of the events occur?

How do failed processes of care, known as contributing factors, impact resident outcomes?

Key Points

Senior care cases arising in skilled nursing and assisted living facilities reveal persistent exposure concentrated in resident safety and monitoring failures, with half of all cases ending in death and a high proportion of clinically severe outcomes.

Resident safety, including falls, and pressure ulcer prevention/management, dominate the loss picture.

Assisted living facility cases, especially those events arising in memory care units, show higher average indemnity and distinctive risk patterns tied to staffing, assessment, communication, and environmental controls.

The percentage of cases closing with indemnity payment trended modestly down over the years covered in this analysis, yet average indemnity increased, influenced by more matters taking 3+ years to close. Resource availability, training sufficiency, and resident placement decisions materially affect exposure. Leadership should treat falls, monitoring lapses, and environmental hazards as enterprise risks with measurable cost signatures, not just clinical quality issues.

Key Points, continued

The distribution of contributing risk issues (factors) is consistent across facility types. The most common factors include the following:

Clinical judgment and assessment gaps: Inadequate resident assessments create missed opportunities for care, allowing conditions to worsen and/or physiological changes to go unnoticed.

Administrative / policy adherence and staffing: Failure to follow protocols, inadequate staffing levels, training, and oversight are issues overrepresented in ≥$500K indemnity paid cases.

Communication breakdowns: Poor handoffs, missed escalation of evolving signs/symptoms, and not reading plan-of-care updates are additional issues overrepresented in in ≥$500K indemnity paid cases.

Documentation insufficiency: Gaps in the documentation of care plans, services provided, and assessments undermine both care continuity and defensibility.

Behavior-related factors: Resident behaviors—especially non-adherence to fall precautions—intersect with staffing and monitoring.

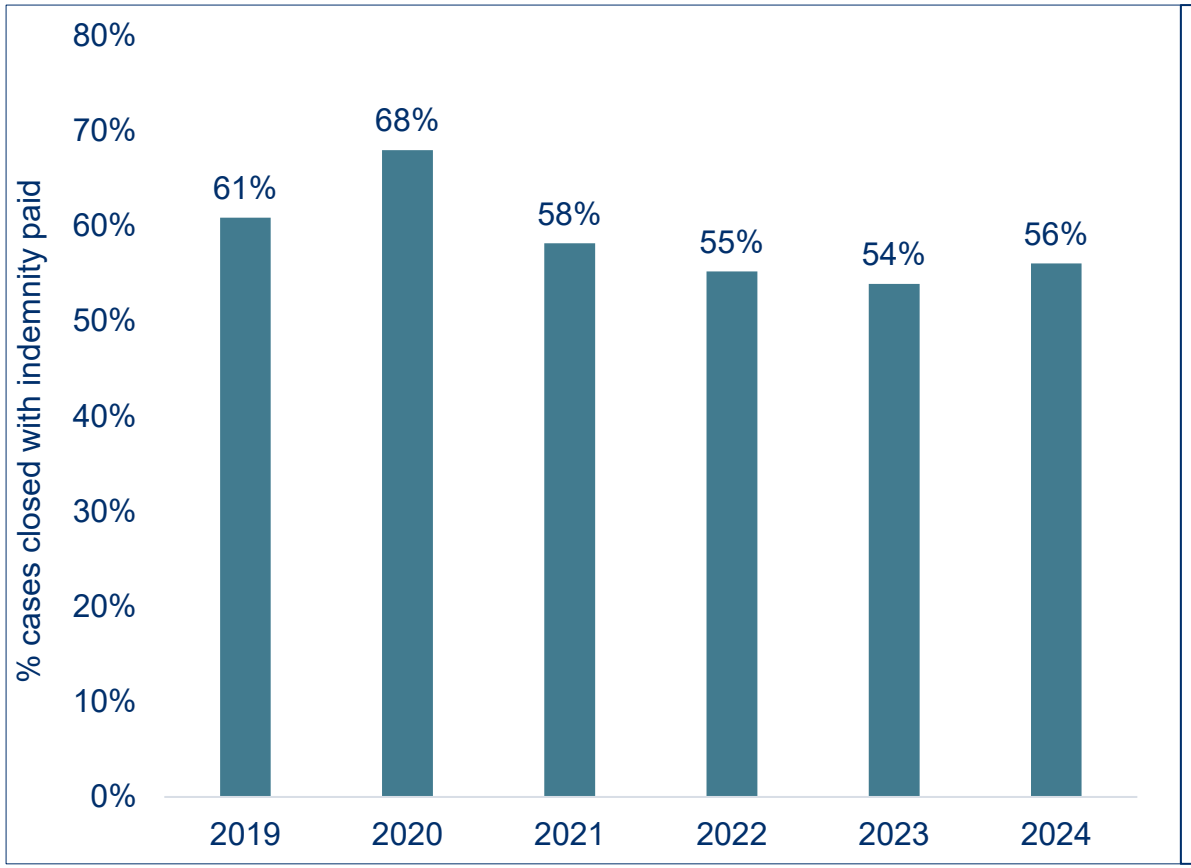
Environment and timing: Weekend/night/holiday shifts and unsound physical environments (e.g., wet floors, hallways full of equipment) elevate risk.

Financial Severity Analysis

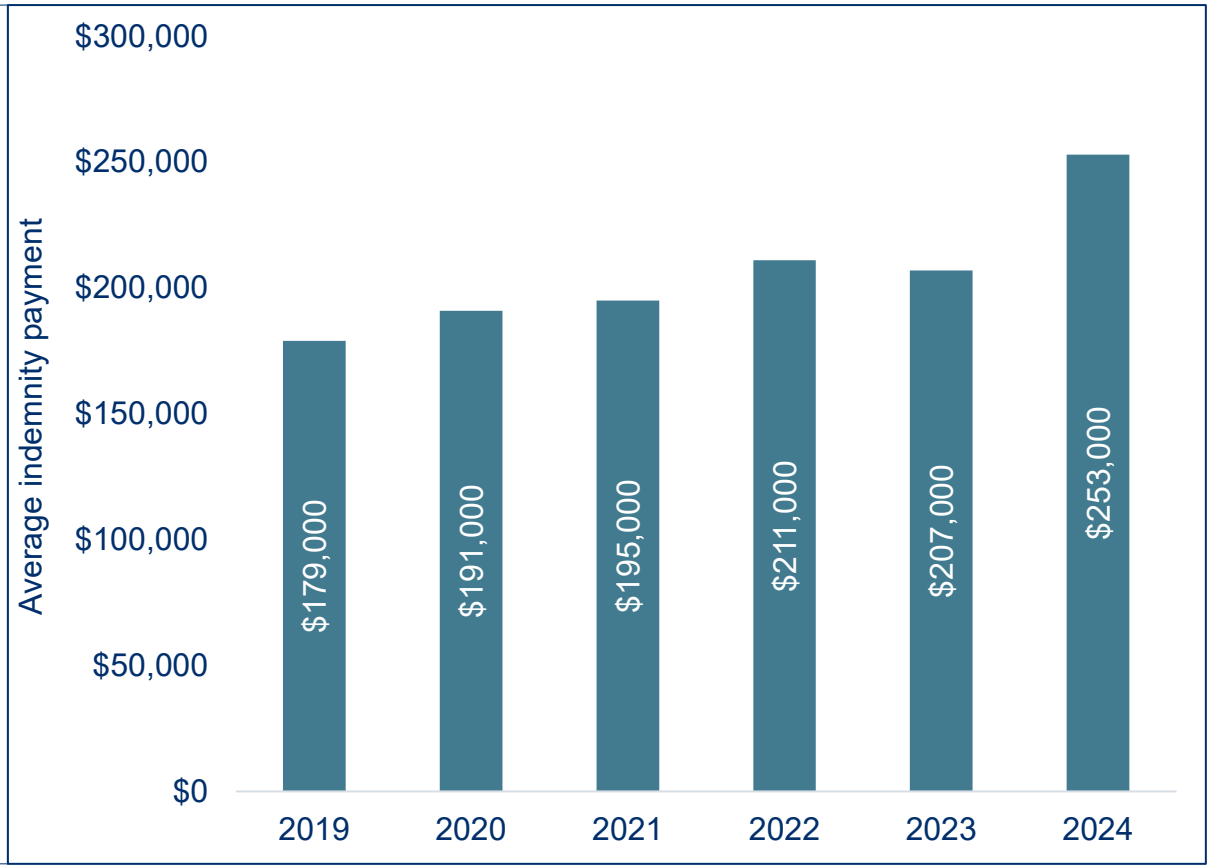
The following section details countrywide financial severity metrics for all clinically coded senior care cases closed with indemnity paid.

Countrywide Indemnity Payment Metrics

The percent of cases that close with indemnity payment has seen a slight downward trend, falling from 61% to 56% over the experience period.



The average indemnity payment on closed cases has increased over the experience period. This is driven by a larger portion of claims taking 3+ years to close. (See next page.)

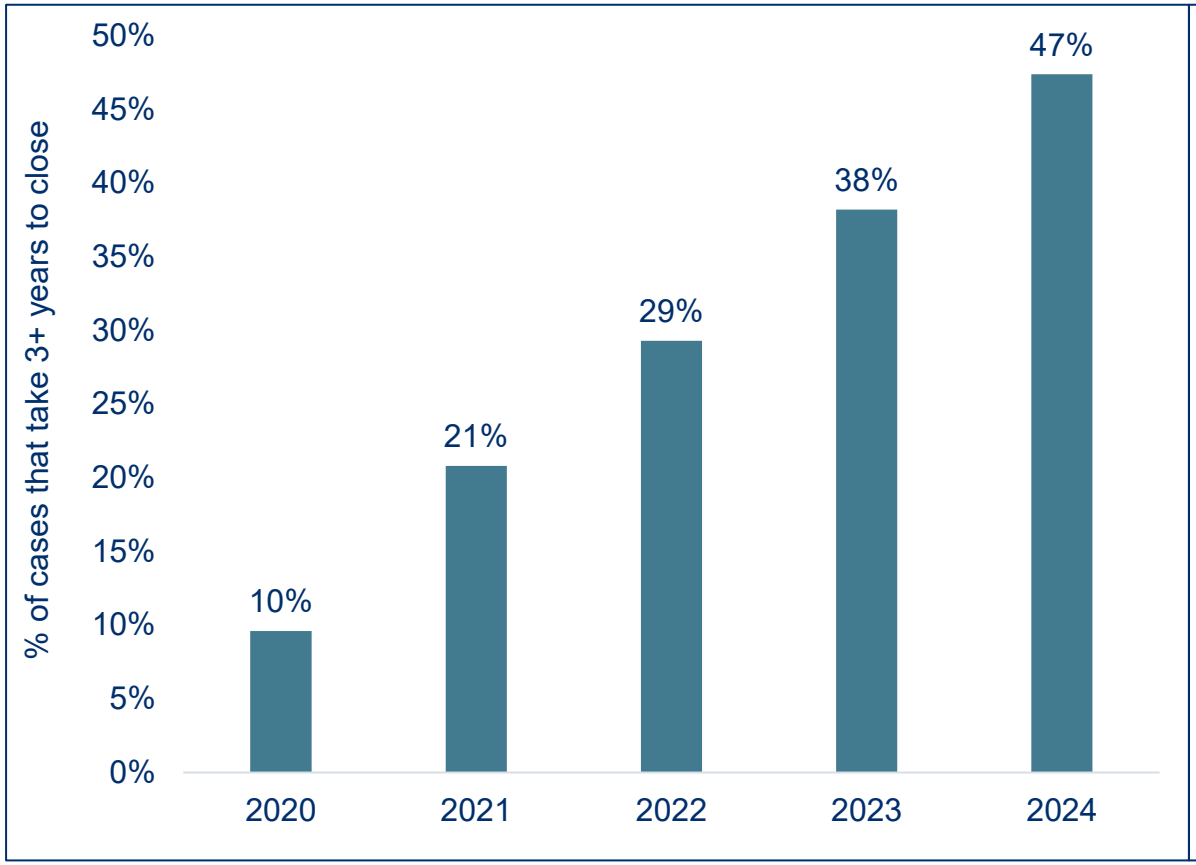


Close year

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025

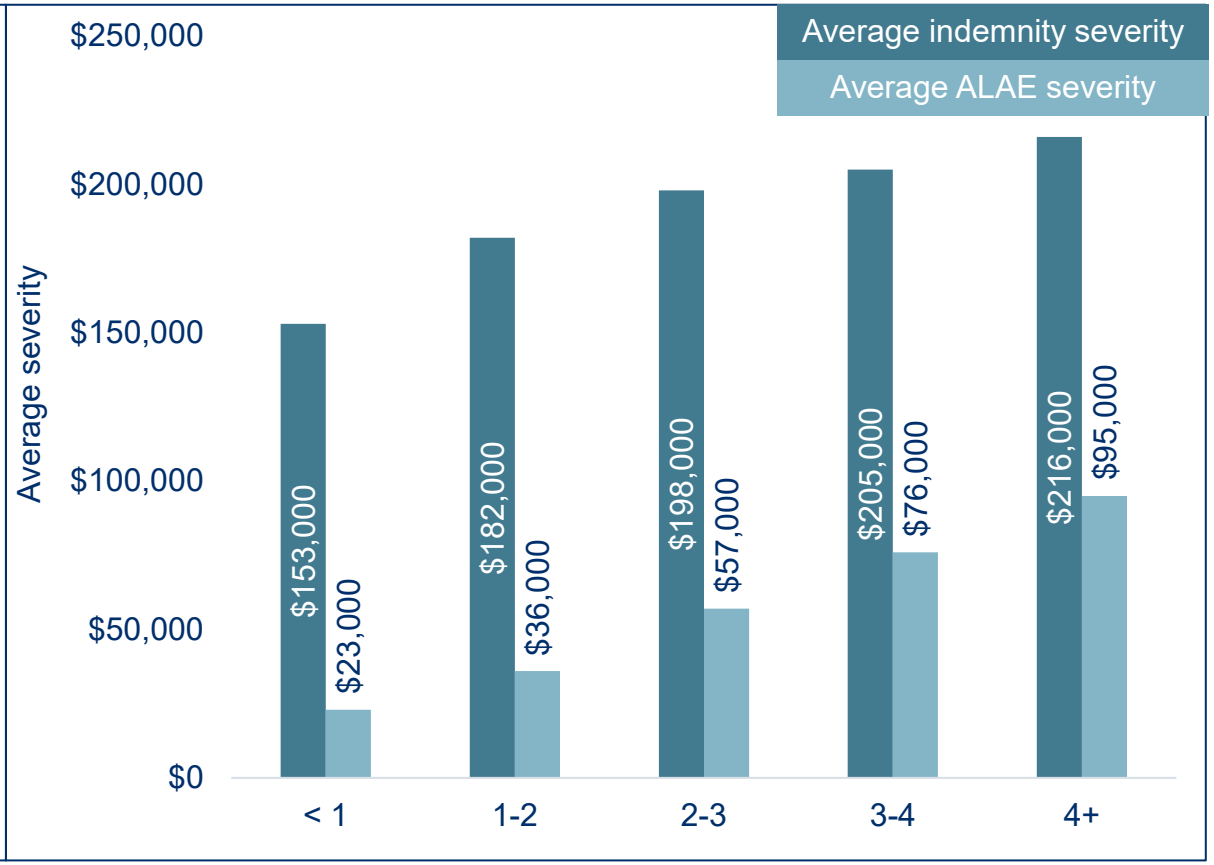
Years from Open to Closed Metrics

The percentage of cases that take more than 3 years to close has increased considerably over the experience period. This is likely due to COVID-related settlement lags.



Close year

Average indemnity and ALAE* payments both steadily increase the longer a case remains open.



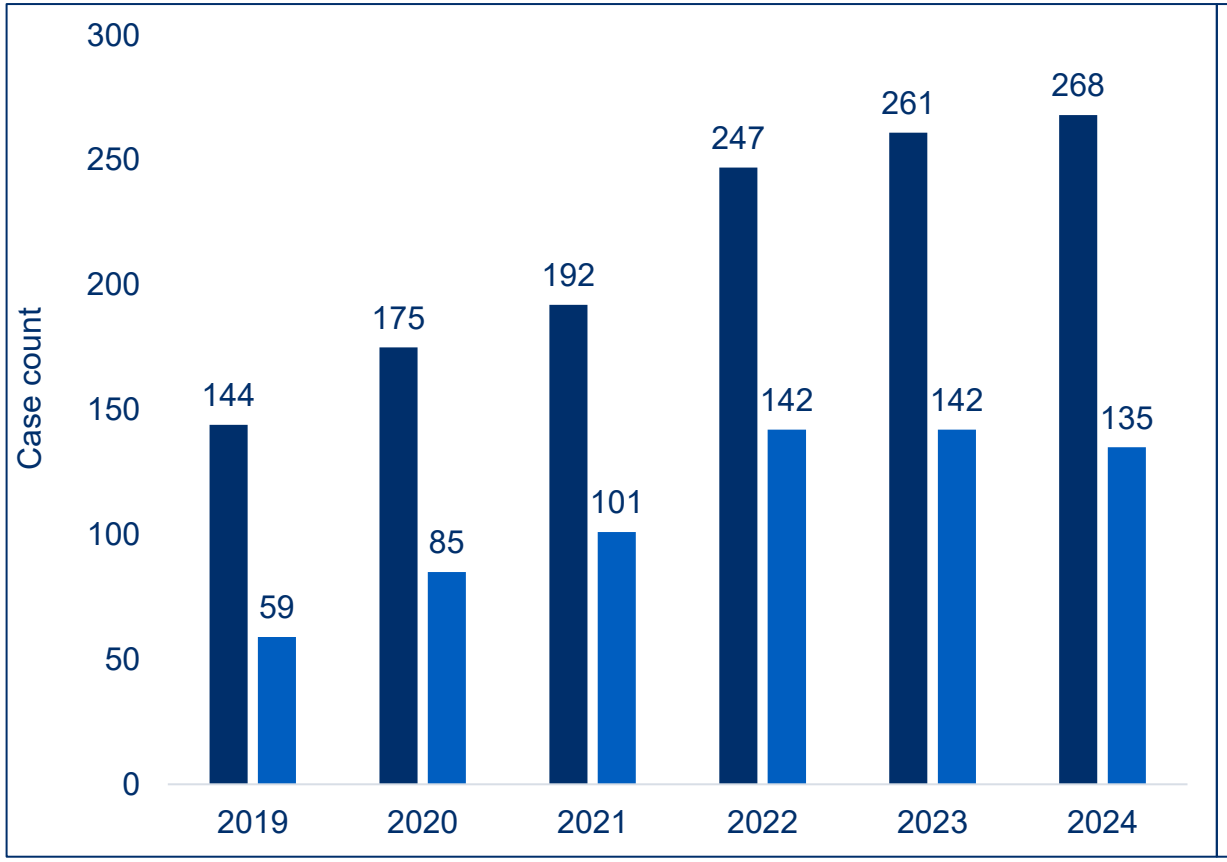
Years from open to close

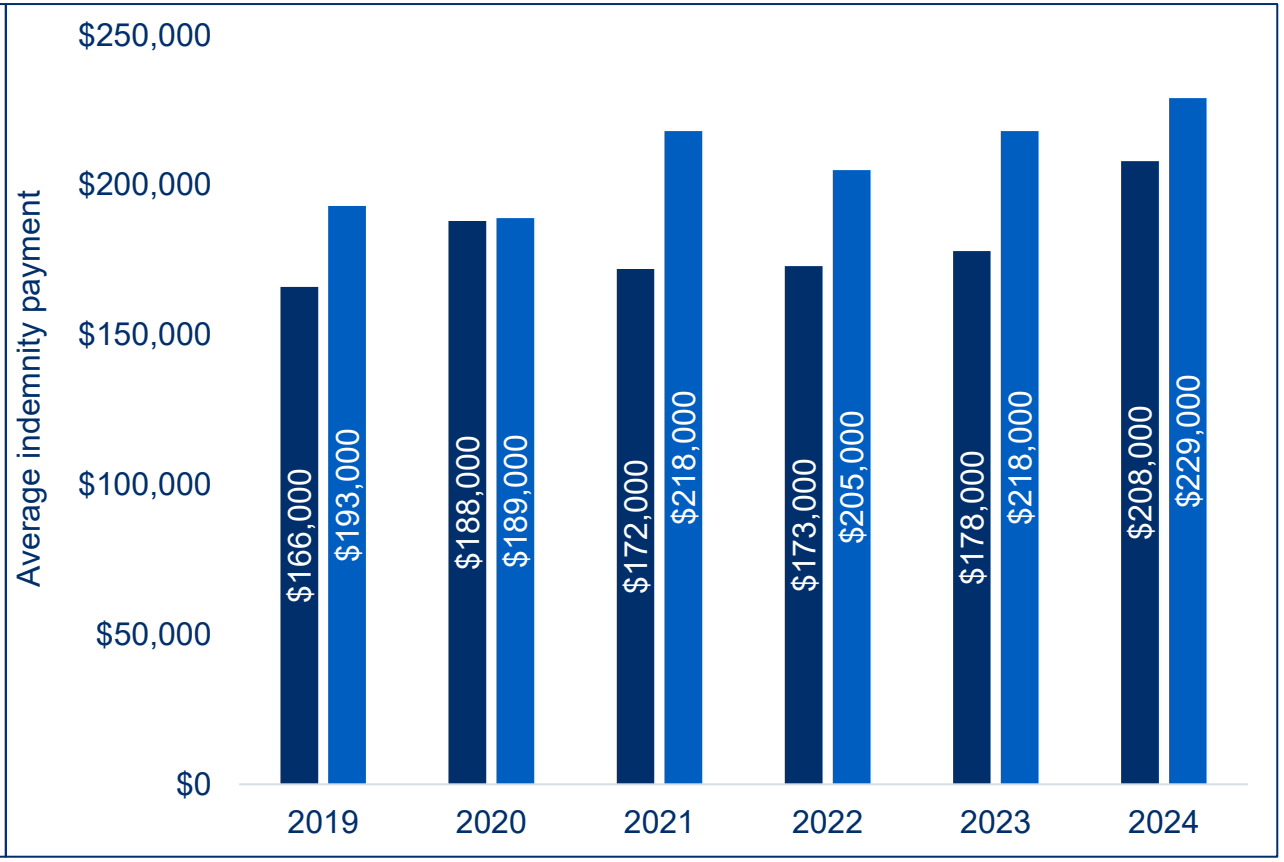
MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *ALAE = allocated loss adjustment expenses (costs of defending cases)

Indemnity Payment Metrics by Facility Type

Within this data set, the number of skilled nursing facility cases is double that of assisted living facilities.

The average indemnity payment for assisted living cases is $211,000 - almost 16% higher than the average of $182,000 for skilled nursing cases.





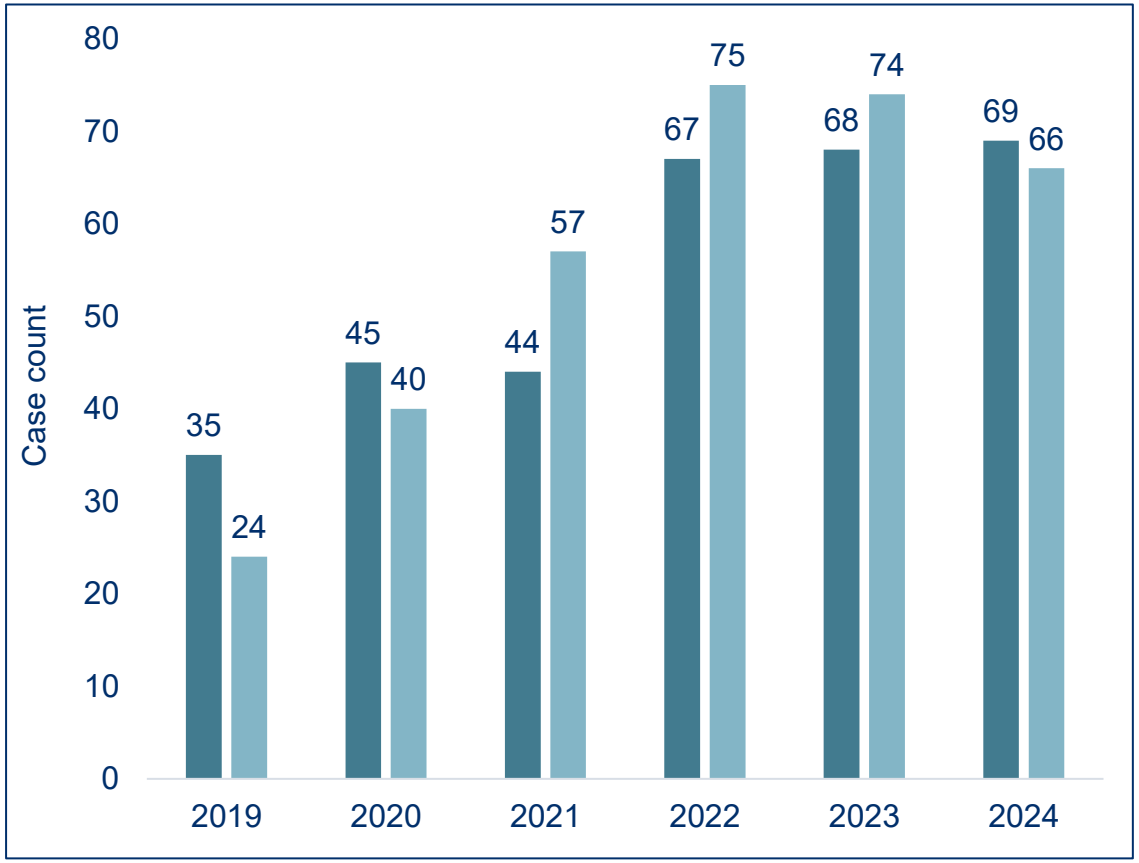
Close year

Skilled nursing | Assisted living

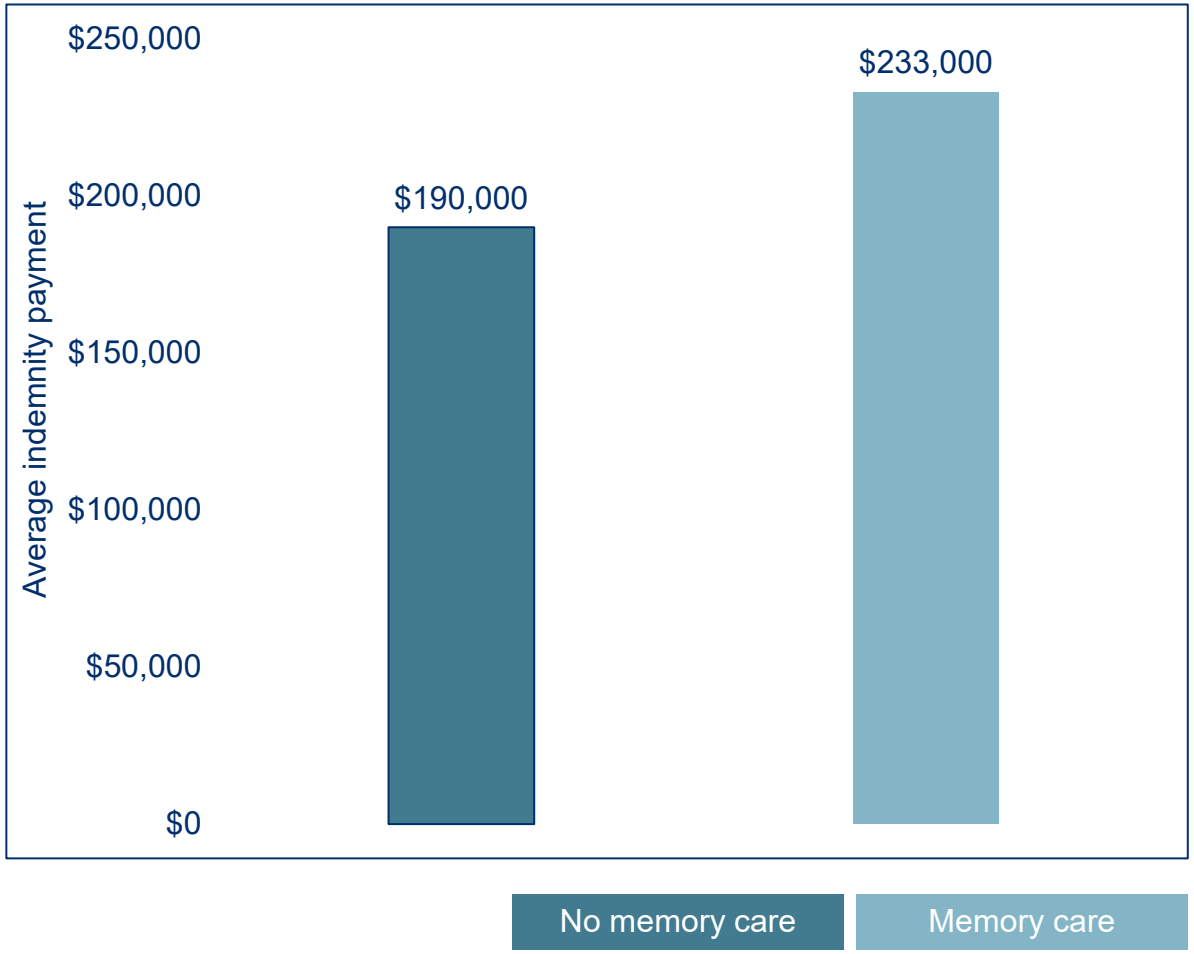
MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025

Assisted Living with Memory Care Metrics

Within this data set, half of the cases that occur in an assisted living facility take place in a memory care unit.



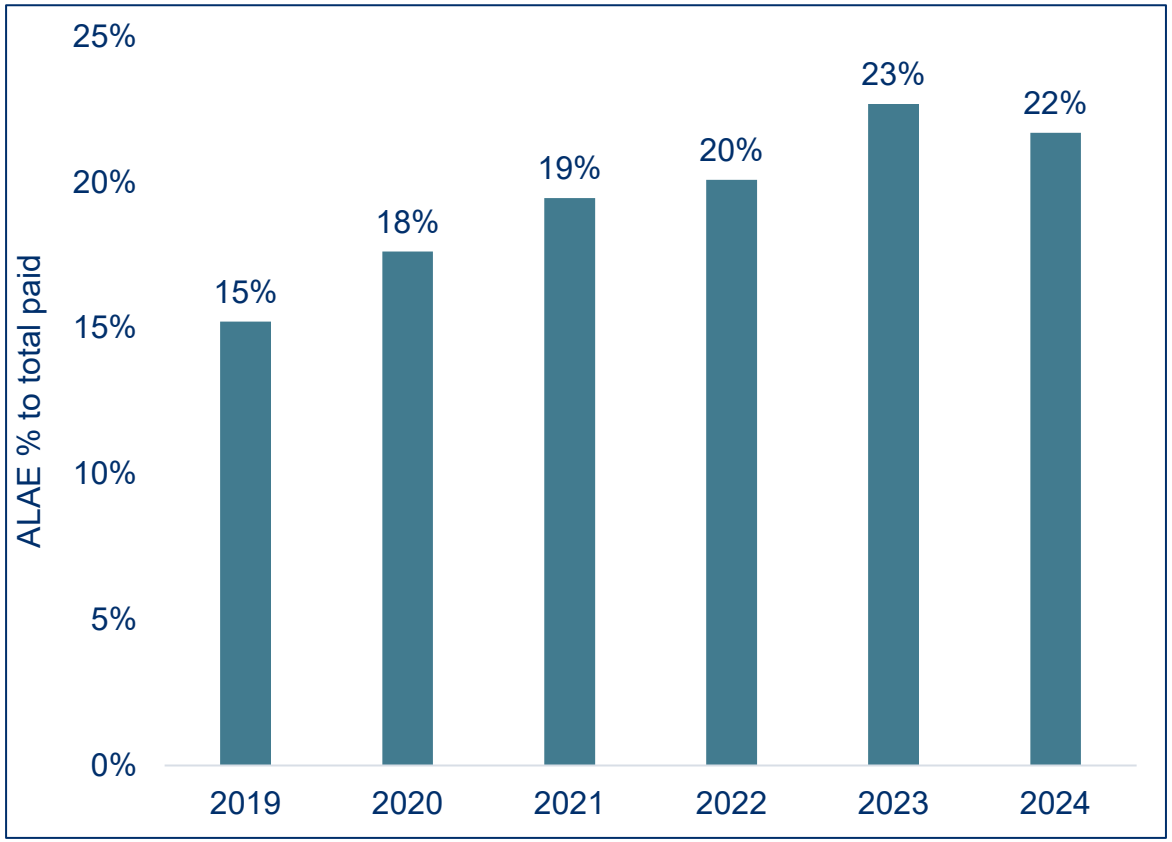
The average indemnity payment for memory care cases is $233,000 - almost 23% higher than the average of $190,000 for assisted living cases with no memory care exposure.



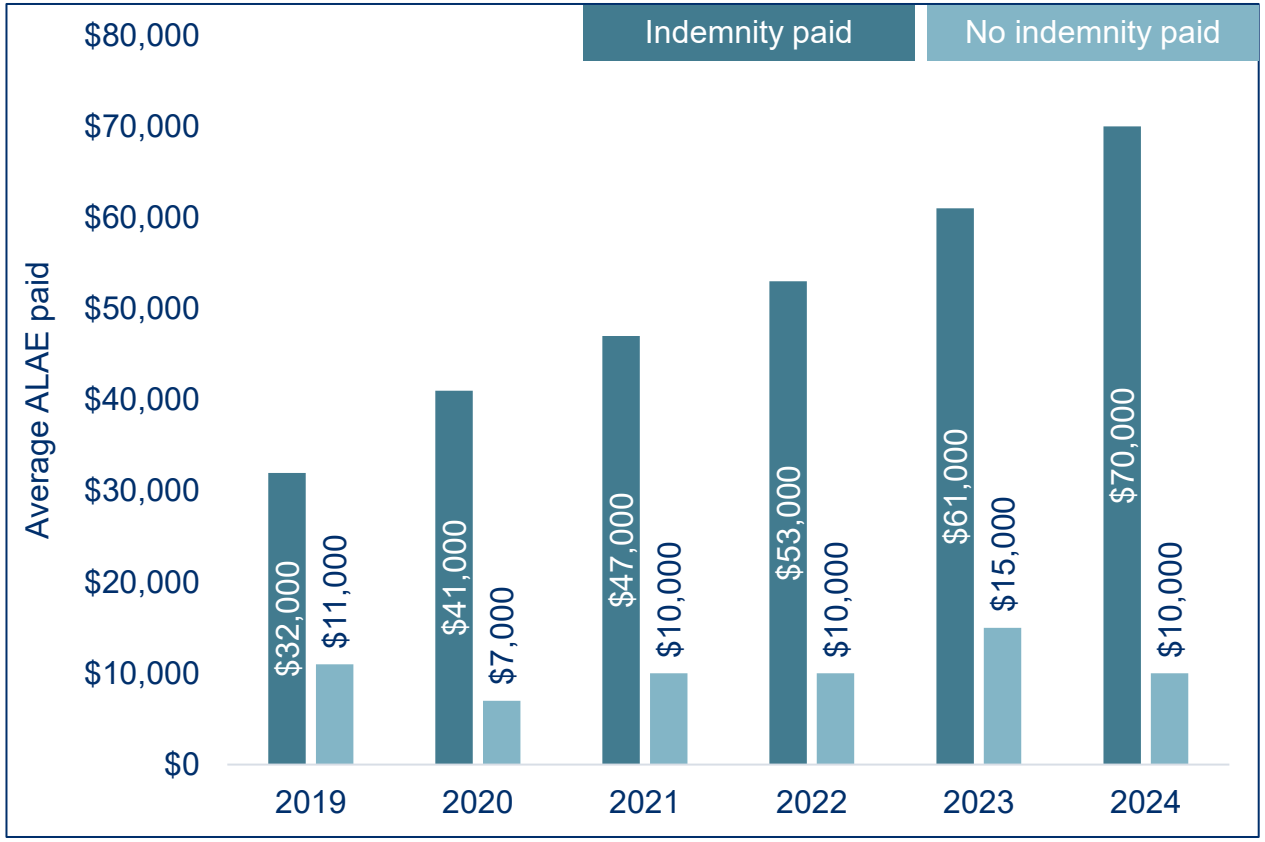
MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; Assisted living facilities (N=740; Memory care N=367; No memory care N=373)

Countrywide ALAE Payment Metrics

For cases closed with indemnity payment over the experience period, the percent spent on ALAE* has been steadily rising.



The average amount of paid ALAE on cases closed with indemnity payment = $53,000, significantly higher than the $11,000 average ALAE on cases with no indemnity paid.

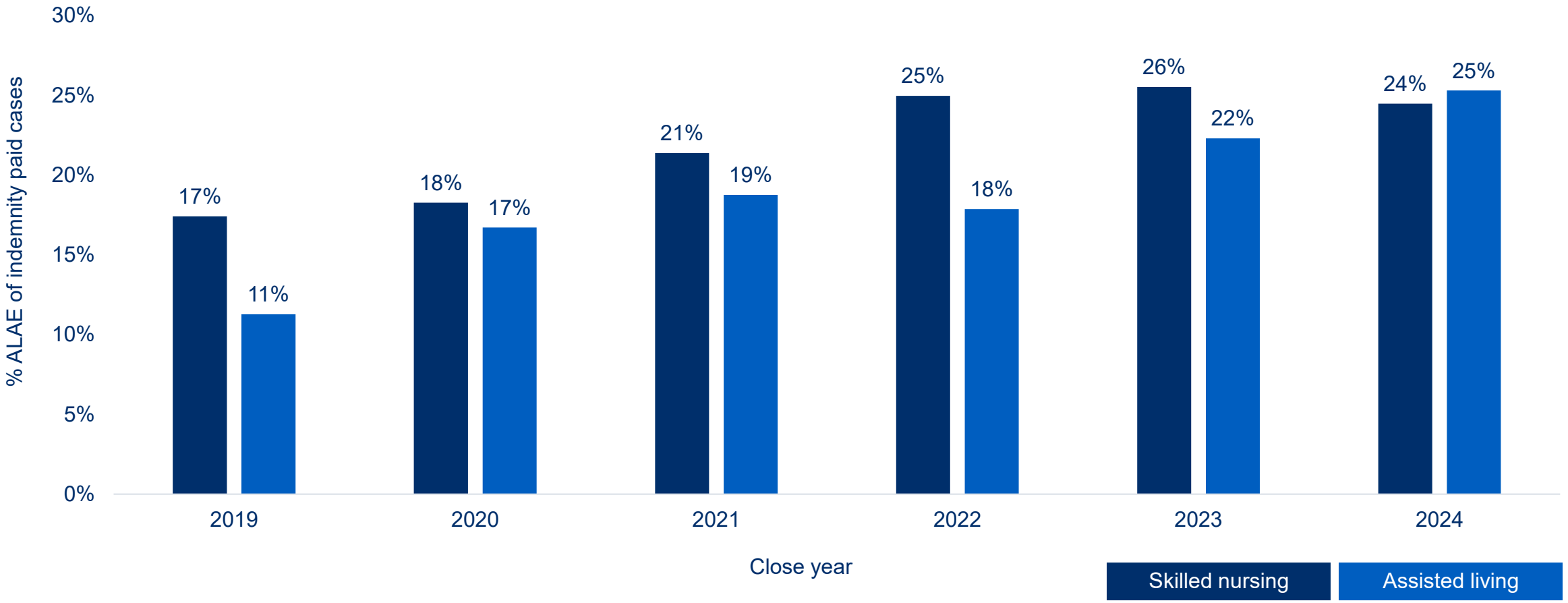


Close year

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *ALAE = allocated loss adjustment expenses (costs of defending cases)

ALAE Payment Metrics by Facility Type

The average percent paid on ALAE* for skilled nursing facilities is 23% - slightly higher than the assisted living facility average of 20%, although the difference has been narrowing in more recent years.



MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *ALAE = allocated loss adjustment expenses (costs of defending cases)

Average Indemnity and ALAE by Profit Status

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *ALAE = allocated loss adjustment expenses (costs of defending cases)

Distribution of Case Volume by State

8 states noted account for:

- 67% of all case volume
- 62% of total dollars paid* on closed cases

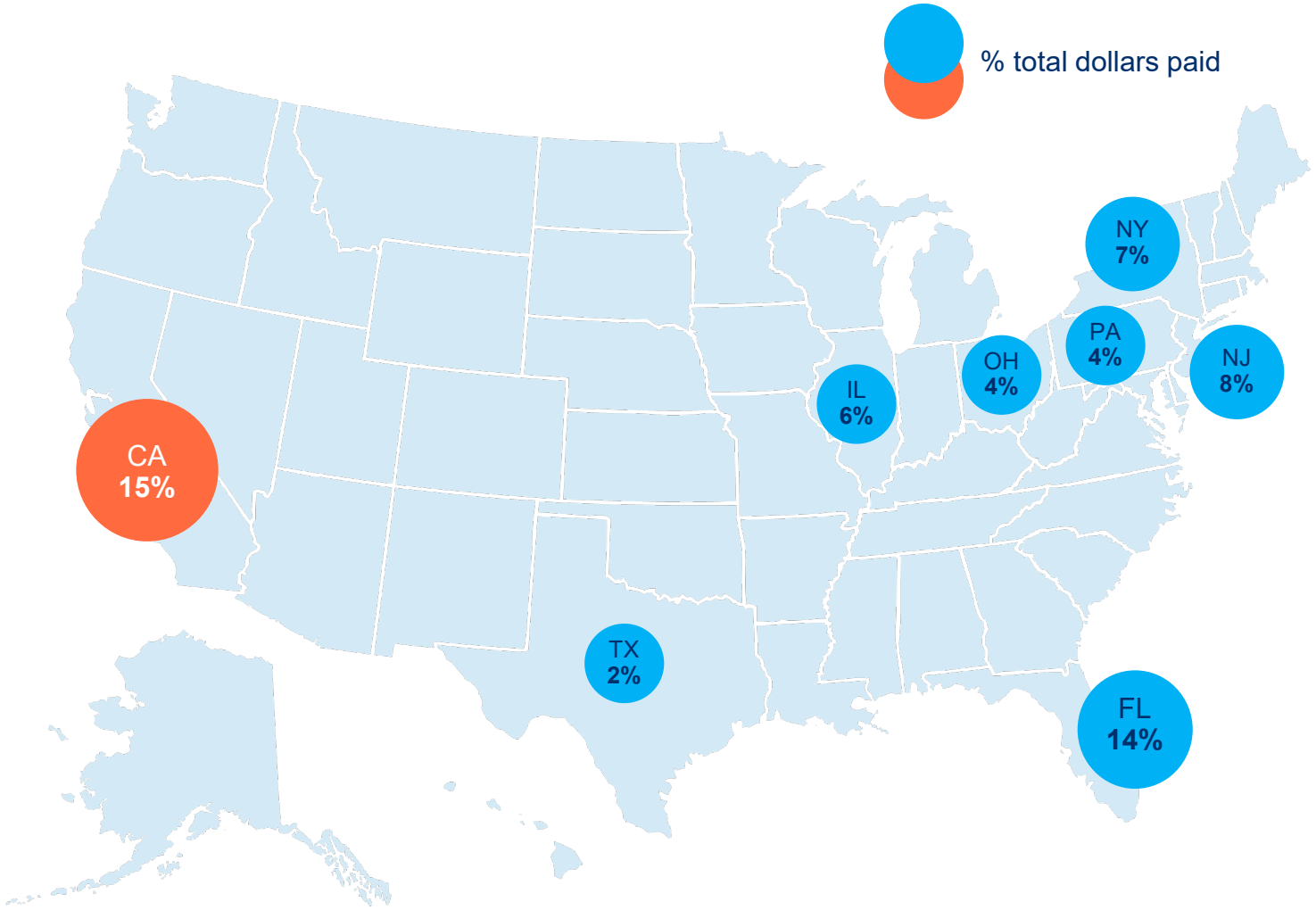
All other states account for </= 4% of case volume each.

Average total dollars paid per closed case across all states (excluding CA) = $228,000.

CA represents 9% of case counts, but 15% of total dollars paid.

Average total dollars paid per closed case for each of the 8 states noted:

CA	$409,000	OH	$196,000
NJ	$255,000	PA	$186,000
NY	$226,000	FL	$182,000
IL	$212,000	TX	$121,000



MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *Total paid = expense + any indemnity paid

Distribution of Large Losses by State

6 states noted account for:

- 58% of all large losses*
- 59% of total dollars paid** on closed cases

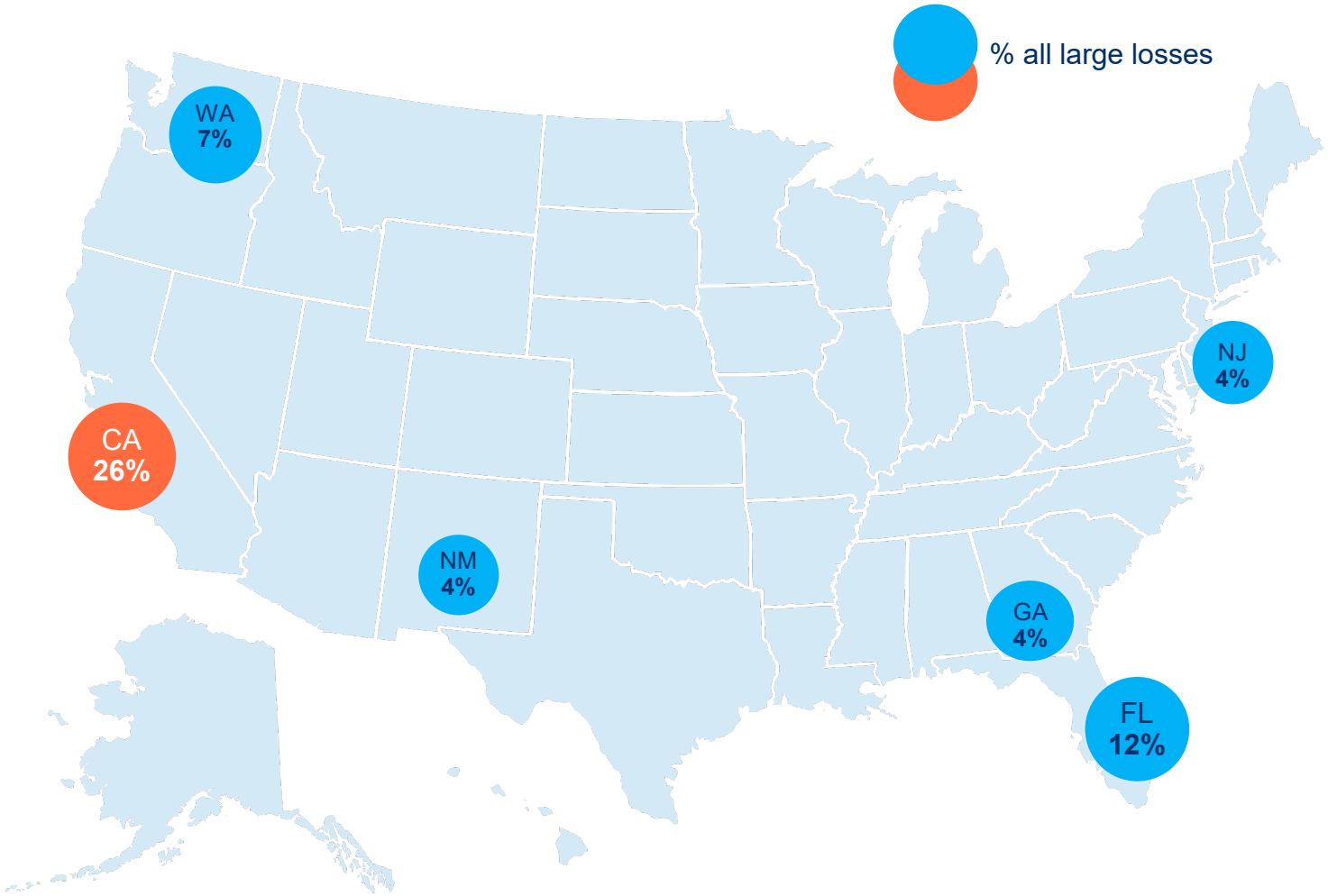
26% of all large losses are from CA.

All other states account for </= 3% of all large losses each.

Average total dollars paid per large loss case across all states (including CA) = $915,000.

Average total dollars paid per large loss case for each of the 6 states noted:

CA	**$1,023,000**	**WA**	**$869,000**
FL	**$920,000**	**NJ**	**$793,000**
GA	**$885,000**	**NM**	**$687,000**

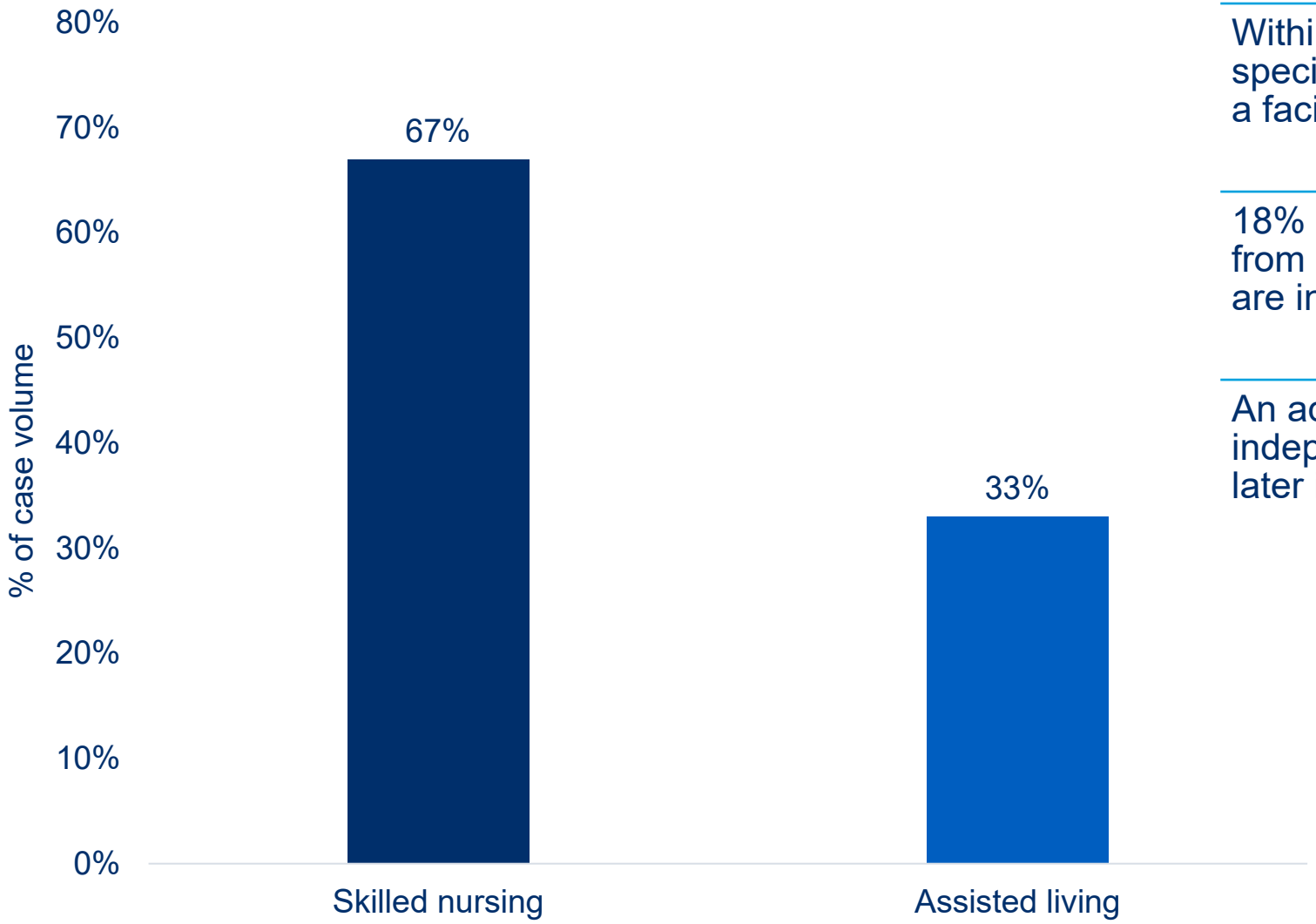


MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); financial valuation as of 12/31/2025; *Large loss = >/=$500K indemnity paid; **Total paid = expense + any indemnity paid

Clinical Risk Analysis

The following section details clinical risk insights across all senior care cases closed with indemnity paid.

Case Volume by Facility Type



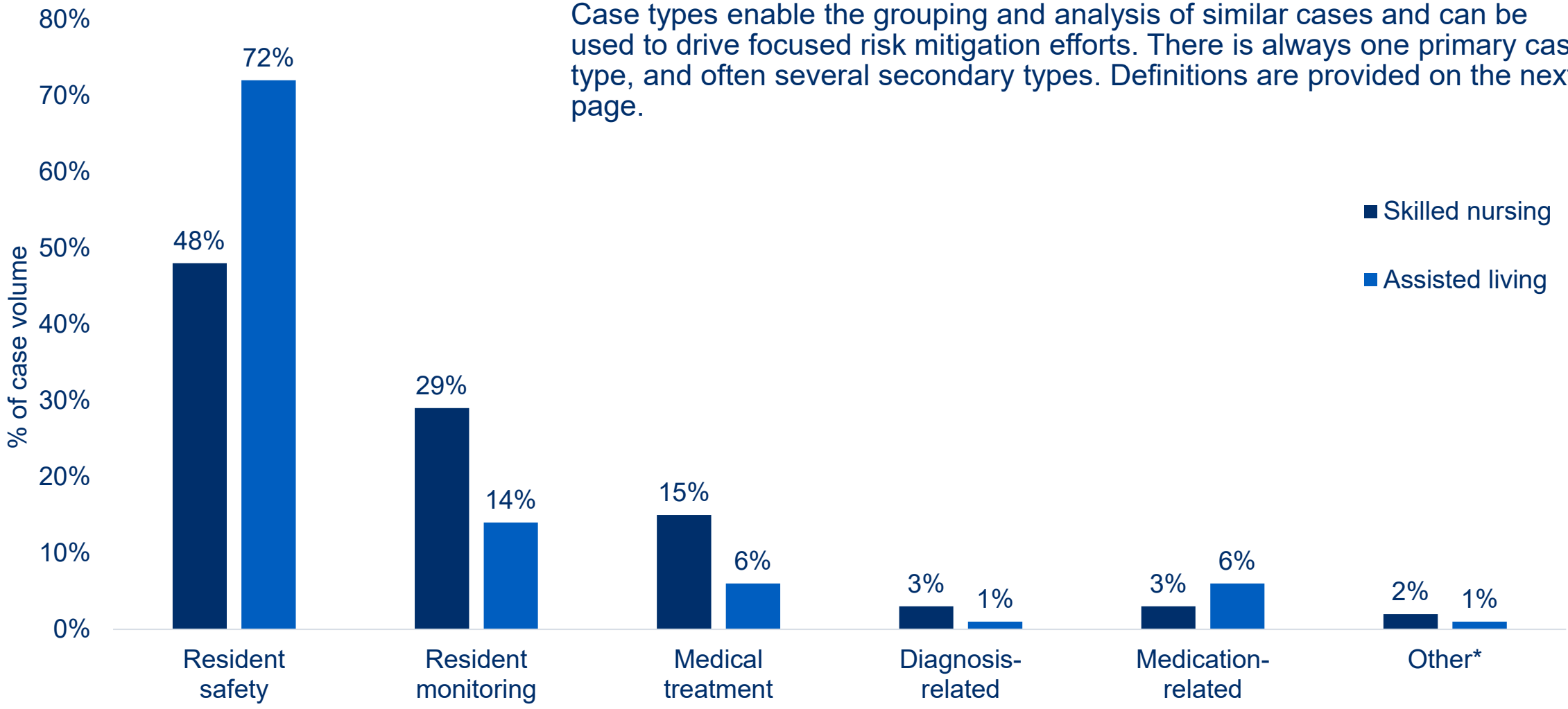
Within the coding taxonomy, memory care is not specified as a facility type, but rather as a unit of a facility.

18% of this case volume is identified as arising from memory care units, the majority of which are in assisted living facilities.

An additional small volume of cases arose in independent living facilities (covered separately later in this report).

Primary Case Types by Facility

Case types enable the grouping and analysis of similar cases and can be used to drive focused risk mitigation efforts. There is always one primary case type, and often several secondary types. Definitions are provided on the next page.



MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); *Other = case types with no significant volume, i.e. confidentiality breaches, provider behavior

Primary Case Types Defined

Resident safety: Includes failure to mitigate the risk of falls, assaults (including sexual abuse), and a variety of other safety-related events, such as injuries during transport.

Resident monitoring: Encompasses inadequate monitoring of residents' physiologic status, including failures to mitigate the risk of pressure ulcers, infections, and progression of underlying conditions. Elopements, while not frequently noted, are also included in this category.

Medical treatment: Reflective of lapses in the general day-to-day care of residents; scenarios often involve infections progressing to sepsis, dehydration, and treatment of ulcers.

Diagnosis-related: Commonly includes delays in recognizing infections, strokes, and fractures.

Medication-related: Covers mismanagement of medication regimens, and ordering, dispensing and administration errors.

Focus on Resident Safety & Monitoring Cases

	Resident falls	Inadequate monitoring of physiological status	Pressure ulcers	Other safety issues	Failure to protect from assaults	Failure to prevent elopement
Skilled nursing	40%	27%	22%	8%	1%	0%
Assisted living	54%	12%	7%	11%	6%	2%

% of case volume

Many of the resident safety cases in both facility types are associated with suboptimal staffing levels, inadequately trained and supervised staff, and nighttime shifts.

The higher proportion of resident safety cases in assisted living facilities is also associated with situations in which a resident might be better suited for care in a skilled nursing facility. Although regulations differ from state to state, assisted living facilities are typically staffed with fewer nurses and certified care givers.

Pressure ulcer-involved cases are captured with an injury code, not as a case type. They are primarily associated with inadequate monitoring and improper management of medical treatment case types.

Other safety issues noted in these cases are varied, including:

Injuries sustained during resident transfers with lift devices

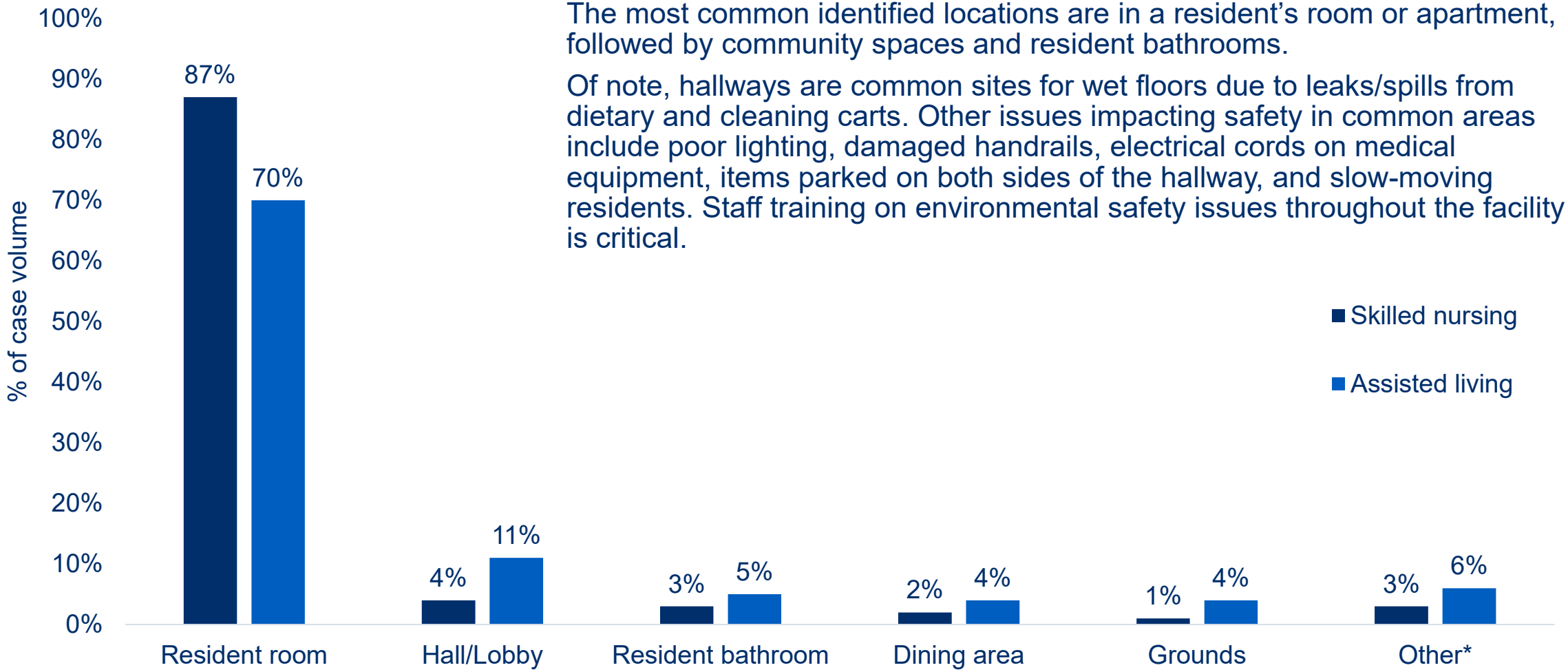
Injuries sustained during vehicle and wheelchair transportation

Hyperthermia or hypothermia suffered when residents are outdoors and unobserved

Choking

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266)

Locations



The most common identified locations are in a resident's room or apartment, followed by community spaces and resident bathrooms.

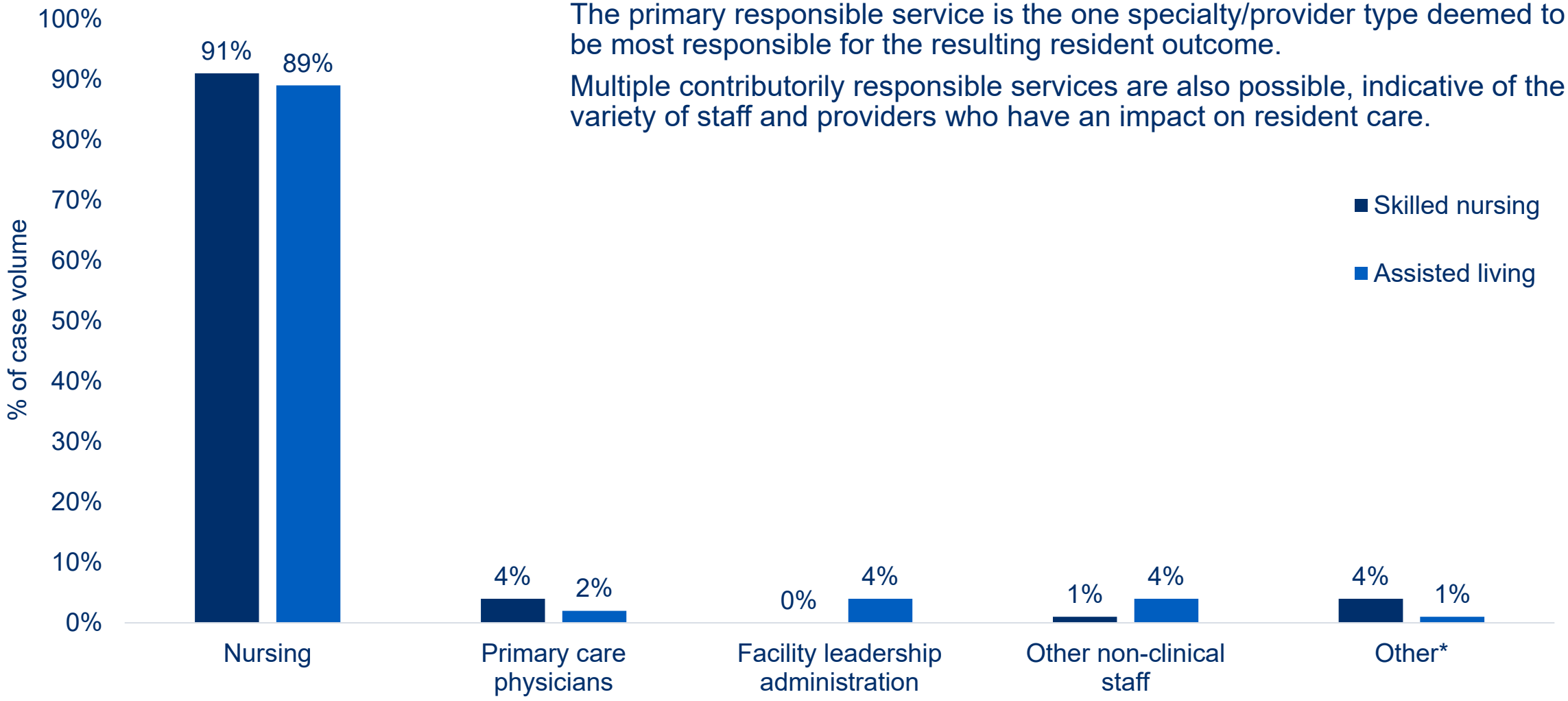
Of note, hallways are common sites for wet floors due to leaks/spills from dietary and cleaning carts. Other issues impacting safety in common areas include poor lighting, damaged handrails, electrical cords on medical equipment, items parked on both sides of the hallway, and slow-moving residents. Staff training on environmental safety issues throughout the facility is critical.

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); *Other = locations with no significant volume, i.e., stairwells, therapy rooms

Most Common Primary Responsible Services

The primary responsible service is the one specialty/provider type deemed to be most responsible for the resulting resident outcome.

Multiple contributorily responsible services are also possible, indicative of the variety of staff and providers who have an impact on resident care.



MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); *Other = services with no significant volume, i.e., physical and respiratory therapy

Clinical Severity

% of case volume

Clinical Severity Categories	Sub-categories	Skilled	Assisted	Definitions
LOW	Emotional Injury Only	2%	5%	Mental distress or suffering that is generally temporary; includes HIPAA violations, discrimination, involuntary stay
	Temporary Insignificant Injury			Lacerations, contusions, minor scars or rash, where no delay in recovery occurs
MEDIUM	Temporary Minor Injury	31%	31%	Infection, fracture set improperly or a fall in the facility, where recovery is complete but delayed
	Temporary Major Injury			Burns, drug side effect; recovery delayed
	Permanent Minor Injury			Loss of fingers or loss or damage to organs; includes non-disabling injuries
HIGH	Significant Permanent Injury	67%	64%	Deafness, loss of limb, loss of eye or loss of one kidney or lung
	Major Permanent Injury			Paraplegia, blindness, loss of two limbs or brain damage
	Grave Injury			Quadriplegia, severe brain damage, life-long care or fatal prognosis
	Death			Death
		50%	46%	% of each facility type's case volume resulting in resident death

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Contributing Factors

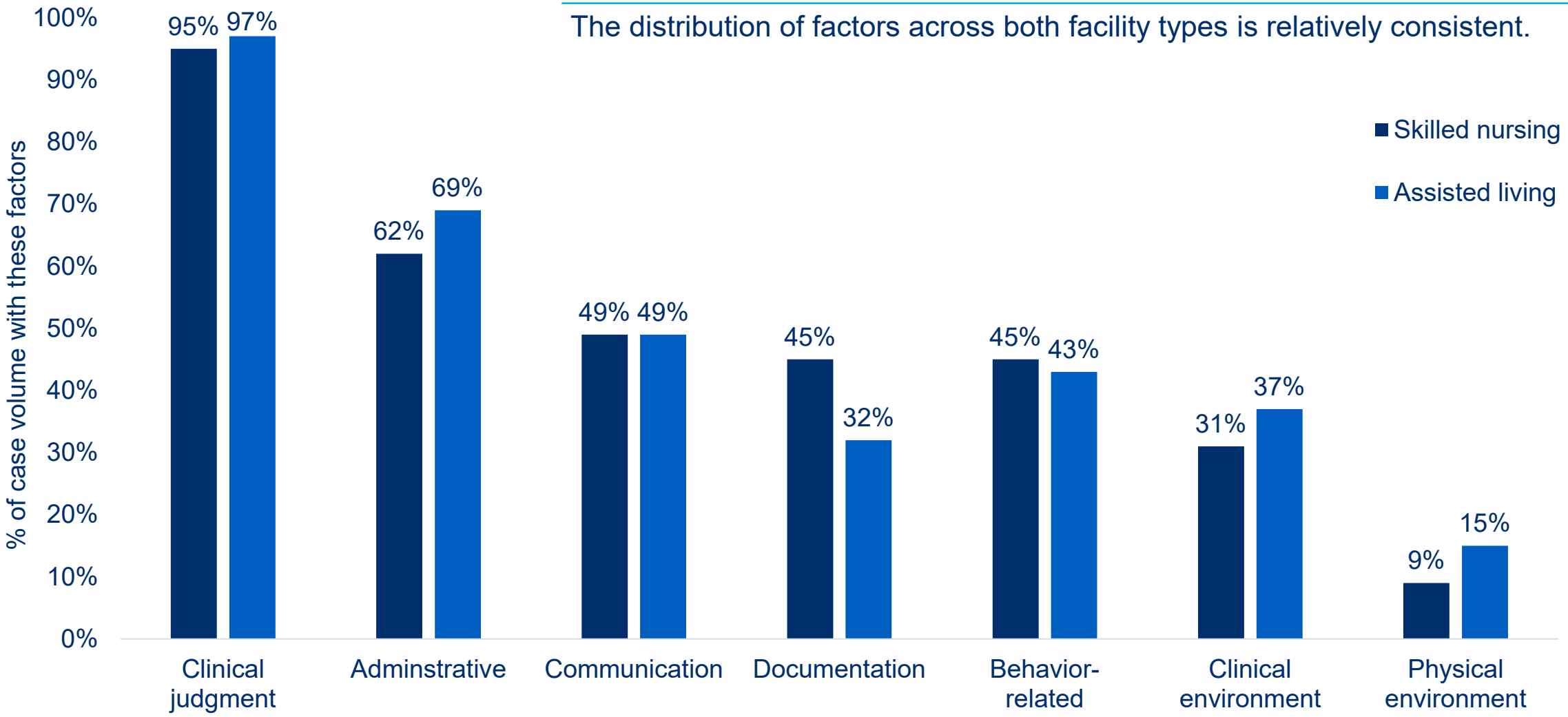
Despite best intentions, processes designed for safe resident outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the resident's outcome, and/or to the initiation of the case, or had a significant impact on case resolution. Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

The following section details failures in the process of care, with a specific focus on those reflected in resident falls, pressure ulcers, elopements and assaults.

Most Common Contributing Factor Categories

The distribution of factors across both facility types is relatively consistent.



MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); More than one factor is identified per case, therefore totals >100%

Most Common Contributing Factor Details

Category	Details	Descriptions
Clinical judgment	Inadequate resident assessments	Inadequate resident assessments create missed opportunities for care, allowing conditions to worsen and/or physiological changes to go unnoticed.
Administrative	Failure to follow policies/protocols	Non-adherence to policies is commonly identified in fall and pressure-ulcer related cases. These cases often involve inadequate assessments and failure to follow existing care plans. Insufficient staff training, managerial oversight, and staffing level issues are commonly associated with failures to follow policies. Of note, administrative factor details including suboptimal credentialing, inadequate staff training, and inadequate staffing levels are noted more often in cases with indemnity payments above $500K.
	Inadequate staffing levels, training/education	
Communication	Suboptimal communication between providers/staff related to changes in resident conditions	As with inadequate assessments, breakdowns in communication across resident care teams create missed opportunities for care. Suboptimal communication with residents/families is noted at almost the same percentage of case volume. Of note, communication factor details including failures to read medical records/plan of care updates, and failures to escalate concerns about resident care/evolving signs/symptoms are noted more often in cases with indemnity payments above $500K.

Most Common Contributing Factor Details, continued

Category	Details	Descriptions
Documentation	Insufficient/lack of documentation reflective of care/services provided	Insufficient documentation of care plans, provision of daily services, and resident assessments can make subsequent malpractice cases more difficult to defend. These issues can also lead to breakdowns in the chain of communication among members of the resident's care team.
Behavior-related	Resident behaviors contributing to events	Behavior-related events are most often associated with falls; also included are resident non-compliance with fall precautions.
Clinical environment	Events occurring during weekend, night, and/or holiday shifts	During these times, staffing levels might be reduced. Commonly associated with this factor are issues with inadequate assessments/monitoring, failures to follow policies, suboptimal communication, and a higher proportion of elopements and assaults.
Physical environment	Failure to ensure a safe living environment	Careful maintenance of the grounds and living environment, including housekeeping services and quick cleanup of spills, is key to providing a safe environment for residents. Monthly environmental rounds, for which staff are trained to identify and mitigate environmental hazards, are also important.

Focus on Resident Falls: Key Points & Contributing Factors

Dementia	Most common comorbidity
	Identified in 76% of assisted living and in 50% of skilled nursing facility cases
Fractures	Identified in 64% of assisted living and in 67% of skilled nursing facility cases
	Death after a fall is noted in 45% of assisted living and in 40% of skilled cases
Most common contributing factors	Failure to follow fall management protocols
	Weekends/nights/holidays
	Verbal and written miscommunication among staff related to resident fall assessments and reports of falls

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); For more information, reference our checklist covering fall assessment and prevention in senior care.

Focus on Resident Falls: Risk Mitigation Strategies

Although not all falls can be prevented, it is critical to have a systematic process of assessment, intervention and monitoring that results in minimizing fall risk. We recommend a multifaceted approach to fall prevention that considers the unique needs and circumstances of all residents.

Conduct daily assessments of residents, and ensure all staff, licensed and unlicensed, are fully trained in how to conduct assessments.

Develop/Revise resident care plans based on daily assessments, and then implement the measures identified in the care plans. Consider a visual alert known to staff to reinforce knowledge of a resident's fall risk.

Ensure ongoing verbal and written communication with the team regarding the resident’s current fall risk status and preventative interventions needed.

Focus on managerial oversight to ensure staff compliance with fall prevention measures. Educate all staff, including environmental services, maintenance, dietary and resident care aides to observe and report fall hazards and near misses.

Conduct a monthly physical environment assessment of each resident care area, during which potential environmental hazards are identified, and mitigated. Include a review of all walking surfaces to ensure they are dry and level.

Investigate all fall events thoroughly. Include a review of any recent changes in resident behavior, medications, illness, and possible environmental fall hazards (e.g. throw rugs, broken or missing handrails) for insights into possible reason(s) for the fall.

Focus on Pressure Ulcers: Key Points & Contributing Factors

Severe outcome	Noted in 72% of all pressure ulcer cases
	67% of these clinically severe patient outcomes reflect resident death due to the cascade of events following poorly managed pressure ulcers.
Most common contributing factors	Inadequate / Inconsistent skin integrity assessments
	Failure to escalate observations of worsening skin conditions to supervising staff and/or physician
	Insufficient documentation of skin assessments
	Insufficient documentation of the care provided
	Insufficient documentation of the actions taken to reduce the risk for pressure ulcer development / worsening

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); For more information, reference our checklist covering pressure injury prevention in senior care.

Focus on Pressure Ulcers: Risk Mitigation Strategies

Preventing pressure injuries requires an interdisciplinary approach to care and coordination among the many individuals involved in developing and implementing residents' care plans.

Additionally, an organizational culture and operational practices that promote teamwork and communication will facilitate an increased focus on pressure injury prevention and optimize residents' care and safety.

Conduct daily skin care assessments of residents, and ensure all staff, licensed and unlicensed, are fully trained in how to conduct assessments. Also inspect mattresses during linen changes, checking for rips/tears/punctures.

Develop/revise resident care plans based on daily assessments, and then implement the measures identified in the care plans (should include requirements for recurring turning/repositioning and use of cushioning devices as needed).

To the extent possible, encourage the resident and family to raise concerns about any changes in skin condition.

Ensure ongoing verbal and written communication with the team regarding the resident's current skin status and preventative interventions needed.

Focus on managerial oversight to ensure staff compliance with pressure injury prevention measures.

Investigate all occurrences thoroughly. Include a review of any recent changes in behavior, diet, new or increased incontinence, medications that might result in sedentary behavior, illness and physical injuries for insights into possible reason(s) for the change in skin condition.

Focus on Resident Elopement & Assaults: Key Points, Contributing Factors & Risk Mitigation Strategies

Elopement-related cases are infrequent, however, half of them result in serious injuries or death. In every case, inadequate monitoring by staff was identified as a critical issue, as were staff failures to follow policies related to safety/security and monitoring.

While **cases involving assaults** were not frequently noted, most were reflective of facility staff failing to take preventative measures to mitigate the known risk of assault. Verbal abuse, boundary infractions and threatened physical acts such as kicking and pushing are behavioral warning signs.

Review prospective residents' histories for wandering events, along with anxiety disorders and preoccupation with past events and relocation.

Review prospective residents' current and past behavioral diagnoses, particularly those that involve aggressive, sexual or violent encounters.

Examine the facility's physical environment to determine whether adequate safety and security measures are in place to prevent residents from exiting the unit and building.

Perform state and FBI background checks on residents for criminal acts, and a search on the National Sex Offender Registry for reported sexual offenses.

Provide staff training on the resident elopement plan and conduct periodic elopement drills on all shifts. Include local law enforcement and emergency first responders.

For current residents with escalating behaviors, facilitate transfer to a higher level of care.

Key points: Mitigating resident elopements and assaults begins with conducting a thorough pre-admission investigation of all potential residents. In addition, constant vigilance of each resident's behaviors, such as wandering and aggression, must be performed to ensure a safe environment for everyone.

MedPro Group senior care cases (skilled & assisted living) closed with indemnity paid 1/1/2017 through 6/30/2025 (N=2266); For more information, reference our checklist covering elopement prevention in senior care and our article covering development of a violence prevention program in senior care facilities.

Case Examples

These case examples are provided to guide understanding of the challenges that both senior care providers and residents face. Learning from these events, we trust that you will take the necessary steps to assess current practices in your facility.

Case Examples

Skilled nursing

Assisted living

Resident fall
Indemnity paid: $825K

A resident with severe cognitive deficits and poor balance was found to have fallen. Her bed was subsequently placed in the low position, with mats on the floor. Two additional falls, both resulting in subdural hematomas, prompted her family to install a camera in her room. She was noted to only be at 'moderate' risk for falls. A final fall resulted in a severe head injury and cervical spine fractures. She was unable to recover and died. Subsequent review of video showed lack of every two-hour checks, and at one point, a gap of nine hours during which she was not assessed for the need for clean, dry clothing.

Resident fall
Indemnity paid: $400K

A new resident opted for an assisted living facility despite being approved for an independent living facility. He did not require assistance with daily activities. Shortly after arriving, he participated in a social activity and then was not seen again until two days later. He was found to have fallen in his room and had been unable to get up from the floor. His mental status was altered, and diagnostic testing revealed a subdural hematoma. His condition did not improve, and he died a few days later. Facility notes reflect no observation/interaction with the resident after he left the social activity.

Case Examples

Skilled nursing

Assisted living

Pressure ulcer
Indemnity paid: $329K

A resident noted to be chronically debilitated and with a known large heel ulcer was admitted for care. The wound did not improve, and file documentation showed delays in implementing wound care orders. A new sacral skin breakdown developed, but staff did not notify the physician for several weeks. Ultimately, additional wounds developed and became infected. The resident was moved home on hospice care and died due to septicemia. Complaints to the Department of Health yielded findings related to substandard facility sanitation, record-keeping and physician notification of declining resident health.

Pressure ulcer
Indemnity paid: $150K

Upon admission to the facility, the resident was noted to have a sacral pressure ulcer, but no wound care orders were entered. In addition, no documentation of staff observation or care for the wound was completed. One week later, an unstageable wound was noted, and documented, but no formal care plan was initiated. By that point, assisted living was not appropriate for the resident, but facility leadership was not notified by staff of the resident's evolving condition. Ultimately, the wound progressed to an infected stage 4 wound and she was admitted to the hospital for further care.

Case Examples

Skilled nursing

Assisted living

Elopement
Indemnity paid: $250K

A resident admitted for hospice care was noted to have a history of wandering and episodes of confusion. He exited the building through the rehabilitation unit door, but was quickly found and brought back inside. Later that same night, during rounds, an aide saw the resident's bathroom light was on and assumed he was in there, but did not check. Several hours later, the resident was noted to be missing, and was found in the courtyard outside of the rehabilitation unit. He died due to hypothermia.

Elopement
Indemnity paid: $101K

A resident was admitted to a second-floor unit in a secure memory unit. He was confused and often awake at night. He was found in the building's electrical room one evening after staff lost sight of him. His wandering behaviors escalated after that, and he began to display agitation and disruptive behaviors. After not being able to locate him for dinner one evening, staff discovered that he had fallen out of a second story window. He sustained several fractures, and was subsequently transferred to a rehabilitation facility. Of note, the resident's care plan reflected no increase in surveillance and assessment after the initial wandering episode.

Case Examples

Skilled nursing

Assisted living

Assault
Indemnity paid: $475K

Two residents whose rooms were across the hall from each other had a weeks' long argument over the volume of their TVs. The argument escalated to the point where one resident pushed the other to the floor, resulting in a cervical spine fracture. After surgery, the injured resident developed pneumonia and died. Subsequent investigation revealed that facility staff were aware of the argument and of escalating aggressive behaviors, but had failed to address the situation.

Assault
Indemnity paid: $1M

A resident with known history of attacking other residents aggressively pushed a female resident to the floor. Facility video recorded staff members reacting inappropriately, carrying her to her room, not notifying the unit manager, and failing to remove the other violent resident. Later, the resident was transported to the hospital, where she was diagnosed with a hip fracture requiring surgical repair. Her condition deteriorated and she never returned to her baseline functionality.

Addendum

The following pages offer additional insights covering independent living facilities, environmental safety, and other issues pertinent to maintaining the safety and well-being of senior care residents.

Focus on Independent Living Facilities

The few independent living cases present in this data set primarily reflect residential safety issues (most often falls and assaults), and less frequently, inadequate monitoring of residents with known medical issues (including the issue of whether emergency pendants/call lights in resident apartments are functioning and/or being monitored).

Other issues noted include failure to provide written agreements for services such as daily safety checks, monitoring of departures from and returns to the facility, and notifying family and/or provider regarding changes in resident conditions.

Some cases involved inadequately trained staff (primarily related to transport assistance), and/or staff failure to ensure that the community environment was free from trip/fall and other hazards.

Inadequate assessment of the appropriateness of independent living environments for some residents was also identified.

Focus on Independent Living Facilities, continued

Specific examples of independent living facility issues revealed during onsite assessments and communication with facility staff are as follows:

Reliance on private duty staff to provide care

Lack of communication and coordination between the facility and nursing agencies contracted to provide resident care in the facility

Failure to respond to emergency alarms (such as resident injury or non-responsiveness) placed in resident apartments; routine assessment of the functionality of these alarms should be performed

Failure to educate residents about safety precautions, including the need to keep external doors locked, to verify the identity of visitors before unlocking external doors, and the existence/location of emergency numbers

Failure to educate residents on actions to take during an emergency, including fire/smoke (and location of fire alarms), gas leaks, weather warnings, active shooters, power outages, leaks, and evacuation or shelter-in-place orders

Failure of timely and appropriate care for unresponsive residents (knowing a resident's DNR status is crucial)

Focus on Environmental Safety Assessments

Assessment of the safety/security of living environments is as critically important to the well-being of residents as is mitigating the risk for falls and pressure ulcers.

Senior care living facilities are complex, high-stakes environments where resident care is often vulnerable to environmental and security risks.

The links below provide valuable guidance designed to assist senior care facility management and staff in assessing safety in six key areas.

Infection Prevention/Control

Fire Prevention/Response

Trip/Fall Hazards

Violence Prevention

Emergency Preparedness

Resident Elopement

Focus on Environmental Safety Assessments, continued

Specific examples of environmental safety issues revealed during onsite assessments and communication with facility staff are as follows:

Failures to conduct routine/regularly scheduled environmental safety assessments

- Assessments should include a check of floors, walls, ceilings, doors, handrails - anything in the resident's environment
- Assessments should include 3-5 staff; ideal representation includes those from infection control, security, facilities, nursing and administration

Failures to ensure all safety devices are in working order

- Includes internal/external cameras, security call boxes, door alarms, personal wandering devices, duress alarms

Failures to ensure staff training on critical facility-specific safety and security-related plans and strategies

- Violence prevention
- Active shooter
- Fire safety
- Environmental disaster (includes hurricanes, tornados, winter storms, wildfires, long-term power outages)

Focus on Other Pertinent Senior Care Safety/Security Issues

Turnover of leadership and employed staff

- Familiarity with residents, and the buildings in which they reside, is key to improving resident safety and resident/family satisfaction.
- Orientation (and ongoing training) of incoming leadership and staff to facility-specific policies and procedures is critically important.

Suboptimal orientation of agency staff

- Orientation of agency staff - not only to the residents for whom they will be caring, but also to the critical processes, plans and strategies of the facility itself - should not be neglected.

Caring for residents with behavioral/psychiatric diagnoses

- Conducting in-person pre-admission assessments is a key first step toward identifying:
  - potential residents with prior aggressive and/or violent behavioral health diagnoses;
  - whether properly qualified staff are available to care for residents with psychiatric disorders; and,
  - whether appropriate behavioral health services are available within the local community.

Engaging residents in activities

- Promoting participation in robust activities designed to maintain physical and cognitive status can elevate resident outlook and sense of purpose.

Focus on Other Pertinent Senior Care Safety/Security Issues, continued

Background checks of all employees, contractors, volunteers, vendors

Failures to identify applicable criminal and/or sex offense history can undermine the safety/security of residents and employees.

Include prospective resident admissions in this process.

Note: A facility/community-employed staff member should always accompany any delivery/service vendors who have not been formally vetted by the organization while they have access within the building.

Resident assessment processes

Documentation of assessments with details pertinent to "what is happening" with each resident, services received, and care plan revisions allows for staff and leadership to communicate, understand, and best meet the evolving needs of residents.

"Walking rounds" during shift-transition reports facilitates communication between caregivers about each resident's current status and needs.

Well-documented assessments can identify residents who would benefit from transfer to a higher level of care (i.e., assisted living to skilled nursing), including those with dementia who are living in non-secured areas of the facility.

Focus on Other Pertinent Senior Care Safety/Security Issues, continued

Other general processes

Identifying opportunities for unsecured resident access to non-resident care areas, such as a walk-in freezer, boiler room, or an external exit door, are critical to preventing elopements.

Consider conducting elopement drills during fire drills; when the environment is chaotic, such as during a fire emergency, staff distraction could result in losing sight of a resident who becomes anxious and wants to flee the area.

Identifying all visitors, especially those staying overnight with a resident, is a key security process. All staff working in the building during this time should be introduced to any overnight visitors, and the visitors should be limited as to where they can traverse within the building.

Conducting frequent courtyard checks and supervising resident smoking areas are critical, and often overlooked, opportunities to enhance resident safety. Security cameras in these areas should be monitored by staff.

Testing and maintenance on all security system devices and equipment should be done routinely (as per manufacturer recommended guidelines and applicable laws).

MedPro Group Data

MedPro is partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro is better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.

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