**In Attendance:** Joanna Martin, Henry Hartsell, Alexandria Hart-Smith, Narresh Bhandari, Becky Moore, Pat Beam, Lois Baer, Nancy Atkinson, Vicki Kirtley, James Joslin, Wendell Short, William Whited, Patricia Shidler, Julie Myers, Mike Cook, Michael Jordan, Patty Scott, Joyce Clark, Lisa Hill, Don Maisch, Esther Houser, Crystal Rushing and Ginger Thompson

Documents included in meeting packets:



* + - 1. Informal greeting
* Attendees began gathering at 9:45 am.

1. Call to order and roll call (Joanna Martin)
   * Joanna called the meeting to order and roll call was done for the Long Term Care Advisory Board members.
2. Review of the ground rules (Ginger Thompson)
   * Ginger went over the ground rules already set by the members and introductions were made around the room.
   * The group suggested and agreed to add the following new ground rules:
     + Desire to improve
     + Open to alternative view points
     + Focus on data driven decision making
3. Review of the meeting notes from September 16, 2015 (Ginger Thompson)
   * A couple of changes were noted:
     + Change Bill under number 4 to William to be consistent throughout the document.
     + Crystal will add the documents to the minutes that were used during the meeting.
   * Hank reviewed the executive summary with the committee and went over the next steps from the last meeting, September 16, 2015.
4. Nurse Aide Ad Hoc intentions and Aim Statement review (Hank Hartsell)
   * The group discussed the new aim statement and came up with the following:
     + “Failure to Report” by (data measure, base, goal) in NF, ALC, Rescare, ADC
   * The group discussed the need to revisit the aim statement to set a target after data is reviewed.
5. Data Update – OSDH Staff (Mike Cook)

* Mike went over the data reports in the meeting packets.
* A critical question was added concerning the requirements for assisted living and residential care.
* James went over the abuse/neglect/misappropriation findings. He pointed out the number went up in the third quarter because of the new law that went into effect.
* Don Maisch stated they will continue to work the back log until it is caught up, which he anticipates will be in calendar year 2016.

1. Continuation of discussion on reducing incidence of failure to report and/or investigate allegations of abuse, neglect, and misappropriations (Ginger Thompson)
   * Hank went over the first swimlane from the nurse aide ad hoc committee and used the swimlane to create a new swimlane of what happens before a notation is made on the screen “failure to report”.
   * The group identified persons/roles who might fail to report allegations of abuse, neglect and misappropriations.
     + Policy body
     + Local law enforcement
     + Medical Director
     + Therapy staff
     + Medical Aide (Direct Care)
     + Housekeeper
     + Maintenance
     + Dietary staff
     + Volunteers
     + Social services
     + Media/news/hotline
     + Contractor
     + Investigator
     + Activities
     + Resident
     + Family
     + Non-staff
     + Director of Nursing
     + Administrator
     + Person who hears it (staff)
     + Nursing staff
     + Staff observe it
     + APs
     + Ombudsman
     + Alleged perpetrator
     + Goes home
     + Hospital or other healthcare providers
2. Discussion of root cause analysis on failure points (Ginger Thompson)
   * Resident or family don’t know that they should report
   * Where to report
   * Lack of knowledge
   * Family not aware of phone numbers to report
   * Complaint numbers not posted or accessible
   * Been reported before…already investigated…no action taken
   * Crime reported to ombudsman and no one else
   * Lack of evidence
   * Staff thinks resident lost property
   * Skip process – straight to private attorney
   * Dementia – don’t believe them
   * Don’t believe it’s true
   * Staff thinks it did not happen
   * Time
   * Investigated internally6 only – did not report externally
   * Staff person tried to solve problem themselves
   * Breakdown due to unknown perpetrator
   * Staff refuse to believe it happened
   * Thinks it is insignificant
   * When administrator is friend of perpetrator
   * Retaliation against staff
   * Fear
   * Retaliation against resident or family
   * Fear of retaliation
   * Nurse Aides make false allegations against each other
   * False allegations
   * Fear of losing jobs, other life circumstances
   * Perpetrator threatens others
   * Does not pull policy out
   * Cannot find policy
   * Policy does not exist or does not address situation
   * Misremembers policy
   * Lack of decision point to intervene
   * Staff not trained on de-escalation
   * Fear of consequences to facility
   * Retribution against facility
   * Lack of ability to deescalate
   * It was consensual
   * Resident defends perpetrator
   * Staff acts in self defense
3. Critical Questions and New Barriers (Ginger Thompson)
   * Facilities failing to report neglect.
     + OIG report estimates abuse under-reported by 40-60% by facilities.

* What data do we need for citations?
* How do we pull abuse/neglect data from other facility types (assisted living, residential care, ICF/ICD)
* What are abuse tags for the other facilities to get data?

1. Next steps and task list (Ginger Thompson)
   * Evaluate clusters and get data baseline in place
   * Prioritize failure points of those most likely to produce results
2. Establishment of additional meeting dates for the Ad Hoc Committee (Joanna Martin)
   * The group discussed the next meeting being on the morning of the next LTCAB meeting on July 13th and will end at noon.
3. Adjourn