MALA CONFERENCE • MISSOURI 2026

HEFFERNAN INSURANCE BROKERS

Because You're Different

The Claim You Prevent Today Is the Claim You Don't Have Tomorrow:

Lessons from Near Misses, Cannabis Policies & Claim Trends



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BEFORE WE BEGIN

A quick note on what this is – and isn't

This presentation is for general educational and informational purposes only. It is not legal advice, and it is not a substitute for it.

Laws, regulations, and claim outcomes vary by state and by situation. Please consult your own attorney about your community's specific circumstances before acting on anything you hear today.

HEFFERNAN INSURANCE BROKERS

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WHAT WE'LL COVER

AGENDA

1. STATE OF THE MARKET
2. LESSONS FROM NEAR MISSES
3. CLAIM & LOSS TRENDS
4. RISK RECOMMENDATIONS
5. CANNABIS POLICIES
6. LEGAL, CYBER & COMPLIANCE



WHY IT MATTERS

$56M

average of the top-50 medical-liability verdicts in 2024 — up from $32M just two years earlier

75%

increase in the average nuclear-verdict size for senior care claims, in two years

48-72%

share of senior living liability claims driven by resident falls — still the number one driver

5-20%

projected 2026 premium increase forecast for senior living professional liability

Source: WTW Marketplace Realities (spring 2026); McKnight's Senior Living; The Baldwin Group



PART 01

STATE OF THE MARKET

Where premiums, underwriting, and renewal expectations stand heading into 2026 — and what I'd start doing about it now.

Here's where I expect your rates to move

Line of Coverage	Rate Change
GL / PL — Favorable Loss Experience & Venue	+10% to +30% (higher with adverse loss or a poor venue)
Property — Non-Challenged Occupancies	-15% to +20%
Property — Challenged Occupancies	+15% to +125%
Workers' Compensation	-5% to flat
Auto	+5% to +25%

If your loss history is clean and your venue is favorable, you have leverage at renewal. If not, start the conversation early.

Source: Renewal market analysis

PART 01 — STATE OF THE MARKET

Commercial lines are finally cooling off

-2%

Commercial lines rates, Q2 2026 — the second straight quarterly decline

-6.3%

Property market softening — it flipped from the hardest-hit line to one of the softest

The Council of Insurance Agents & Brokers says average commercial premiums fell in Q2 2026 — but not everywhere. Commercial auto, general liability, and umbrella all posted increases, and umbrella rose the most, driven by nuclear verdicts. Respondents point to stronger competition and expanded capacity as the reason rates are easing.

My read: don't get comfortable. The softening is real, but it's uneven — and umbrella is moving the opposite direction.

Source: The Council of Insurance Agents & Brokers (CIAB)

PART 01 — STATE OF THE MARKET

Home and auto costs aren't giving anyone a break

Average annual home insurance premiums hit $2,966 in 2026, and full-coverage auto is climbing right along with it. Commercial rates are cooling — personal lines are not.

YOU MAY HAVE FEWER OPTIONS

Carriers have pulled back from difficult markets — 7 of the 12 largest home insurers have paused or limited new California applications.

RENEWALS WILL TAKE LONGER

Underwriting is more thorough now. A clean, complete application is what gets you a fair look.



Source: The Zebra; LendingTree; Insurify; Bankrate; CIAB

This is what your underwriter is actually reviewing for PL/GL

When they underwrite your risk, licensed beds matter less than these nine things:

- Census
- Surveys
- Staffing Ratio
- Loss History
- Geography
- Age of Residents
- Risk Mitigation Efforts
- Staff Training
- Policies & Procedures

Source: Pendulum Risk Management Services



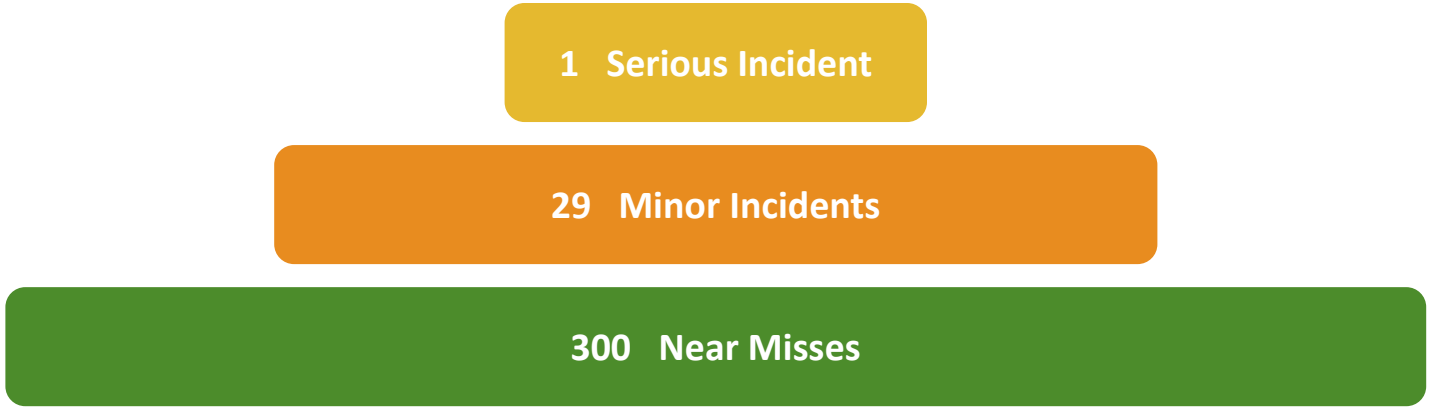
PART 02

LESSONS FROM NEAR MISSES

The claim you never file starts with the incident you almost had. Here's how to actually use that.

What's below the surface

Safety research consistently finds a wide base of near misses beneath every serious incident — the classic 1 : 29 : 300 ratio. Every unreported near miss is a missed chance to fix the pattern before it becomes a claim.



TAKEAWAY

A facility that tracks near misses is managing risk. A facility that only tracks claims is just keeping score.

Ratio illustrates the well-established safety-pyramid principle applied to long-term care.

PART 02 — LESSONS FROM NEAR MISSES

10 Major Risk Areas for Assisted Living

1 Falls

Fall assessments, care plans, transfers, gait belts, footwear, medications, environmental hazards, post-fall procedures

2 Pressure injuries / skin integrity

Turning/repositioning, nutrition/hydration, skin assessments, mobility and documentation

3 Improper or inadequate care

Failure to follow the resident's care plan, inadequate ADL assistance, improper transfers, missed care

4 Failure to monitor

Changes in condition, vital signs, behavior, cognition, pain, hydration and other warning signs

5 Abuse, neglect & exploitation

Staff-to-resident abuse, resident-to-resident incidents, financial exploitation, reporting and investigation

6 Medication errors

Wrong medication/dose/time, missed medications, documentation, medication aide competency and training

7 Elopement / wandering

Dementia residents, door alarms, monitoring, assessment, response procedures and documentation

8 Failure to recognize need for higher level of care

"Acuity creep," declining residents, delayed transfer to skilled nursing/hospital care

9 Failure to follow physician orders / delayed medical treatment

Communication with physicians/families, recognizing changes in condition, timely escalation

10 Staffing, training & competency

Adequate staffing, orientation, ongoing training, supervision, turnover, abuse prevention and competency verification

Based on CNA claims data, supplemented by CMS, CDC, AHRQ and AHCA/NCAL guidance

What Counts as a Near Miss?

If it could have caused harm and didn't — by luck, not by design — it belongs in this list.

Falls & Near-Falls

A resident catches themselves, or staff intervenes just in time

Medication Near-Errors

Wrong dose or timing caught before administration

Elopement Attempts

A resident reaches an exit before being redirected

Resident-to-Resident Conflict

Escalating behavior interrupted before contact occurs

Environmental Hazards

Spills, equipment failures, or blocked egress found first



Source: MASWM / Senior Living Risk Series

Make Reporting a “Good Catch,” Not a Write-Up

Programs succeed when the form is short and the tone is positive — staff are being praised for catching something, not blamed for it.

GOOD CATCH FORM

Date:

Time:

Incident

Name of Reporter: (optional)

Description of Good Catch:

Four fields, one story

Date, time, incident, and what was caught — anyone can complete it in under a minute

Confidential by design

Routed through the QA/peer-review process, separate from the resident record

“Good Catch,” not incident

Framing it as a save, not a mistake, is what keeps the reports coming

Feeds the bigger picture

Every form becomes a data point in your incident tracking and trending reports

Form structure adapted from Pendulum's Near Miss / Good Catch Reporting Form.

When something does happen: the flow

Near-miss prevention and incident response are the same discipline — one just starts a step earlier.

1. **Immediate Actions**
   Assess, treat, notify the physician, call EMS if needed.
2. **Other Notifications**
   Administrator, DON, and resident representative informed.
3. **Follow-up Interventions**
   Remove the hazard; monitor the resident every shift for 72 hours.
4. **Documentation**
   Assessment, facts, orders, interventions & notifications, all recorded.
5. **Care Plan Updates**
   Problem, interventions, and reoccurrence prevention added to the plan.
6. **Incident Investigation**
   Root-cause review within 24 hours — environment, policy, witnesses, equipment.
7. **Risk / Quality Management**
   Findings roll into trending reports reviewed by the QA / Risk Committee.

Adapted from Pendulum's Post-incident Process Flow resource document.



PART 03

CLAIM & LOSS TRENDS

The data tells you where to spend your next risk-management dollar. Here's what it's saying right now.

$287,597

average assisted living claim cost, 2024 dataset

$251,296

average skilled nursing claim cost, same dataset

Source: CNA Aging Services Claims Report: 12th Edition, 2024

Causes of loss – where the dollars actually go

Cause of Loss	Claims Closed w/ Payment	% of Claims	2023 Severity
Fall: Resident	1,190	75.03%	$189,129
Abuse	89	5.61%	$269,885
Skin / Wound Injury	72	4.54%	$219,844
Medication Variance	62	3.91%	$112,381
Fall: Non-Resident	51	3.22%	$30,243
Fracture: Non-Fall	28	1.77%	$166,562
No-Injuries	21	1.32%	$64,959
Choking	18	1.13%	$421,875
Infection	15	.95%	$169,860
Elopement / Missing Resident	14	.88%	$357,560
Transfer Injury	13	.82%	$210,418
Medical Records Request	13	.82%	$178,802

Falls are three out of every four claims closed with payment. Everything else is a rounding error by comparison.

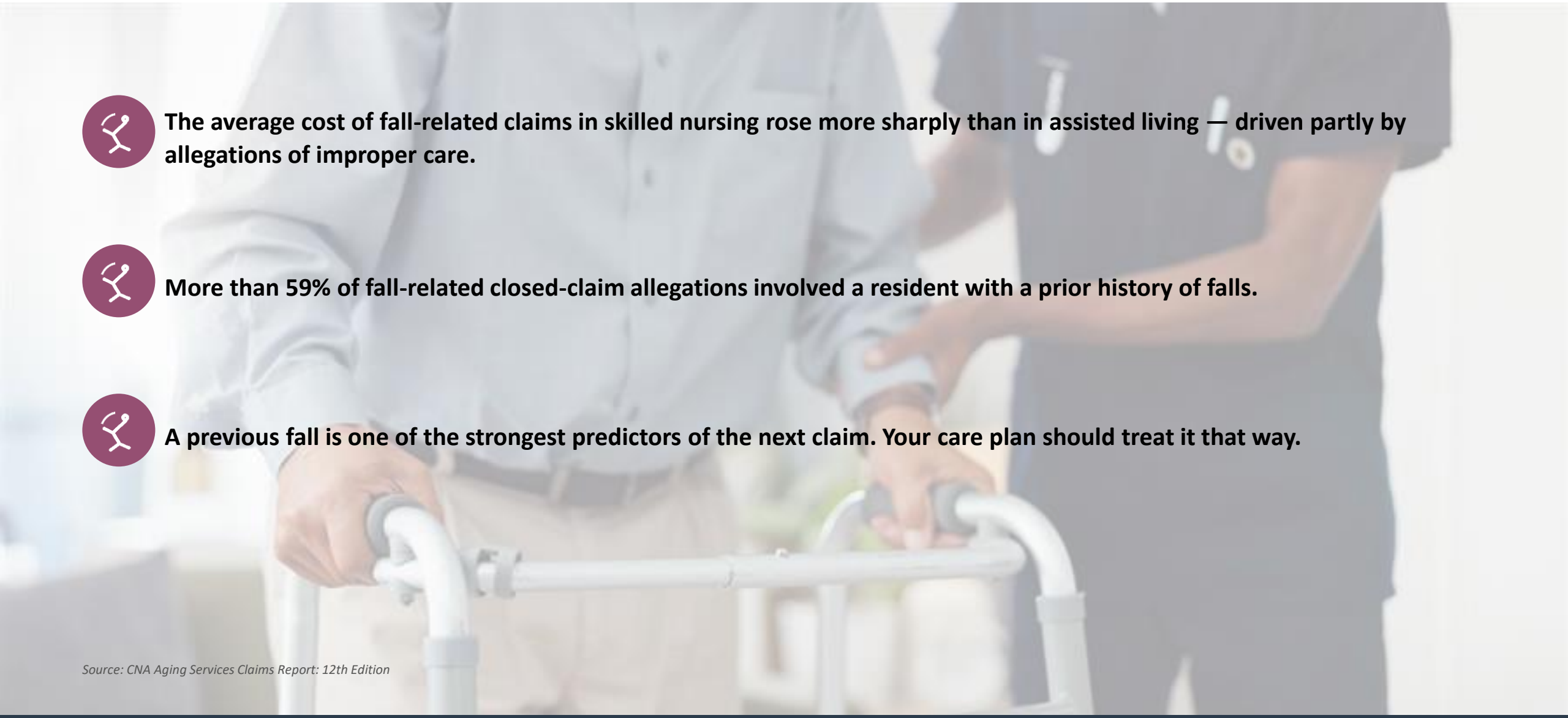
Source: 2023 Senior Living Cause of Loss Claim Statistics

Costs are climbing across every care setting

- Average cost of a claim is up broadly since the 2018 report — now $259,443, up from $250,048.
- Assisted living's average claim cost continues to exceed skilled nursing in the 2021–2023 dataset.
- Independent living claims are a small share of volume, but a large-loss risk when they occur.

Source: CNA Aging Services Claims Report: 12th Edition

Fall-related claims are getting more expensive, faster



- **The average cost of fall-related claims in skilled nursing rose more sharply than in assisted living — driven partly by allegations of improper care.**
- **More than 59% of fall-related closed-claim allegations involved a resident with a prior history of falls.**
- **A previous fall is one of the strongest predictors of the next claim. Your care plan should treat it that way.**

Source: CNA Aging Services Claims Report: 12th Edition

The 10 rules I'd hold every community to on falls (1 of 2)

1

Every resident gets a fall-risk assessment — and it is updated.

Not just on admission. ***Reassess after a fall, significant change in condition, medication change, hospitalization, or change in mobility.***

2

A high-risk resident must have an individualized fall-prevention plan.

"Fall precautions" isn't enough. The plan should identify the ***resident's specific risks and exactly what staff are expected to do.***

3

Staff must actually know the resident's fall plan.

This is where training becomes critical. A beautifully written care plan does nothing if the ***CNA/caregiver doesn't know the resident needs assistance to the bathroom or uses a particular device***.

4

Every fall gets a meaningful investigation—not just an incident report.

Ask: What happened? Why did it happen? What was the resident doing? Who was present? What medications were involved? Was the care plan followed?

5

Every fall triggers a post-fall huddle and care-plan review.

WTW specifically identifies ***post-fall huddles*** as part of a fall-prevention pathway.

The 10 rules I'd hold every community to on falls (2 of 2)

6

Look for patterns, not isolated incidents.

A community should be tracking falls by:
resident · location · time of day · shift · activity · staff involved · injury severity · day of week · medication/medical factors.

If three residents are falling in the same bathroom at 2–4 a.m., that's a system problem—not three unrelated accidents.

7

Medication review has to be part of fall prevention.

Sedatives, hypotensives, psychotropics and other medications can contribute to fall risk. Medication management should be incorporated into the fall investigation and reassessment.

8

Environment and equipment must be routinely audited.

Bathrooms, flooring, lighting, beds, handrails, walkers, wheelchairs, footwear, call systems and other assistive devices should be inspected—not just after an accident.

9

Staffing has to match resident acuity.

If a resident requires two-person assistance and there is only one caregiver available, the community has created a predictable fall exposure. WTW identifies staffing shortages among the important clinical risks in senior living.

10

Management has to measure the results and hold someone accountable.

I'd require a monthly fall dashboard showing: ***total falls · falls per 1,000 resident days · repeat fallers · falls with injury · falls requiring hospitalization · falls by location/time/shift · root causes · corrective actions · whether corrective actions worked.***

PART 03 — CLAIM & LOSS TRENDS

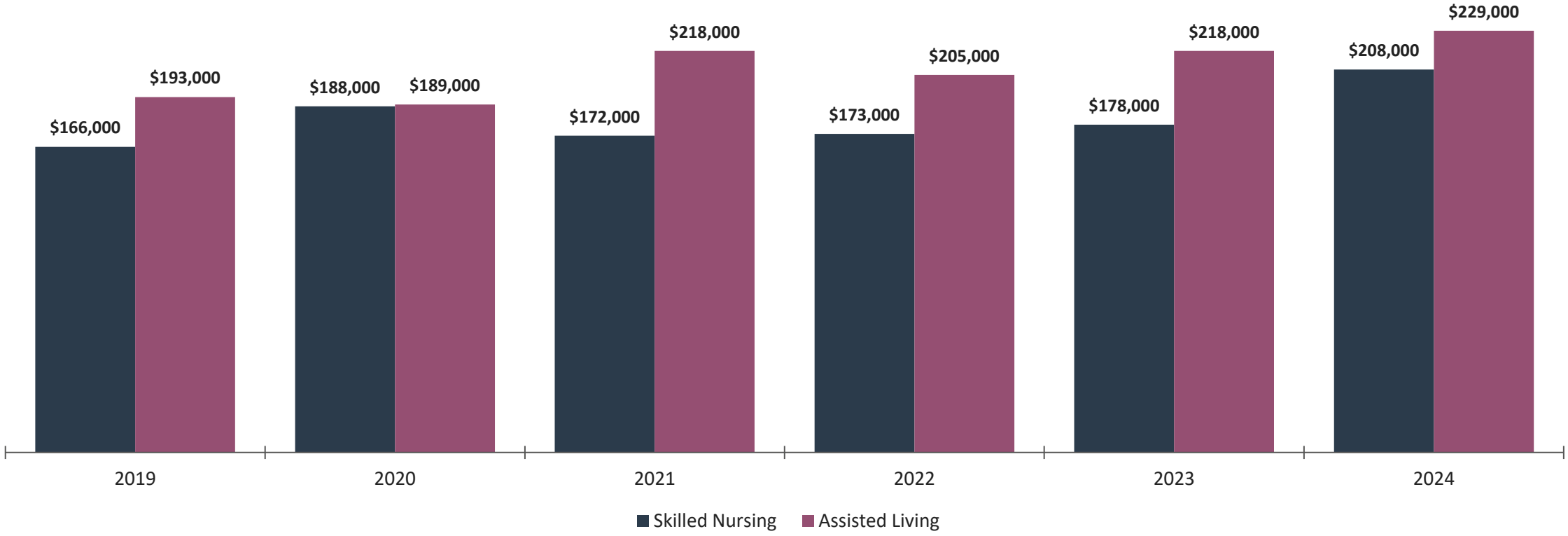
Shock verdicts I want every administrator/owner to see

VERDICT	RISK ISSUE	WHAT HAPPENED
$23.6M	Medication / staffing / oversight	2026 Georgia nursing-home verdict involving PruittHealth-Fitzgerald. The jury found PruittHealth and related entities liable; the case involved allegations concerning unauthorized medications, understaffing and oversight.
$17.6M	Understaffing / failure to provide care	2026 Ohio nursing-home wrongful-death verdict involving a resident with multiple sclerosis. The estate alleged chronic understaffing and inadequate care leading to UTI/sepsis and death.
$12.5M	Pressure injuries	Verdict involving an assisted-living facility; the plaintiff's firm reports it as the largest Florida assisted-living facility verdict.
$12.2M	Pressure injuries / negligent nursing care	Cook County jury verdict involving bedsores that ultimately contributed to the resident's death.
$10.5M	Assisted-living negligence	Jury verdict against a Florida assisted-living facility.
$10M	Fall / failure to respond	New York nursing-home case involving an unwitnessed fall. The resident was not appropriately assessed or transferred for approximately two months and subsequently died.
$6.25M	Staff supervision / care-plan failure	Resident choked during a meal. The plaintiff alleged the facility failed to provide the supervision required by the resident's care plan.
$5.5M	Pressure injury / documentation	Nursing-home resident developed an untreated sacral pressure injury, sepsis and death. The plaintiff alleged medical-record metadata showed care had been documented but not actually provided.
$4.25M	Fall	Reported jury settlement/verdict involving a nursing-home resident's fall and death.
$4M	Wandering / elopement	Reported nursing-home verdict involving a resident wandering/elopement case.

Missouri shock verdicts

AMOUNT	TYPE	RISK ISSUE	WHY IT'S IMPORTANT
$3.45M	Jury verdict	Fall / inadequate assistance / staffing / training	89-year-old resident at John Knox Village Care Center fell while using the bathroom, suffered a cervical fracture and died. The estate alleged inadequate 24-hour oversight, inadequate training and failure to assist him. The verdict included $2M punitive damages.
$2.48M	Judgment	Fall / evacuation / staff error	69-year-old resident in a Gladstone residential care facility suffered permanent brain injury when an aide missed a step while evacuating her in a wheelchair during a fire drill. A Clay County judge awarded $2,477,701.99.
$1.5M	Jury verdict	Fatal fall	Jackson County jury awarded $1.5M in a wrongful-death case involving a woman who died after breaking her hip at a nursing home.
$1M–$1.5M	Settlement	Fatal fall	A Missouri nursing-home case involving an 87-year-old resident who fell, fractured her knee and subsequently died reportedly settled for $1M; another Missouri source reports a $1.5M fatal-fall result.
$1.385M	Settlement	Malnutrition / dehydration / pressure injuries / sepsis	84-year-old resident suffered extreme weight loss, dehydration, malnutrition and decubitus ulcers before dying from blood infection/gangrene.
$1M	Settlement	Elopement / wandering / training	80-year-old dementia resident left a Missouri residential care facility, was struck by a vehicle and died. Allegations included failure to assess/monitor wandering risk, failure to activate door alarms and inadequate manager training.

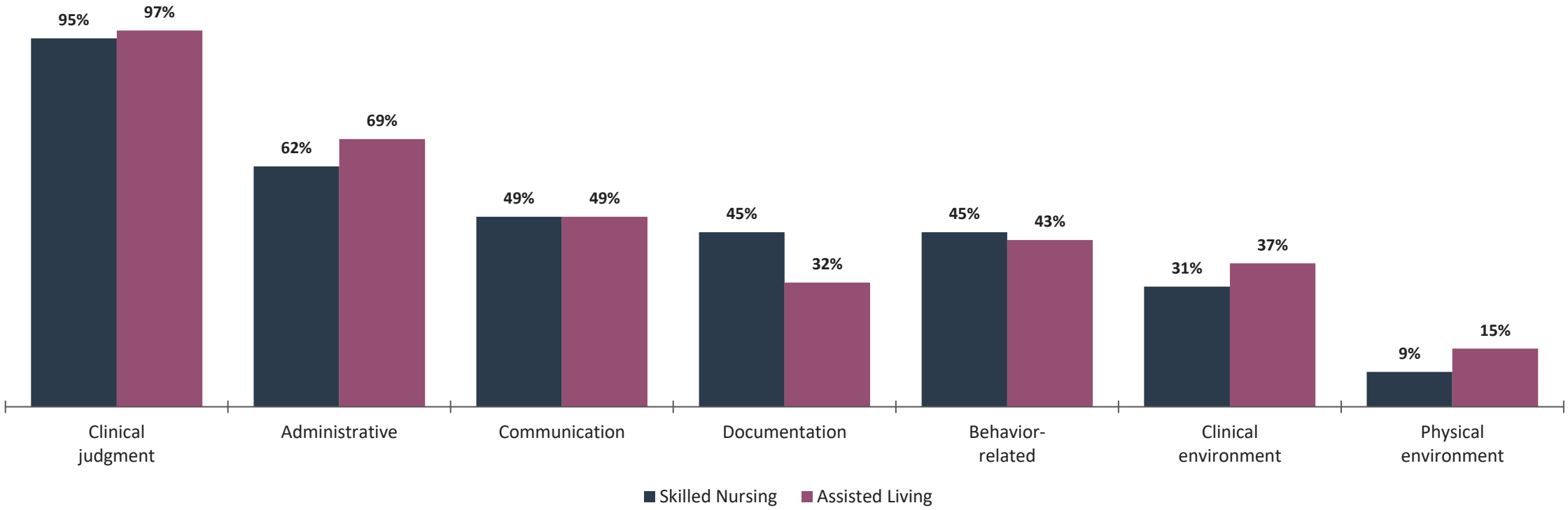
Assisted living keeps outpacing skilled nursing on cost



Assisted living's average indemnity is 16% higher than skilled nursing on cases closed with payment in 2024.

Source: MedPro Group senior care cases closed with indemnity paid, 1/1/2017–6/30/2025

What's actually contributing to these claims?



Source: MedPro Group Senior Care Data Insight, 2026

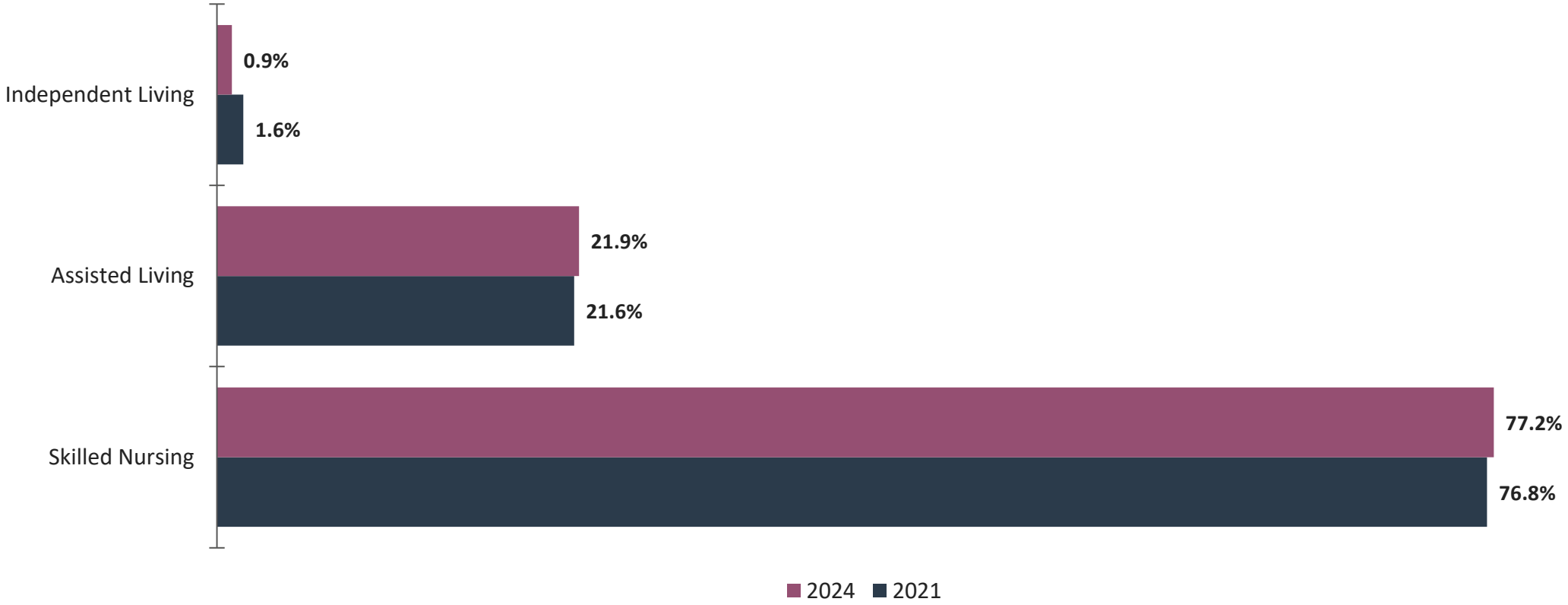
The five allegations with the highest severity

1	$384,088	Resident abuse
2	$312,107	Failure to move resident to a higher level of care
3	$311,480	Failure to follow physician's order
4	$306,373	Medication error
5	$303,883	Elopement



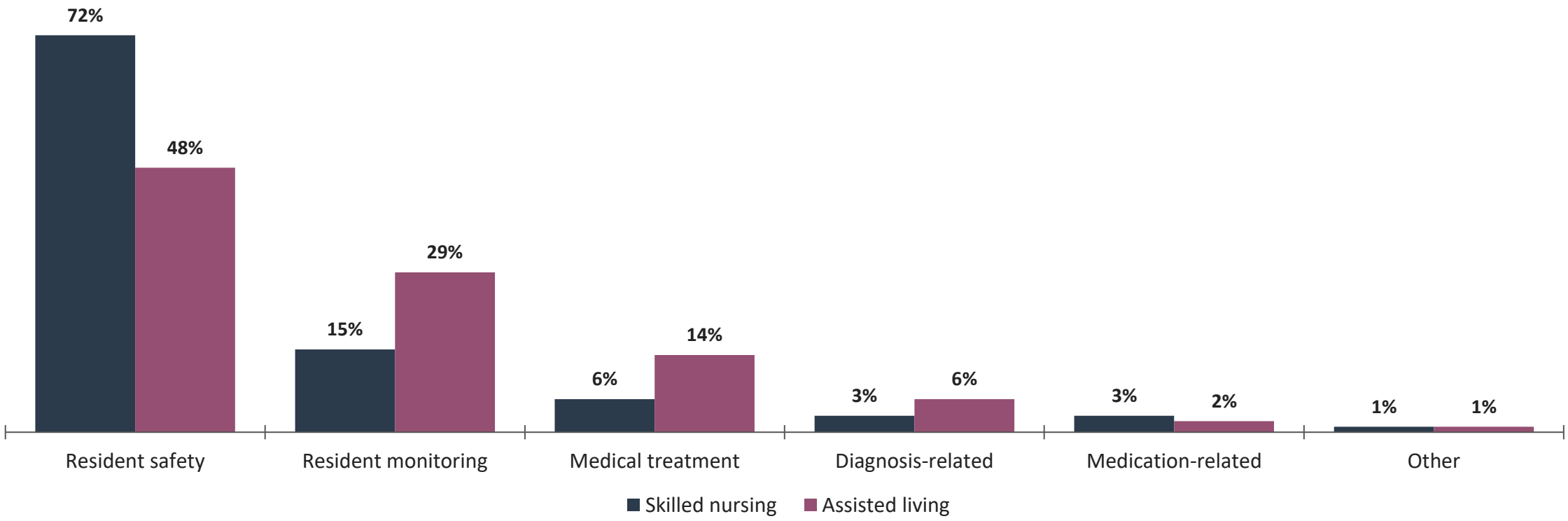
Source: CNA Aging Services Claims Report: 12th Edition (2024)

Skilled nursing still carries the most claim volume



Source: CNA Aging Services Claims Report; closed claims with paid indemnity of $10,000+

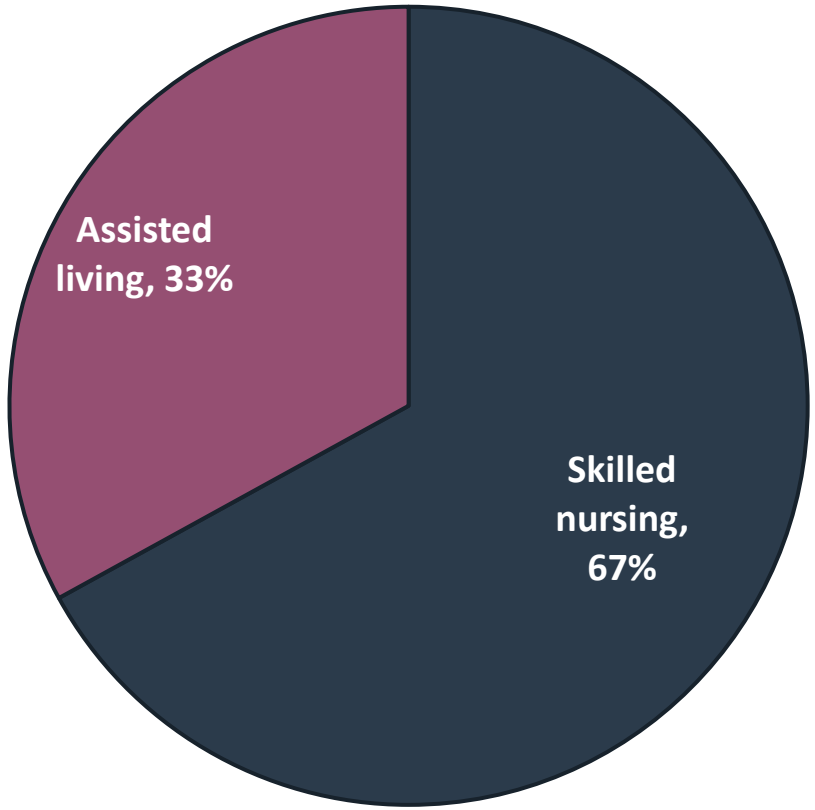
What drives claims: skilled nursing vs. assisted living



Assisted living: 48% resident safety and 29% resident monitoring.

Source: MedPro senior-care claims data, closed cases with indemnity paid, 1/1/2017–6/30/2025. Each claim has one primary case type; a case can have multiple secondary types.

MedPro senior-care claims by facility type



WHERE THE CLAIMS OCCUR

Percentage of 2,266 MedPro senior-care cases closed with indemnity paid, January 2017 through June 2025.

Memory care
represents 18% of total case volume but is a unit within a facility type, primarily assisted living; it is not an additional slice.

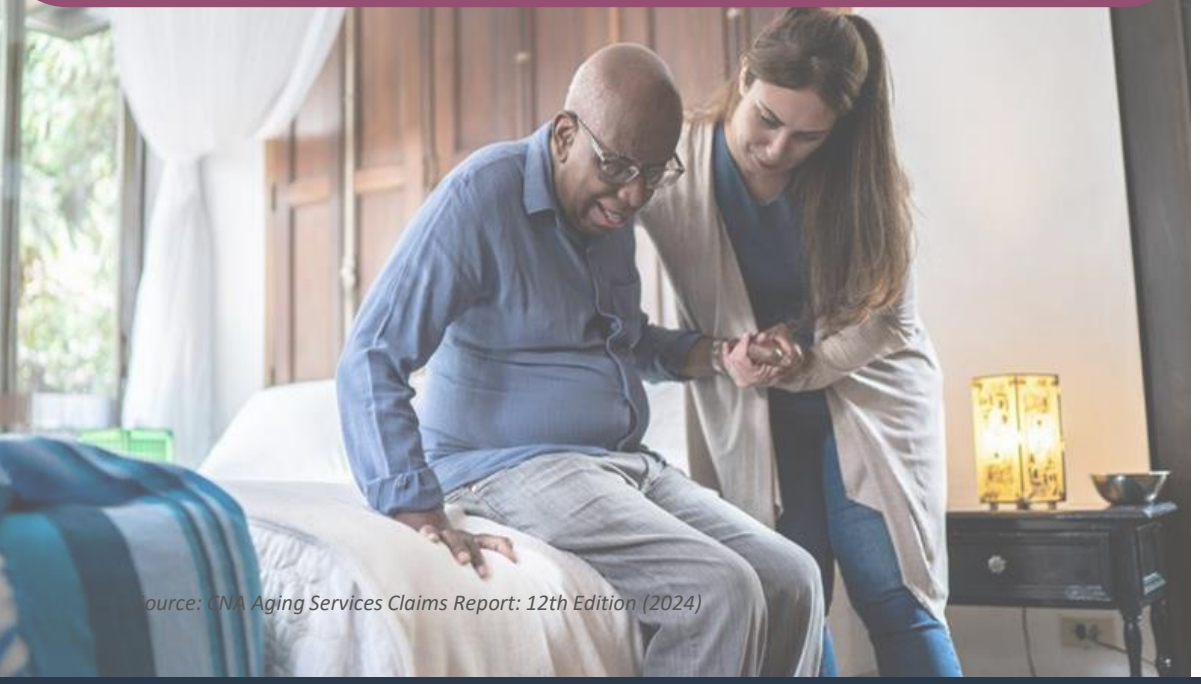
Independent living
is identified separately by MedPro as a small volume; no percentage is published.

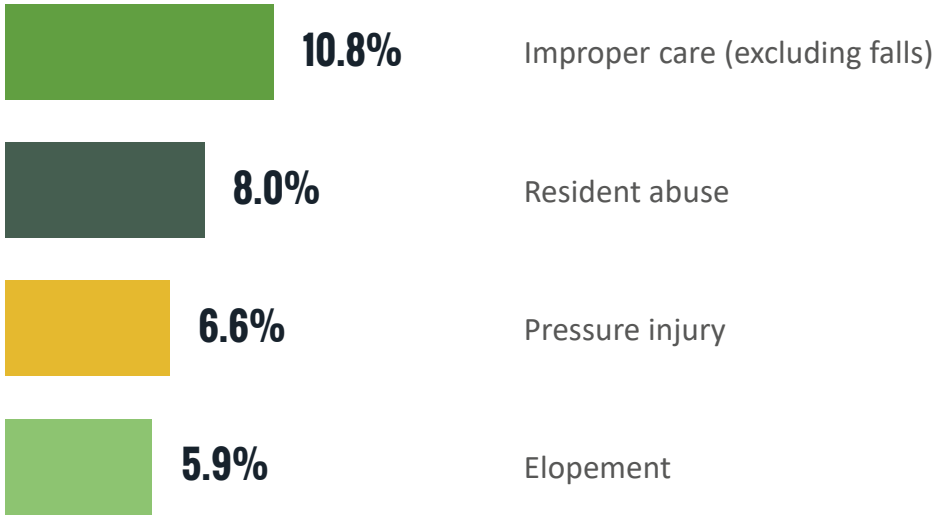
Source: MedPro senior-care claims data, closed cases with indemnity paid, 1/1/2017–6/30/2025.

In assisted living, one allegation dominates

53.0%

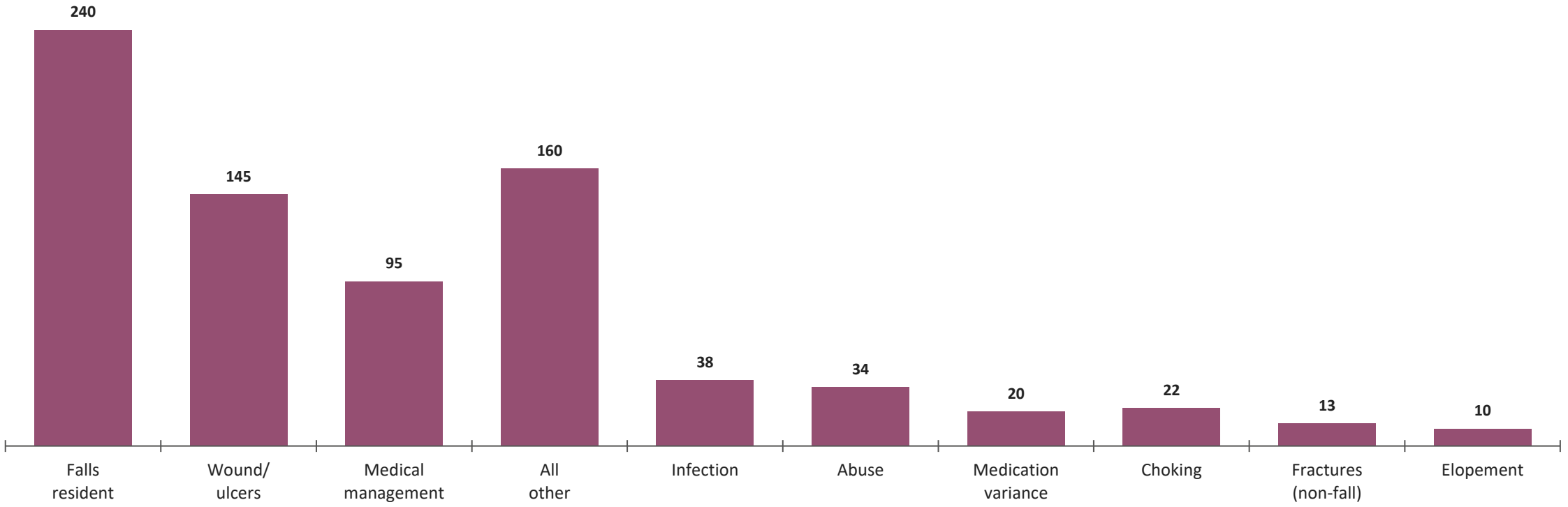
Resident falls





Source: CNA Aging Services Claims Report: 12th Edition (2024)

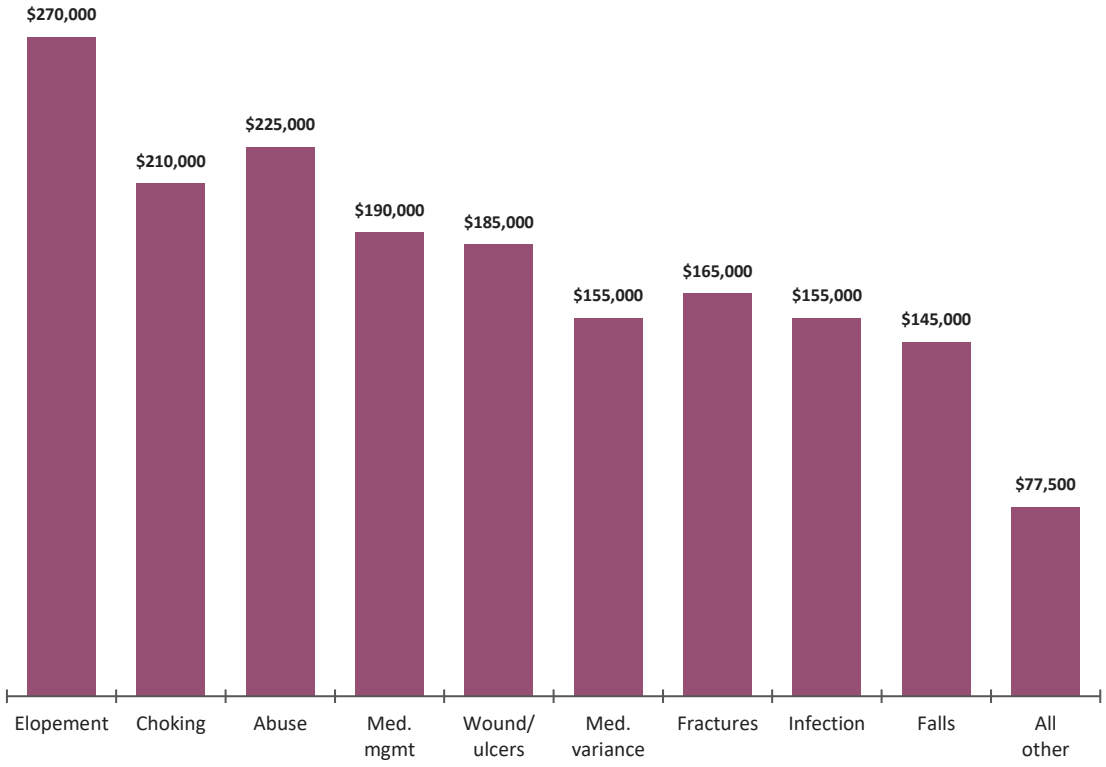
Falls dwarf every other cause of loss combined



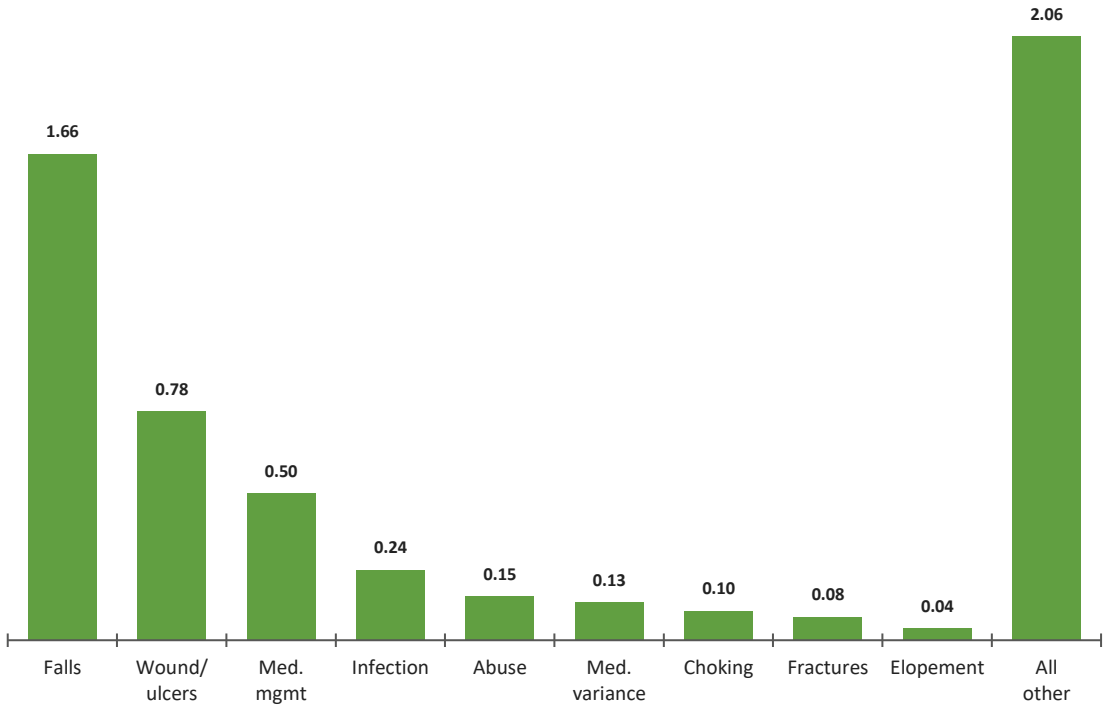
Source: WTW Senior Living 2025 Claims Benchmarking Study

Two very different stories: how often, and how bad

Severity ($ per claim)



Frequency (per 1,000 exposures)



Source: WTW Senior Living 2025 Claims Benchmarking Study

48-72%

of senior living liability claims are fall-related

23%+

higher average severity for memory-care claims vs. standard claims

$500K+

claims disproportionately show documentation & communication failures

$32M 2022 → **$56M** 2024

Sources: McKnight's Senior Living (WTW verdict data); The Baldwin Group, 2026 mid-year report

PART 03 — CLAIM & LOSS TRENDS

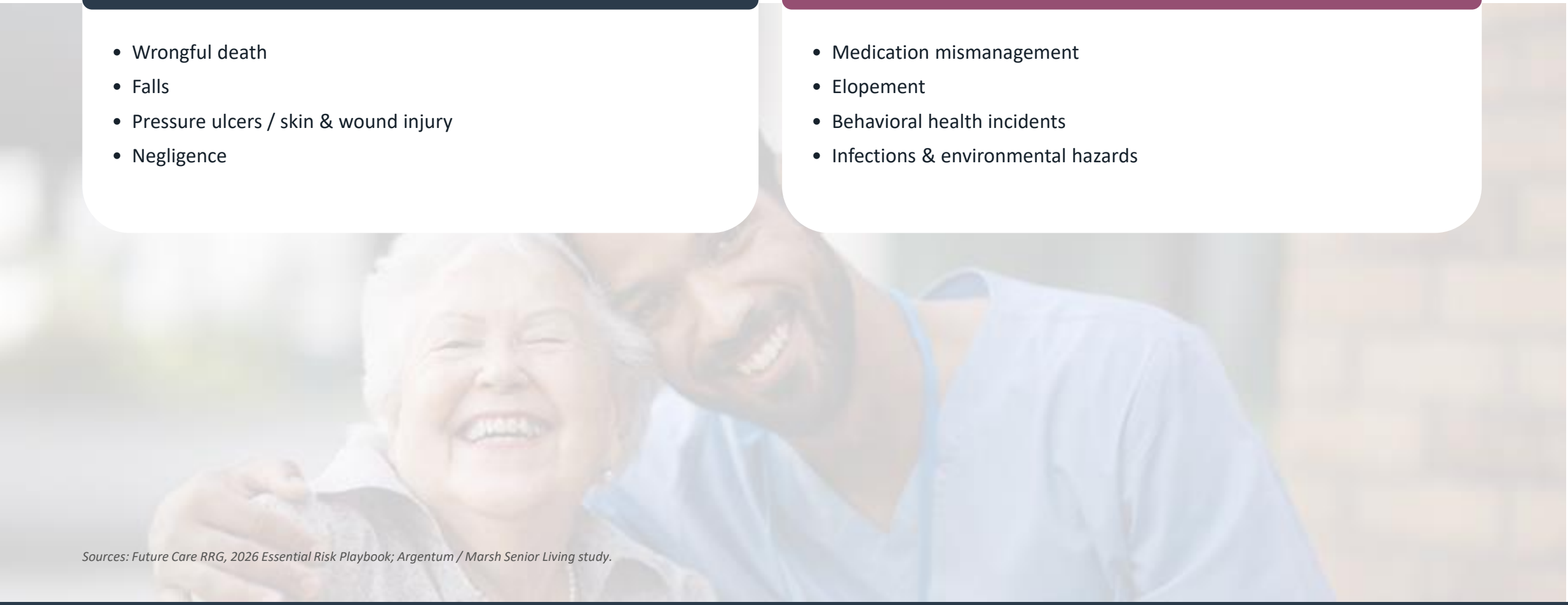
Today's top claim drivers

MOST COMMON (2025)

- Wrongful death
- Falls
- Pressure ulcers / skin & wound injury
- Negligence

FASTEST GROWING (2026)

- Medication mismanagement
- Elopement
- Behavioral health incidents
- Infections & environmental hazards



Sources: Future Care RRG, 2026 Essential Risk Playbook; Argentum / Marsh Senior Living study.



PART 04

RISK RECOMMENDATIONS

Practical, prioritized fixes — from admissions to staffing to falls. Nothing fancy, just the things that actually move your loss ratio.

PART 04 — RISK RECOMMENDATIONS

Customer Service

The last thing on this list is the first thing residents notice.

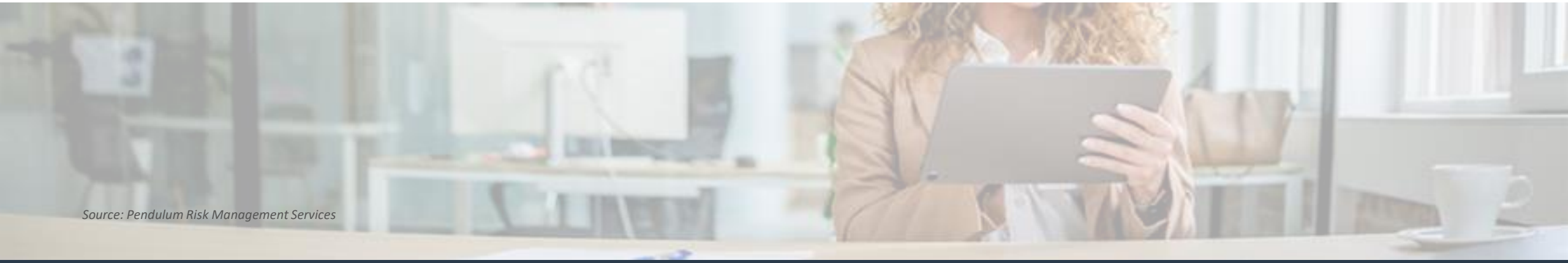
- **A documented service-recovery program**
- **Clear, written service standards**
- **Documented employee training on those standards**
- **A protocol for reporting service delivery failures**
- **Regular employee and resident satisfaction surveys**



Source: Pendulum Risk Management Services

Incident Reporting

- A formal incident management policy and procedure
- A written notification protocol for state/federal agencies and your carrier
- A working incident reporting process — not just a form nobody uses
- A formal disclosure process for incidents and adverse events, apology statement included
- A safety committee that actually reviews what comes in



Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

Environment



Rounds catch what paperwork misses.

- Leadership rounds
- Maintenance rounds
- A facility that's clean and odor-free
- Limited resident access to dangerous areas
- A secured, well-lit, hazard-free exterior
- Management rounds
- Formal, documented checklists
- Appropriate lighting throughout
- Alarmed egresses

Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

Resident Records & Documentation

If it isn't written down, it didn't happen — at least not in front of a jury.

- Every change in condition — notifications and follow-up included
- Factual documentation of events, with follow-up to prevent a repeat
- Critical communication, including read-back on every verbal and phone order
- Resident and family education, documented every time

Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

Fall Management – What I'd Check For

Same rank, the operational checklist version.

- Tracking and trending of falls, including fall rate and falls with significant injury
- A written fall policy and procedure
- Care planning documentation
- Use of a fall assessment tool
- Fall mitigation strategies
- Education and training

Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

Admission Process

1. A written policy and procedure for the admission process
2. A screening process with a family interview, physician assessment, and medical/cognitive/activities/social history review — plus sex offender status
3. An arbitration or mediation clause in the admission agreement
4. Language in the admission package built for aging-in-place



PART 04 — RISK RECOMMENDATIONS

What happens when admission goes wrong

Take your time deciding if a new resident is the right fit. Don't let census pressure make that call for you. These are real settlements:

$1M

A new resident passed away in their sleep — staff hadn't woken them for medicine. Settled for the full policy limit.

$1.75M

A respite resident was found unresponsive after two days, with a head injury no staff had witnessed.

$400,000

A new resident eloped within the first week of admission.

Source: Pendulum Risk Management Services

Operational Policies & Procedures

- Written operational policies and procedures — developed and actually implemented
- Sex offender database checks on every admission and every resident
- A written grievance / complaint policy
- A written social media policy

Source: Pendulum Risk Management Services

Human Resources

- National background checks and sex offender screening
- A documented general and department-specific orientation
- Skills competency checklists for new clinical staff — at hire and annually
- Documented CPR, first aid, and emergency training
- High-risk topics in annual training: abuse, resident rights, elopement, falls, skin injury, safety

Source: Pendulum Risk Management Services

Elopement Management

- Semiannual elopement drills
- Window restrictors
- An assessment tool in active use
- Electronic monitoring sensors
- Staff education and training
- A written elopement policy and procedure
- Exit door alarms and notifications
- Interventions at the moment of elopement, and on return
- Verifying resident location after every drill, activity, or field trip

Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

Risk Management Program

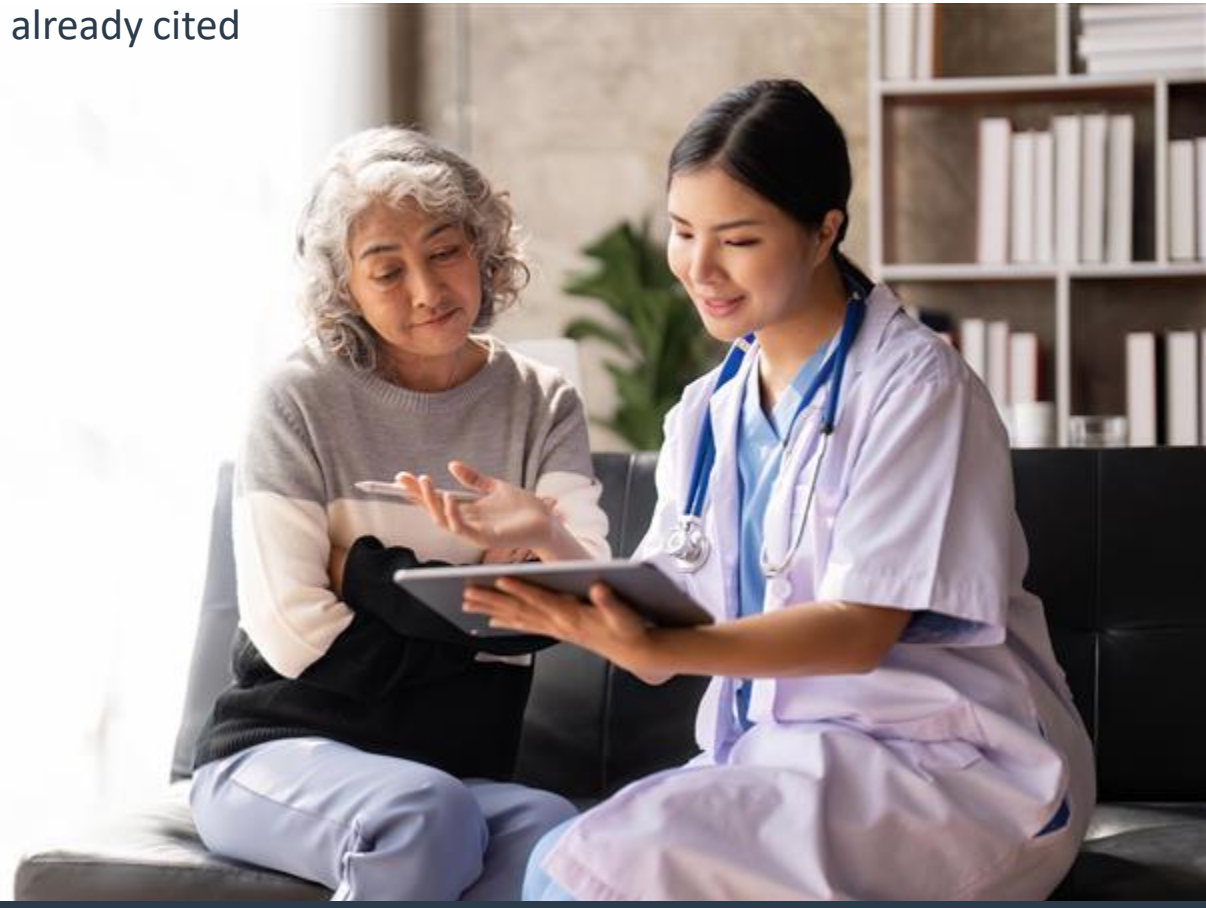
Everything above rolls up into this one.

- A simple, WRITTEN risk management plan — with named committee members and roles
- Committee minutes that reflect real issues, discussion, action plans, and resolutions
- Documentation of tracking and trending over time

Source: Pendulum Risk Management Services

Underneath all ten: a culture of safety

- Purposeful daily, weekly, and monthly meetings
- When something happens, build the action plan as if you're already cited
- Confirm the safety of every other resident first
- Stay survey-ready, always



Source: Pendulum Risk Management Services

The Gap – where your risk actually lives

The gap is the space between what's written and what actually happens on the floor. Close it by asking:

1. What does the policy or procedure actually say?
2. What is general practice — really?
3. What happens during and after an incident?
4. What do the regulations require?
5. How well have you trained staff on all of the above?



Source: Pendulum Risk Management Services

PART 04 — RISK RECOMMENDATIONS

What WTW claims benchmarking tells us about managing risk when staffing is tight (1 of 2)

The goal isn't simply to get through the shift. It's to prevent a staffing shortage from becoming a resident injury, claim, or regulatory event.

Identify your highest-risk residents first

Falls, elopement, transfers, medication needs, and behavioral risks should drive staffing priorities.

Know who cannot be left unattended

Make sure every caregiver understands which residents require direct supervision or assistance.

Prioritize critical care over routine tasks

Toileting, transfers, medication administration, meals/hydration, and resident monitoring come first.

Communicate staffing gaps immediately

Don't allow the next shift—or management—to discover the problem after an incident occurs.

Reassess residents when staffing changes

A resident's care plan may assume a level of staffing that isn't available during a shortage.

What WTW claims benchmarking tells us about managing risk when staffing is tight (2 of 2)

Don't substitute an untrained employee for a trained one

Staff competency matters, particularly for transfers, medication administration, dementia care, and fall prevention.

Review every incident for a staffing connection

Ask whether staffing levels, assignments, training, workload, or communication contributed to the event.

Document what changed

If normal services or monitoring cannot be provided, document the staffing situation and the steps taken to mitigate the risk.

Fix the system—not just the individual incident

Track patterns and determine whether recurring staffing shortages are creating predictable claims exposures.

Escalate high-risk situations

If the community cannot safely meet a resident's needs, leadership needs to know immediately.

PART 04 — RISK RECOMMENDATIONS

Three habits that quietly manage acuity risk

Manage Acuity

Know exactly who's aging in place beyond what your license and staffing model support.

Educate Family

Make sure the family understands the level of care — before there's a bad surprise.

Slow Down at Admission

Spend real time on the admission assessment. It's cheaper than what happens if you rush it.

Source: Pendulum Risk Management Services



PART 05

CANNABIS POLICIES

Legal in more states than ever, and still unresolved federally. Silence is not a policy — and I see too many communities relying on it.

PART 05 — CANNABIS POLICIES

You're standing in the middle of a legal patchwork

FEDERAL LAW

- Cannabis remains a Schedule I substance
- Staff risk their professional license by administering it
- Medicare/Medicaid certification requires federal compliance
- Possession, storage, or distribution carries federal exposure

STATE LAW

- Most states now permit medical or adult use
- Registered residents generally have a right to use where legal
- Rules on storage, administration, and caregiver roles vary by state
- A few states (Virginia, Massachusetts) directly address staff involvement

Sources: cannabisforseniors.org; Buchanan Ingersoll & Rooney / McKnight's Senior Living

PART 05 — CANNABIS POLICIES

Missouri: legal doesn't mean you have to allow it

Medical and adult-use (21+) cannabis are legal in Missouri, but legalization does not require a private property owner or facility operator to allow use on its premises. The constitution expressly preserves restrictions on public use and workplace use.

What you may restrict

- Prohibit smoking cannabis on the property
- Restrict possession or use in common areas
- Adopt lease or residency rules addressing cannabis use

What the answer turns on

- Level of care: independent living, assisted living, or skilled nursing
- Whether the resident has a Missouri medical marijuana card
- Whether the facility receives federal funding

Why skilled nursing is harder

- Cannabis remains illegal under federal law
- Many nursing facilities participate in Medicare and Medicaid and follow federal regulations
- Facilities often cite federal law and medication-management rules to restrict use, even where state law permits it

One limit to know: a lease signed after December 8, 2022 may not prohibit a tenant from lawfully possessing and consuming marijuana by means other than smoking.

Legal reference: Missouri Constitution, Article XIV, Section 2 (effective December 8, 2022). Confirm how it applies to your community with Missouri counsel.

PART 05 — CANNABIS POLICIES

Five policy musts, whatever your community decides

Ambiguity is the exposure. Write it down, and apply it the same way every time.

1 **Self-administration, secured**

The common lockbox model — the resident or a designated caregiver procures and controls access.

2 **No smoking or vaping indoors**

Near-universal restriction. Permit only non-smokable forms: oils, tinctures, edibles, topicals.

3 **Staff don't administer or store**

Unless your state law expressly allows it, keep clinical staff out of direct handling.

4 **Assess before use**

Baseline the resident, update the care plan, and watch for fall-risk and drug-interaction effects.

5 **Extra safeguards in memory care**

Require surrogate consent and secure storage away from cognitively impaired residents.



Source: The Pipeline Cannabis Law Advisor, "Best Practices for Managing Marijuana Use in Senior Care"

What a sample Missouri cannabis policy covers (1 of 2)

1 Purpose

Promote resident safety, legal compliance, protection of staff and residents, and a safe living environment around the possession, use, storage, and administration of cannabis products.

2 Scope

All residents, visitors, family members, employees, contractors, and volunteers on property owned, operated, or managed by the Community.

3 Definitions

Cannabis: marijuana, marijuana-infused and THC-containing products, and related derivatives permitted under Missouri law, from plant material and edibles to tinctures, capsules, oils, vapes, and topicals. Medical Cannabis Resident: a resident with a valid Missouri medical marijuana authorization.

4 General policy

The Community may set reasonable restrictions on possession, storage, use, administration, and consumption on its property. Cannabis use is not a resident right that overrides health, safety, operational, or regulatory requirements.

5 Smoking and vaping

Prohibited in any indoor location, including apartments, resident rooms, bathrooms, hallways, common and dining areas, healthcare spaces, and Community vehicles, and within 25 feet of entrances, exits, windows, and air intake systems.

6 Possession

Allowed only if lawful under Missouri law, in original labeled packaging, within legal quantity limits, and stored according to the policy. The Community may require documentation of lawful possession.

7 Storage requirements

Keep products in a locked container, prevent access by other residents, prevent diversion or sharing, and store according to package instructions. More precautions may be required where resident safety concerns exist.

8 Administration and self-administration

Residents who are independently capable may self-administer, subject to care plan review, assessment of safety risks, and Community rules. The Community does not prescribe, recommend, furnish, dispense, or supply cannabis.

Sample policy template for discussion. Have Missouri counsel review before implementation.

What a sample Missouri cannabis policy covers (2 of 2)

9 Staff responsibilities

Employees do not purchase cannabis for residents, recommend products, store cannabis in employee areas, administer it unless authorized by law and approved by Community policy, or handle resident cannabis except for safety or emergencies.

10 Medical cannabis residents

Should provide medical marijuana identification if applicable, current physician information, and disclosure of use to the nursing or wellness team, supporting medication reconciliation, drug interaction monitoring, fall-risk and cognitive assessment, and care planning.

11 Resident safety assessment

May be conducted when cannabis use may affect balance, cognition, judgment, mobility, medication interactions, or behavioral health. The Community may require care plan modifications if safety concerns are identified.

12 Prohibited conduct

Distribution, sale, or sharing; cultivating plants or manufacturing products; smoking or vaping in prohibited areas; use that creates safety risks to self or others; and impairment that disrupts Community operations.

13 Visitors

Must comply with all Community cannabis policies. Visitors may not smoke or vape cannabis on Community property, provide products to residents contrary to policy, or store products on the premises.

14 Federal law considerations

Cannabis remains prohibited under federal law notwithstanding Missouri legalization. The Community may add restrictions needed to meet federal, insurance, lender, licensing, or regulatory obligations.

15 Enforcement

Violations may result in written warnings, care plan modifications, restriction of possession privileges, removal of prohibited products, and discharge proceedings consistent with applicable law and resident agreements.

16 Resident acknowledgment

The Community does not provide cannabis or guarantee safe cannabis use. Residents remain responsible for complying with Missouri law, Community rules, and safety requirements.

Sample policy template for discussion. Have Missouri counsel review before implementation.

The defensible middle: controlled use, not a ban

THE BEST PRACTICE

For a senior living provider, the best practice is not an outright prohibition unless necessary, but a controlled-use policy.

That approach is generally easier to defend in liability litigation than either a complete ban or unrestricted use.

CONTROLLED USE EMPHASIZES

- No smoking or vaping
- Mandatory disclosure
- Medication review
- Impairment assessments
- Locked storage
- No staff administration
- No redistribution

PART 05 — CANNABIS POLICIES

Where the exposure actually hides

WORKERS' COMPENSATION

Staff injured responding to an impaired resident, or handling product they shouldn't handle.

PREMISES & GENERAL LIABILITY

A resident falls or is injured while impaired — supervision and care-plan documentation get examined first.

REGULATORY & CERTIFICATION

Perceived non-compliance with federal law can threaten Medicare/Medicaid participation.

STAFF ACCOMMODATION REQUESTS

Employee medical-cannabis use raises ADA and disability-accommodation questions for HR.

Source: MASWM / Senior Living Risk Series

PART 05 — CANNABIS POLICIES

In a claim, four questions get asked about your policy

Claims involving resident injury, wrongful death, medication management, or tenant rights can hinge on the adequacy and enforcement of your cannabis policy.

Written

Did the community have a written cannabis policy?

Enforced

Was that policy consistently enforced?

Disclosed

Was the policy disclosed to residents and families?

Compliant

Did the community follow Missouri licensing and resident-rights requirements?



PART 06

CYBER & COMPLIANCE

Cyber readiness, and getting ahead of the 2026 HIPAA changes before they're mandatory.

Top 5 ways an assisted living community can prepare for a cyberattack

1. BACK UP EVERYTHING — AND TEST THE BACKUPS

- Maintain offline/isolated backups.
- Test restoration regularly.
- Make sure critical resident and operational information can be accessed if systems go down.

2. REQUIRE MFA EVERYWHERE

- Email
- EHR/EMR systems
- Remote access
- Financial systems
- Administrator accounts

3. TRAIN EMPLOYEES TO RECOGNIZE AN ATTACK

- Phishing emails
- Fake password-reset requests
- Suspicious attachments
- Vendor/payment scams

One employee clicking can become a community-wide problem.

4. CREATE A 72-HOUR DOWNTIME PLAN

Know how the community will operate if the EHR, phones, medication systems, internet or computers are unavailable.

- Paper medication records
- Resident contact information
- Emergency contacts
- Staffing information
- Physician information
- Critical care documentation

5. KNOW WHO TO CALL BEFORE YOU NEED THEM

Have a written cyber-response list with:

- IT/cybersecurity provider
- Cyber insurance carrier
- Breach counsel
- Forensic specialist
- Management contacts
- Law enforcement/regulatory contacts

Cyber check: could your community operate for 72 hours without its technology?

MFA → BACKUPS → EMPLOYEE TRAINING → CONNECTED DEVICES → INCIDENT RESPONSE

1

Multi-factor authentication (MFA)

Require MFA for:

- Email
- Electronic medical/health records
- Remote access
- Administrative accounts
- Cloud-based systems

Why it matters: A stolen password alone should not give an attacker access to the community's systems. HHS specifically recommends strong, unique passwords combined with MFA.

2

Backups — can you actually restore your data?

Don't just ask, "Do we have backups?" Ask:

- Are backups disconnected/isolated from the network?
- Are they encrypted?
- How often are they performed?
- When was the last successful restoration test?
- Could you operate if the EHR went down for several days?

HHS recommends secure backups and testing the restoration process, not simply having a backup.

3

Employee training — especially phishing

Train employees to recognize:

- Phishing emails
- Fake Microsoft/Google login screens
- Suspicious attachments
- Wire/payment-change requests
- Fake vendor invoices
- Social engineering phone calls

And test employees periodically with simulated phishing. Big question: What happens when an employee clicks the wrong link?

4

Know what's connected to your network

Maintain an inventory of:

- Computers/tablets
- Medication-management systems
- Cameras/security systems
- Wi-Fi devices
- Medical devices
- Printers
- Servers
- Third-party/vendor connections

HHS notes that organizations need to understand where ePHI exists and what systems have access to it.

5

Have a cyber incident playbook — before the attack

Every community should know:

- WHO do we call?
- WHAT gets shut down?
- HOW do we continue resident care if systems are unavailable?
- WHEN do we notify the cyber carrier?
- WHERE are our backup records?

The plan should include the cyber insurer, breach counsel, forensic vendor, IT provider and management team. HHS also recommends tested incident-response and ransomware-recovery procedures.

Five things I want on your cyber checklist

1. Keep constant surveillance of the system
2. Know your triggers — go to immediate shutdown and escalation
3. Communicate to all stakeholders, fast
4. Implement your business continuity processes
5. Implement downtime recovery processes



Source: ASPR TRACIE, Healthcare System Cybersecurity: Readiness & Response (Oct 2022)

Preparedness – before anything happens

- A written, regularly tested Incident Response Plan and IT Disaster Recovery Plan
- Known shutdown triggers, with pre-authorized people who can activate them
- Full tabletop exercises 1-2x a year, plus unit-level drills at least twice a year
- An accurate, current mission-critical systems inventory

Source: ASPR TRACIE, Healthcare System Cybersecurity: Readiness & Response (Oct 2022)

Response – the first hours matter most

- Report incidents immediately to CISA/FBI to unlock federal, state, and local support
- Activate your Incident Management Team and Business Continuity / COOP plans
- Communicate scale, expected duration, and instructions continuously — it reduces staff stress
- Move quickly to downtime forms and manual documentation

Source: ASPR TRACIE, Healthcare System Cybersecurity: Readiness & Response (Oct 2022)

Recovery – plan for it to take longer than you think

- Treat recovery as a continued phase of downtime — systems come back incrementally, not all at once
- Plan for migrating manual documentation back to electronic records — some data may not reconcile
- Track response costs by category (personnel, equipment, supplies, lost revenue) for insurance and FEMA claims

Source: ASPR TRACIE, Healthcare System Cybersecurity: Readiness & Response (Oct 2022)

What's changing for ePHI security

As cyber threats targeting healthcare rise, the expected 2026 updates tighten how electronic protected health information has to be secured.

STRICTER REQUIREMENTS

Safeguards once “addressable” become expected or required — less flexibility, more accountability.

ENHANCED PROTECTIONS

Encryption and multi-factor authentication move to the center of securing patient data.

GREATER VISIBILITY & CONTROL

You need to clearly know where patient data lives, who accesses it, and how it's protected.

TIGHTER TIMELINES

Once finalized, you may have as little as 60 days to reach compliance.



Source: MASWM / Senior Living Risk Series

Getting ready before it's required

This is more than a compliance exercise. It's a chance to build resilience and reinforce resident and family trust.

1

Assess your current risk

Where does ePHI live, and who can reach it?

2

Strengthen your security posture

Prioritize encryption and MFA now, before they're mandatory.

3

Tighten your documentation

Show clearly how patient data is safeguarded and monitored.

4

Build the muscle for a fast response

A 60-day compliance window leaves no room to start from zero.



Based on anticipated 2026 HIPAA Security Rule updates — consult counsel for guidance specific to your organization.

Prevented claims all share one thing: someone saw the risk before it became a file number.

See It

Build a near-miss reporting habit that surfaces problems while they're still small.

Manage It

Put clear, written policy behind ambiguous risks — starting with cannabis.

Track It

Review claim and severity trends regularly, and act on what they're telling you.

Secure It

Get ahead of the 2026 HIPAA changes with encryption, MFA, and clear documentation.

Source: MASWM / Senior Living Risk Series

The claim you prevent today is the claim you don't have tomorrow

- Near misses are data — build the habit of reporting and reviewing them.
- Write a cannabis policy before a resident or a regulator forces the question.
- Let severity trends, not just frequency, guide where you invest in prevention.
- Start preparing for the 2026 HIPAA changes now — 60 days won't be enough.

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