ABUSE/NEGLECT/MISAPPRORIATIONS/EXPLOITATION

Clarifications and Updates

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Objectives

- 1. Learn how the current abuse, neglect and exploitation tags are surveyed.
- 2. Learn the intent of the Interpretative Guidelines and how they are utilized.
- 3. Discuss and learn the common misconceptions about these regulations
- 4. The participant will be able to assure that their processes within their facility are accurate, update and utilized correctly.

F 600: Freedom from Abuse, Neglect and Exploitation

- *§483.12 : The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.*
- *§483.12(a) The facility must—*
- *§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;*

Intent

- ***INTENT §483.12(a)(1)***

- *Each resident has the right to be free from* ***abuse, neglect and corporal punishment of any type by anyone.***

- ***NOTE****: Refer to tag F602 for misappropriation of resident property and exploitation, and F603 for cases of involuntary seclusion.*

Definitions

- ***§483.12(a)(1)***
- *"**Abuse**," means "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."*
- *"**Neglect**," means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."*

Definitions

- *"**Sexual abuse**," is defined as "non-consensual sexual contact of any type with a resident."*
- *"**Willful**," as defined and as used in the definition of "abuse," "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."*
- ***NOTE:** For purposes of this guidance, "staff" includes employees, the medical director, consultants, contractors, and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.*

Staff to Resident Abuse of Any Type

- *Nursing homes have diverse populations including, among others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences, speech/language challenges, and generational differences. When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population. A facility cannot disown the acts of staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. CMS does not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for an employee to claim his/her action was "reflexive" or a "knee-jerk reaction" and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited.*

Interpretative Guidance

- ***NOTE**: It should not be assumed that every accident or disagreement that occurs between an employee and a resident should be considered to be abuse. Accidents that may not be considered to be abuse include instances such as a staff member tripping and falling onto a resident; or a staff member quickly turning around or backing into a resident that they did not know was there.*

Staff To Resident Abuse

- ***All allegations/occurrences of all types of staff to resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes.***
- *This includes physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion. Also, it would include staff taking or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging.*

Resident to Resident Abuse of Any Type

- *A resident to resident altercation should be reviewed as a **potential situation** of abuse. When investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder.*
- *`Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term "willful".*
- *The word "willful" means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate ("willful") action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. If it is determined that the action was not willful (a deliberate action), the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible, and that each resident receives adequate supervision (See F689).*

Resident to Resident Abuse

- ***Mental/Verbal Altercations: Required to Report:***
  - *Intimidation*
  - *Bullying-Aggressive behavior in which someone intentionally and repeatedly causes another person physical/mental injury or discomfort (American Psychological Association)*
  - *Communication that creates a hostile environment that is motivated by an actual or perceived characteristic, such as race, color, religion, sex, disability, sexual orientation.*
  - *Credible threats of violence or sexual assault*
  - *Inappropriate sexual comments*

Required to Report

- *Unwanted touching of the breasts or perineal area*
- *A resident who fondles or touches a person's sexual organs and the resident being touched lacks the capacity to consent (NOTE: even if the resident wants the touching, if he/she lacks the capacity to consent, it must be reported)*
- *Sexual activities where one or both residents lack capacity to consent*
- *Sexual assault or battery (ex. rape, sodomy, coerced nudity)*
- *Forced observation of masturbation, or pornography*
- *Forced, coerced or extorted sexual activity*
- *Taking and/or posting sexually inappropriate photographs or videos of residents on the internet*

Not Required to Report unless it rises to the level of the above:

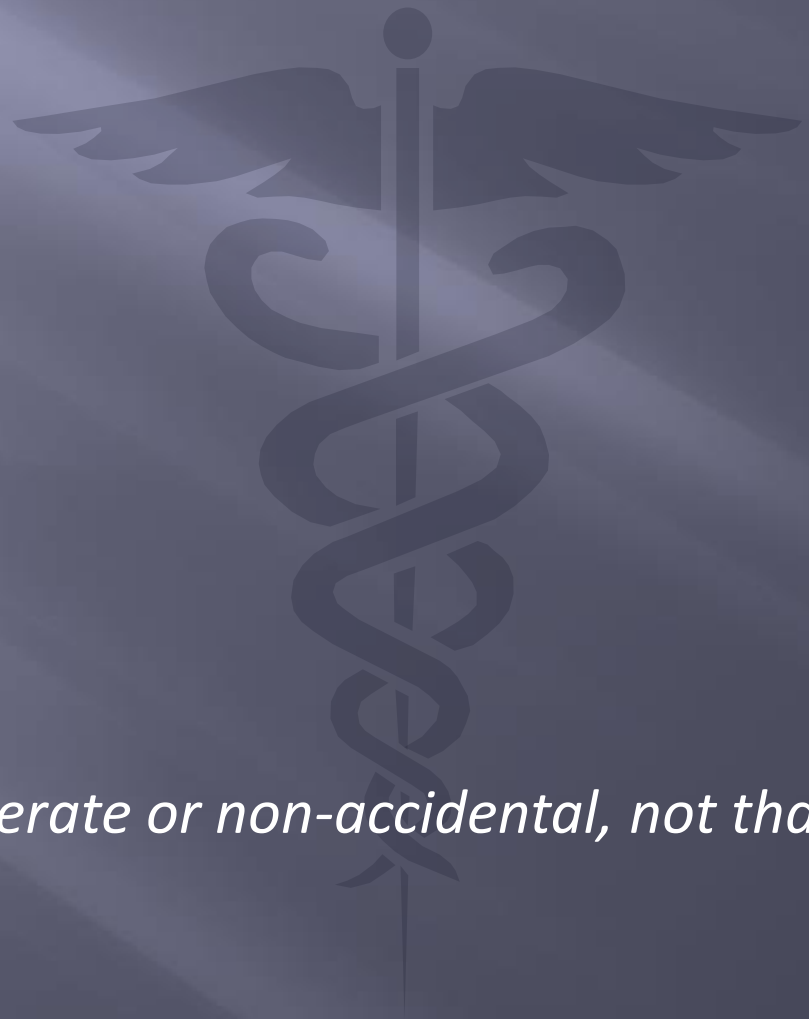
- *Non-targeted or general outbursts*
- *Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations*
- *Arguments or disagreements, not included in the "Required to Report" column*
- *Consensual sexual contact between residents who have the capacity to consent:*
- *Affectionate contact such as hand holding or hugging or kissing in a friendly way*

Physical Altercations

- *Examples of resident to resident physical altercations that must be reported are provided below. They include, but are not limited to:*
- *Any physical contact that is likely to cause injury and involves a resident with a known history of physical, verbal or sexual interactions that are considered to be negative, aggressive or intrusive.*
- *Any willful action that results in physical injury, mental anguish, or pain.*

Willful Actions

- *Hitting*
- *Slapping*
- *Punching*
- *Choking*
- *Pinching*
- *Biting*
- *Kicking*
- *Throwing objects*
- *Grabbing*
- *Shoving*



**The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm*

Willful acts that result in:

Physical Injury:

- Death
- Injury requiring medical attention (such as a fracture, a cut requiring suturing)
- Fracture(s), subdural hematoma, concussion
- Bruises, as indicated by red or purple colorations of the skin;

Williful Acts that result in:

Mental Anguish:

- Fear of a person or place or of being left alone or of being in the dark, disturbed sleep, nightmares
- Extreme changes in behavior, including aggressive or disruptive behavior toward a specific person
- Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts

Willful Acts that result in:

Pain:

- Complaints of pain, related to the altercation
- Possible nonverbal indicators of pain may include:
  - Groaning, crying, screaming
  - Grimacing, clenching of the jaw
  - Resisting care

General Examples

The general examples below illustrate possible cases that would likely not need to be reported, as long as it does not meet any of the requirements listed above. Every case is fact specific and all facts, circumstances and conditions involving the event/occurrence would need to be examined.

- *Light tap to stop an irritating behavior or get attention that does not result in physical injury.*
- *A resident with cognitive impairment is loudly verbalizing, another resident approaches and lightly places his/her hand over the resident's mouth, says "be quiet" and walks away. However, if staff responded to a resident in this manner, this would be reportable.*
- *A resident who is slow, impedes the pathway of another resident, such as in the dining room, the other resident nudges the resident out of the way to get to his/her table faster, but there is no harm to the victim or the victim receives a minor bruise/scratch.*

Exs of Reporting Suspicious Injuries of Unknown Source

-"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when all of the following criteria are met:

-The source of the injury was not observed by any person other than the affected resident; and

-The source of the injury could not be explained by the resident; and

- *The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.*

Injuries of Unknown Origin

- ***NOTE**: If the injury is explained and appears to be a result of abuse, it would be reportable.*
- ***NOTE**: Even if the injury is not reportable, the facility is responsible to adequately assess and monitor the resident and notify the physician/resident representative as appropriate.*

Required to report: Injuries of Unknown Origin

-Unobserved/Unexplained fractures, sprains or dislocations (e.g., may be suspicious for a resident who is dependent on staff for mobility, positioning, transfers)

- *Unobserved/Unexplained injuries that could have resulted from a burn, including blisters or scalds*

-Unobserved/Unexplained bite marks

- *Unobserved/Unexplained scratches and bruises found in suspicious locations such as the head, neck, upper chest or back*

-Unobserved/Unexplained lacerations with or without bleeding

- *Unexplained/Unobserved skin tears in sites other than the arms or legs*

-Unobserved/Unexplained bruises in shapes, including finger imprints

- *Unobserved/Unexplained facial injuries, including facial fractures, black eye(s), bruising, or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth*

-Unobserved/Unexplained bruising or other injuries in the genital area or breasts

Not Required to Report for Injuries of Unknown

- *Bruising that occurs for a resident on anticoagulants or has had medical tests/lab draws*
- *Injuries where the resident was able to explain or describe how he/she received the injury as long as there is no allegation of abuse or neglect*

Examples of Reportable Events Related to Potential Neglect

When process or structure failures…

- *Failure to provide sufficient, qualified, competent staff to meet residents' needs for residents requiring skilled nursing care such as ventilator/tracheostomy care, dialysis care, or IV therapy*

When Serious outcomes occur:

-Resulting in, for example, respiratory distress, fluid overload, or infection/exsanguination that are deemed avoidable.

- *Failure to provide sufficient, qualified, competent staff to meet residents' needs for residents requiring skilled nursing care such as ventilator/tracheostomy care, dialysis care, or IV therapy*
- *When Serious Outcomes Occur Resulting in, for example,:*
  - *Respiratory distress, fluid overload, or infection/exsanguination that are deemed avoidable.*

Neglect: When Processes or Structures Fail

- *Failure to provide training and/or monitoring of staff using resident care equipment (such as lifts, transfer belts, standing devices) as identified in the resident's care plan, manufacturer's guidelines, or current standards of practice*
- *When Serious injury or outcomes occur:*
  - *Resulting in fractures, head trauma, or other injuries requiring medical intervention.*

Neglect: Reportable when:

- *If smoking is allowed in designated areas, failure to provide assessment of the resident for safe smoking, failure to provide and use appropriate protective clothing per assessment, failure to provide adequate monitoring and supervision of area, failure to monitor and supervise a resident using oxygen equipment who smokes*

- *Serious injury or outcome occur:*

  -Resulting in the surrounding area catching fire, and the resident requiring medical attention for burns.

Neglect: When Processes or structures fail:

- *Failure to meet payroll or pay supplier bills, resulting in residents not receiving goods or services*
- *Serious injury or outcomes occurs:*
  - *Resulting in insufficient staff to answer call lights and provide care, lack of essential care items such as linens, lack of sufficient amounts of food.*

Neglect: When process or structures fail:

- *Failure to monitor water temperatures or heating equipment such as wall heaters, or equipment used for therapy (such as hot packs) as identified in the resident's care plan, manufacturer's guidelines, or current standards of practice*

- *Serious injury or outcomes occur:*
  - *Resulting in burns or injuries requiring medical intervention.*

Neglect: When processes or structures fail:

- *Failure to identify, monitor and supervise staff who refuse to answer call lights, refuse to provide toileting assistance when requested*

- *Serious Injury or Outcome Occurs:*
  - *Resulting in residents left in fecal material or urine and developing skin breakdown or a significant skin condition.*

Neglect: When processes or structures fail:

Failure to provide training, monitoring and supervision for vehicular transport or residents according to manufacturer's guidelines and standards of practice; for example, forgetting/leaving a resident in the vehicle, wheelchair/mobility devices not secured, unsafe use of ramps, failure to use appropriate seat belt devices

- *Serious Injury or outcome occurs:*
  - *Resulting in serious injury requiring medical intervention or death*

Failure to identify, monitor and supervise a resident(s) with exit-seeking behaviors: Serious Injury or outcome occurs:

- *Resulting in a resident leaving a facility without staff knowledge regardless of whether or not an injury occurred.*

Neglect: When processes or structures fail

- *Failure to train, monitor and supervise staff to respond correctly to medical or psychiatric emergencies resulting in serious injury or outcomes:*
  - *Resulting in injury requiring medical interventions or death*
- *Failure to provide psychosocial services and supervision to residents with suicidal ideation: resulting in serious injury or outcomes:*
  - *Resulting in suicide attempts*

Exs: Reportable Allegations of Misappropriation of Resident Property and Exploitation

The facility must exercise reasonable care for the protection of the resident's property from loss or theft. See tag F584, 42 CFR §483.10(i)(1)(ii). The facility is expected to be responsive to a resident's concerns about lost items. Examples of allegations of misappropriation of resident property and exploitation that must be reported include, but are not limited to:

- *Theft of personal property;*
- *Theft of money from bank accounts;*
- *Unauthorized or coerced purchases on a resident's credit card;*
- *Unauthorized or coerced purchases from resident's funds;*
- *Missing dentures;*
- *Missing medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain;*
- *A resident who provides a gift to staff in order to receive ongoing care, based on staff' supervision; and*
- *A resident who provides monetary assistance to staff, after staff had made the resident believe that staff was in a financial crisis.*

Non reportable allegations of misappropriation of property:

Examples of allegations that would not be reported are:

- *Theft of nominal items with little to no monetary or sentimental value, such as sugar packets or loose change.*
- *Lost items that are not listed under "must be reported."*

- ***NOTE:** In some situations, the facility may initially evaluate an occurrence to determine whether it meets the definition of an "alleged violation." For example, if a resident states that his or her belongings are stolen, the facility may make an initial determination whether the item has been misplaced in the resident's room, in the laundry, or elsewhere before reporting misappropriation of property. However, if the alleged violation meets the definition of abuse, neglect, exploitation or mistreatment, the facility should not make an initial determination whether the allegation is credible before reporting the allegation.*

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Examples of Reportable Allegations of Mistreatment

- ***"Mistreatment,"*** *as defined at §483.5, is "inappropriate treatment or exploitation of a resident."*
- *Examples of allegations of mistreatment may be identified under abuse and/or exploitation.*
- **Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602 and F603.**

Other Reportable Abuse

Visitor to Resident Abuse of Any Type

- *Allegations of abuse have been reported between spouses, or residents and their parents or children, in addition to visitors who are not members of a resident's immediate family. The surveyor may obtain information from the resident's social history, to the extent possible that identifies concerns or issues regarding relationships between the resident and relatives, friends, and/or visitors. The surveyor should interview the social worker and review the resident's assessment and care plan to determine whether the facility identified and provided interventions on how to address the concerns. (Also see F745-Medically Related Social Services).*
- *In addition, the survey team must review whether the facility has developed and implemented policies and procedures related to visitor access. This would include safety restrictions, such as denying access or providing limited and supervised access to a visitor who has been found to be abusing, exploiting, or coercing a resident or who is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed. Any such restriction should be discussed with the resident or resident representative first. Also, the resident maintains the right to deny visitation according to his/her preferences. See guidance at F563- Visitation Rights and F564- Resident Right to Visitors.*

Deprivation of Goods and Services by Staff

- *Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s).*
  - *We get many complaints about this both on site and through the complaint intake .*

Non-Sexual Physical Contact with Residents

- *Nothing in this guidance is intended to limit a resident's ability to receive non-sexual contact, such as holding a resident's hand. It is not the intent of this guidance for facilities to foster "no contact of any type" policies/procedures/practices between staff and residents or residents and others, assuming such contact is consistent with the resident's preferences. It should also not be assumed that all physical contact involving a resident would constitute sexual abuse.*

Capacity and Consent

- ***Capacity and Consent***
- *Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity.*

Investigation

- *Determinations of capacity to consent depend on the context of the issue and one determination does not necessarily apply to all decisions made by the resident. For example, the resident may not have the capacity to make decisions regarding medical treatment, but may have the capacity to make decisions on daily activities (e.g., when to wake up in the morning, what activities to engage in). Determinations of capacity in this context are complex and cannot necessarily be based on a resident's diagnosis alone. Capacity on its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation. Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with State law, if applicable. The facility's policies, procedures and protocols, should identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded. See also 42 CFR §483.10(f) [F561] for concerns related to the resident's right to self-determination through support of resident choice,*
- *and 42 CFR §483.10(b)(3)-(7) [F551] for concerns related to the exercise of the resident's rights by the resident representative.*

Residents with Designated or Legally Appointed Representatives

-A resident may have a representative that has been appointed legally under State law through, for example, a power of attorney, guardian, limited guardian, or conservatorship. These legal appointments vary in the degree that they empower the appointed representative to make decisions on behalf of the resident. While a legal representative may have been empowered to make some decisions for a resident, it does not necessarily mean that the representative is empowered to make all decisions for the resident. The individual arrangements for legal representation will have to be reviewed to determine the scope of authority of the representative on behalf of the resident.

-A resident may also have designated an individual to speak on his/her behalf for decisions for care or other issues. However, it is necessary for the resident, his/her representative and the facility to have a clear understanding of the types and scope of decision- making authority the representative has been delegated.

Residents with Designated or Legally Appointed Representatives

-Any decision-making power that is not legally granted to a representative under state law is retained by the resident. It is the responsibility of the facility to ascertain what decisions the representative is legally empowered to make on behalf of the resident.

-More specifically, regarding consent for sexual activity, State law and the legal instruments setting up resident representation may be silent on that topic. The facility must be aware of the representative's scope of authority regarding resident decision-making.

-When a resident with capacity to consent to sexual activity and his/her representative disagree about the resident engaging in sexual activity, the facility must honor the resident's wishes irrespective of that disagreement if the representative's legal authority does not address that type of decision-making for sexual activity. If the resident representative's legal authority addresses decision-making for sexual activity, then the facility must honor the resident representative's decision consistent with 42 CFR §483.10(b).

Allegations of Sexual Abuse

There are additional considerations when investigating allegations of sexual abuse involving:

- *Sexual abuse by a staff member;*
- *Resident to resident sexual abuse; and*
- *Sexual abuse by a spouse or visitor.*

For any alleged violation of sexual abuse, the facility must:

- *Immediately implement safeguards to prevent further potential abuse;*
- *Immediately report the allegation to appropriate authorities;*
- *Conduct a thorough investigation of the allegation; and*
- *Thoroughly document and report the result of the investigation of the allegation.*

- *See Tags F608, F609, and F610.*

Allegations Staff to Resident Sexual Abuse

Nursing home staff are entrusted with the responsibility to protect and care for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff member's role as a caregiver and will be considered an abuse of power. Also, for some health care professionals, it is prohibited by licensure or certification requirements for professionals to have a relationship with a resident (or patient).

***NOTE**: Refer to applicable State professional licensure/certification requirements and/or scope of practice.*

-Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed before the resident was admitted to the facility, such as a spouse or partner, and must be thoroughly investigated. However, in a rare situation, it may not be considered to be sexual abuse when a nursing home employee has a pre-existing sexual relationship with an individual, (i.e., spouse or partner) who is then admitted to the nursing home, unless there are concerns about the relationship not being consensual.

Allegations of Resident To Resident Sexual Abuse

Allegations of Resident To Resident Sexual Abuse

-Studies show that a considerable amount of unwanted sexual contact in nursing homes may be initiated by a resident who is sexually aggressive as a result of disease processes such as brain injuries or dementia. In addition, a resident may have a pre-occupation for sexual activity, or have had a prior history of sexual abuse. The resident who is sexually aggressive may target a resident who is unable to protect him/herself, and may involve various types of sexual aggression such as fondling both over and under clothing, masturbation in the presence of another resident and is unwanted by that other resident, forcing oral sex, or sexual intercourse.

-If there is an allegation that a resident did not wish to engage in sexual activity with another resident or may not have the capacity to consent, the facility must respond to it as an alleged violation of sexual abuse.

Allegations of Visitor to Resident Sexual Abuse

- ***Allegations of Visitor to Resident Sexual Abuse***
- *In certain situations, sexual activity between a resident and a visitor (e.g., spouse, partner) may not be considered to be abuse, if there was a pre-existing sexual relationship, the resident has the capacity and ability to consent, and the resident wishes to continue with the sexual relationship. Regardless, the nursing home must ensure that a visitor(s) is not subjecting any resident(s) to sexual abuse. In addition, the nursing home staff must immediately act on any allegation or suspicion that a visitor is engaging in improper sexual activity with a resident (See F608, F609, F610).*

Real Examples of FRIs

- Case 1
- Resident #1 used a wheelchair and could make his needs known. The resident was able to propel self in wheelchair. LD was alert with periods of disorientation. Res able to follow simple 1 step commands and communicated through words and gestures. LD was care planned that able to smoke but needed to be separated from other smokers to decrease agitation. Res. had room to self until recently, when got a new roommate and had been known to be cranky after new roommate transition.
-
- On 10/8/18 both residents were on smoking patio. The adm witnessed Resident #2 raise his fist at Resident #1 during the 11 am break after both wheelchairs became locked, when the two residents tried to pass each other. Resident #1 shrugged his shoulders and moved his wheelchair to pass LD without hitting his wheelchair. No physical contact was made. The adm immediately separated the two resident and explained to Resident #2 that bumping the chair was only an accident.
-
- Adm educated department heads with regard to Resident #2 care plan and asked them to place res on smoking patio away from group to decrease incidents of agitation. The dept heads shared the instructions with staff assigned to monitor smoking area.
-
- Police were not involved. The allegation was substantiated. ***This was not a deficiency and shouldn't have been reported to the state and it shouldn't have been substantiated.***

Case #2: Not Reportable not abuse

- Case 3
- Both Residents were alert, oriented and able to communicate needs verbally.
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- On 10/7/18 both Residents had a verbal altercation with each other. There was not any hitting or injuries noted to either Resident. Incident was witnessed by Staff - Charge Nurse on 2nd shift.
-
- Both Residents were interviewed. Both Residents were upset at first, calmed down and apologized to each other after the altercation. Res RD requested to change rooms and request was granted. There had not been any other concerns regarding either Resident.
-
- DSS nor Law Enforcement was called.
-
- Staff was in-serviced on Resident to Resident altercation.
-
- Fac substantiated the allegation of Resident to Resident based on statements from Res JT and Res RD. Both Residents admitted to the dispute. ***This should not have been substantiated, nor reported***

Case 3: Not reportable

- Res #1 was alert, oriented and was able to communicate needs verbally. Res was able to propel self via WC.
-
- Res #2 was alert with periods of disorientation. Res was able to follow simple 1 step commands. Res used words and gestures to communicate. Res was Care Planned to smoke but was recommended to smoke away from other Residents.
-
- On 10/8/18 both Residents were on the designated smoking patio and were smoking. Res Res. #2 flicked a cigarette at Res #1. The cigarette did not reach Res #I. Res #2 was informed that the behavior was not acceptable and was removed from the smoking patio.
-
- Res #2 was not frightened or upset. Res did not receive any injuries. All Residents in the smoking area wore smoking aprons and the area was supervised.
-
- The incident was witnessed by Staff

Tag: Should it have been cited?

- F 609
-
- Based on staff interviews and record review, the facility failed to file at 24-hour and 5-day report to the Health Care Personnel Investigations Division for an incident of resident (Resident #55 toward Resident #3) to resident abuse. Resident #55 hit Resident #3 on the back of the head with no negative outcome to Resident #3. This was for 1 of 1 incident reviewed for resident to resident abuse.
-
- The findings included:
- Review of the facility policy titled: "Reporting Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property" dated last revised 4/26/17 read as follows: The state survey agency and state agency for adult protective services should be notified in accordance with state law through established procedures of any allegation of abuse within 2 hours after the allegation is made if the events upon which the allegation is based involves abuse. If the events upon which the allegation is based do not involve abuse and do not result in serious injury, the allegation many be reported no later than 24 hours.
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- a. Resident #55 was admitted on 10/3/16 with a diagnosis of unspecified Schizophrenia. Resident #55's quarterly Minimum Data Set (MDS) dated 12/8/17 indicated he had a Brief Inventory of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment and was not coded for any behaviors.
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- b. Resident #3 was admitted 5/13/14 with cumulative diagnoses of seizures and dementia. Resident #3 quarterly MDS dated 12/14/17 indicated a BIMS score of 2 indicating severe cognitive impairment and he was coded for behaviors not directed toward other.
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- Review of a nursing note dated 1/12/18 at 9:20 AM read Resident #55 and Resident #3 had a verbal altercation in the hall. The note indicated both residents were separated at that time. Resident #55 went into the dining room where Resident #3 was sitting and hit Resident #3 with an open hand on the back of the head. Both residents were again separated. The psychological services provider was called and Resident #55's medications were adjusted. The responsible party for both residents were notified as well as the physician.

A great interview

- An interview was conducted with Resident #1's MD on 01/24/19 at 11:08 AM. The MD stated that on the morning on 12/06/18 one of the NAs noticed Resident #1 was weak and she notified the nurse and the nurse went and assessed her and found the weakness and signs of stroke. The Nurse notified the NP who came to work early in the morning and she evaluated Resident #1 and sent her to the ER. The MD stated that she generally did not get hospital records from patients unless she needed additional information. The MD reviewed the hospital records and stated that the CT basically showed a stroke that was literally in the middle of the event which could go on for hours. The MD stated that the window for TPA was 3 hours but is also dependent upon other factors like age, health, co-morbidity and if the patient can handle the TPA. The MD stated that Resident #1 was her usual self on 12/05/18 when she evaluated her and was sleeping through the night and staff noted the weakness, facial droop, and slurred speech at 5:30 AM but had no idea of when those symptoms started. The MD added that she wished the staff would have contact the on-call MD so that they could have gotten Resident #1 to the hospital sooner but was not sure if that would have changed the outcome. The MD stated that Resident #1 should have been a code stroke immediately when staff noted the symptoms. She added that she had counseled the daughter that Resident #1 was having mini strokes and Resident #1 was comfort care only and according to that I should not even sent her to the hospital. However, the family faced with likely stroke the family wanted everything done so it was appropriate to send her to the hospital. The MD added that Resident #1 experienced the consequences of bad vascular disease.