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To: DQA BNHRC Staff

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Surveyor Guidance on Investigating & Reporting Alleged Violations

The purpose of this memo is to clarify for BNHRC survey staff what constitutes an alleged violation, including a violation of resident-to-resident abuse, which should be reported. For purposes of this memo, an incident includes any allegation involving mistreatment, abuse or neglect of a resident, misappropriation of a resident's property, or injuries to a resident of unknown source.

This memo contains important clarification regarding:

- Definitions under Federal and State Law;
- Nursing Home Investigating & Reporting Requirements;
- Resident-to-Resident Altercations;
- Case Examples; and
- Resources.

Per CMS direction, all nursing homes must immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the facility administrator and to the Division of Quality Assurance (DQA). CMS defines "immediately" to be as soon as possible but not to exceed 24 hours after discovery of the incident.

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further incidents while the investigation is in progress. The results of all investigations must be reported to the administrator (or their designee when the administrator is absent from the building) and to the DQA Office of Caregiver Quality (OCQ) within 5 working days of the incident. If the alleged violation is verified, the facility must take appropriate corrective action.

Definitions under Federal and State Law

The attached document, entitled "Misconduct Definitions," provides a comparison of the federal and state definitions in nursing home settings. Participating Medicare and Medicaid nursing homes must first review the federal definitions; if an incident potentially meets the federal definition, it is not necessary to review the state definitions.

Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Because the federal definitions do not specify that the incident has to involve a caregiver, nursing homes are required to submit allegations of abuse or mistreatment by anyone, including resident-to-resident incidents, to DQA immediately.

Nursing Home Investigating & Reporting Requirements

Reference:
- CMS S&C Memo 05-09
- DQA Memo 10-008 with Misconduct Definitions

All nursing homes must develop written procedures specifying:

- What incidents are to be reported and when;
- How and to whom staff are to report incidents;
- How internal investigations will be completed for different types of investigations and what constitutes a "thorough" investigation;
- How residents will be protected from further incidents while an investigation is conducted;
- How staff will be trained on the procedures related to allegations of misconduct; and
- How residents (and guardians, as appropriate) will be informed of those procedures.

All nursing homes must ensure that all employees, contractors, volunteers, and residents are knowledgeable about the nursing home's reporting procedures and requirements. Staff must be trained to immediately report to the administrator (or their designee when the Administrator is absent from the building) all incidents of misconduct, including abuse or neglect of a resident, misappropriation of a resident's property, or injuries to a resident of unknown source. Immediately upon learning of an incident, nursing homes must take the necessary steps to protect residents from possible further incidents of misconduct or injury.

Initial Evaluation

In limited circumstances when it is unclear whether an allegation meets the definition of a reportable incident, nursing homes may first conduct an initial evaluation of an allegation. Generally the initial evaluation is restricted to misappropriation of a resident's property and injuries of unknown source. For example, a resident alleges that someone took something belonging to them so staff ask to check the closets and drawers for the missing item or a resident

has an unexplained injury so staff check the chart to see if someone had witnessed an injury earlier and ask the DON if anyone reported it.

Missing Item example:

Resident Carl reports to CNA Joan that someone has stolen his bathrobe. Joan reports the allegation immediately to her supervisor, Louise. Louise knows that Carl's family often does his laundry. Louise calls Carl's daughter who confirms that she took the bathrobe home with her yesterday.

In this case, the initial evaluation determines that no misappropriation of Carl's property occurred. It is not necessary to report the allegation to DQA.

Injury example:

RN Monique observes a bruise on the right hand of Resident Linda. Monique asks Linda how she got the bruise. Linda replies that she doesn't know. Although Monique doesn't find the bruise particularly suspicious, she checks Linda's records and finds that a CNA saw Linda bump her right hand into a wall two days before and another CNA documented the bruise later that night.

In this case, the initial evaluation confirms that no injury of unknown source occurred because there is documentation in the file about the source of Linda's injury. It is not necessary to report the injury to DQA.

If these steps have been taken and documented, it is not necessary for the entity to immediately report or conduct a thorough investigation. An initial evaluation should be concluded quickly and does not extend the timeline for reporting.

Thorough Investigation

All nursing homes must immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident and document the findings for each incident. A thorough investigation may include:

- Collecting and preserving physical and documentary evidence;
- Interviewing alleged victim(s) and witness(es);
- Interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source;
- Interviewing other residents to determine if they have been abused or mistreated;
- Interviewing staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused;
- Interviewing staff who worked previous shifts to determine if they were aware of an injury or incident; and
- Involving other regulatory authorities who may assist, e.g., local law enforcement, elder abuse agency, Adult Protective Service agency.

CMS does not specifically identify what information must be included in a thorough investigation. If you determine that the facility did not conduct a thorough investigation, then it's important to identify what information was not obtained by the facility during their investigation and why the information may have had an impact on the outcome of the investigation. The surveyor should attempt to interview facility staff that conducted the investigation and ask why they did not obtain the information as a part of their investigation.

The response from facility staff should be considered when determining whether the facility's investigation was thorough.

Resident-to Resident-Altercations

Reference: Resident-to-Resident Altercation Flowchart

An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as a potential situation of abuse under the guidance for 42 C.F.R. § 483.13(b) at F223. Note that the federal definition of abuse indicates that the act must be "willful" and that it needs to have resulted in physical or psychosocial harm to the resident or would be expected to have caused harm to a "reasonable person" if the resident cannot provide a response.

For a definition of "willful," refer to the interpretive guidelines at F323 Resident-to-Resident Altercation where, under Resident-to-Resident Altercations, it notes, "An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance for 42 CFR §483.13(b) at F223. "Willful" means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under F323."

All altercations must be immediately reported to the administrator; further, all incidents must be reported to DQA if facility staff members determine that the aggressor's actions were willful or if the facility cannot immediately rule out willful intent. Providers may immediately conduct an initial evaluation to analyze a resident-to-resident altercation to determine if it meets the definition of abuse (e.g. the resident(s) had willful intent and resulted in physical or psychosocial harm to a resident).

Neither CMS nor DQA mandate a specific evaluation tool or method. Facilities use a variety of assessments in determining a resident's mental status. Questioning the resident about his/her understanding of the consequences of his /her actions is important. This interview should take place immediately after the occurrence, if possible. If the resident cannot understand cause and effect, cannot remember the incident or understand what is being referred to, it is unlikely that the resident is/was able to form intent. On the other hand, if the resident remembers the occurrence, knows that his/her actions could have harmed another person, or verbalized intent (e.g., "I'm going to get you"), then the resident is/was able to form intent. Under these circumstances, the incident is reportable if injury, or the potential for psychosocial injury using the reasonable person concept, has occurred.

A diagnosis of dementia or Alzheimer's does not rule out the ability of a person to form intent. The facility needs to determine if the resident has the ability to understand the possible outcome of his/her actions. Does the resident understand that if s/he hits, bites, pushes, etc. another person, that person could be injured? If the resident does not understand, the incident is not reportable. If the resident does understand, or if the facility does not rule out intent (either because the facility did not try to determine intent or was unable to rule out intent), then the incident should be reported if injury, or the potential for psychosocial injury using the reasonable person concept, has occurred.

In determining "willful," surveyors should interview facility staff who conducted the investigation and ask how they determined whether the resident's action was willful or not willful. Observe the resident, and review the resident's record, including the Resident Assessment Instrument, progress notes, physician's orders, and nurses' notes for an assessment of the resident's overall condition and behavioral history. Surveyors should not cite the failure to report resident-to-resident altercations (as abuse) to DQA unless the altercation resulted in physical or psychosocial harm (may apply the reasonable person concept) and there is evidence of willful intent.

Case Examples

Two residents, each with a diagnosis of dementia are involved in an altercation. Staff heard the residents yelling and found resident A standing over resident B. Resident A was shouting, "I told you to stay out of my room." Resident B was lying on the floor of resident A and had sustained a one-centimeter laceration to his arm. When questioned, resident B was unable to relate what happened. Resident A stated that he struck resident B when he failed to leave the room. Resident B has a history of wandering and resident A has a history of being very territorial.

Analysis: Both elements of abuse - injury (1-cm. laceration) and intent - are present so this is reportable. Resident A was able to state that he had hit resident B and gave the reason for striking him. This would indicate an ability to form intent. The resident had an injury, a laceration to his arm. In addition to reporting, the facility is responsible for assessing the situation, identifying measures to keep residents safe, and for updating the care plans of Resident A and/or B.

While being pushed in her wheelchair in the hallway, resident A, who has dementia and a history of striking out, swats resident B on the arm as she passes her. Resident B states she is not hurt (no pain) and that she is not afraid of resident A. When asked why she hit resident B, resident A does not recall having done this.

Analysis: Neither of the elements of abuse are present so this is not reportable. It does not appear that resident A is/was able to form intent because she does not recall the incident. Resident A's care plan shows that she has a history of unprovoked striking out and her assessment shows that she does not understand that this could hurt someone. Injury has not occurred; resident B does not have a laceration, denies pain, and states she is not afraid of Resident A. Even though this is not reportable, the facility is responsible for assessing the situation, identifying measures that may be needed to keep other residents safe from Resident A, and updating the care plan as necessary.

A staff member observed a male resident fondling the breasts of a female resident. The female resident was interviewed but has severe dementia and could not relate what happened. The male resident has a psychiatric diagnosis but was able to be interviewed. He denied fondling the resident.

Analysis: This is reportable. The female resident has a history of severe dementia and is unable to give consent. There is nothing in the record to indicate that these two residents have an intimate history and that this was a consensual act. Although the male resident has a psychiatric

diagnosis, the facility was able to interview him and believed that he knew what he was doing. Regardless of whether this was a reportable incident, the facility is responsible for assessing the situation, identifying measures to keep residents safe, and for updating the care plan(s) of the residents involved.

Staff overheard resident A, who is alert and oriented, shout at his roommate (resident B), "Shut the hell up. You moan all the time. Shut up or I'll shut you up."

Analysis: This is reportable because verbal abuse has occurred. Resident A has knowingly threatened resident B. Intent to cause harm is present. Federal interpretative guidelines define "verbal abuse" as the use of oral, written or gestured language and include "threats of harm", regardless of the age, ability to comprehend, or disability of the victim.

A resident's daughter reported that her mother's ruby ring, which she last saw two days ago, was missing. The resident has mild dementia, but the daughter insisted the resident did not misplace it. The daughter implied a staff member was responsible.

Analysis: At this point this is not reportable because the facility has no evidence of deliberate misplacing or wrongful use of the ring. The ring could be lost. The facility can conduct an initial search. If staff do not find the ring during this initial search (which must be done immediately), this is reportable.

The facility was given $21.00 by three different families on Wednesday, so their family members could go to the zoo outing on Friday. The person at the desk took the money and gave it to the nurse, who locked it in the medicine drawer. On Friday morning, the Social Worker asked the nurse for the money for the three residents to go to the zoo. There was no money in the medicine drawer.

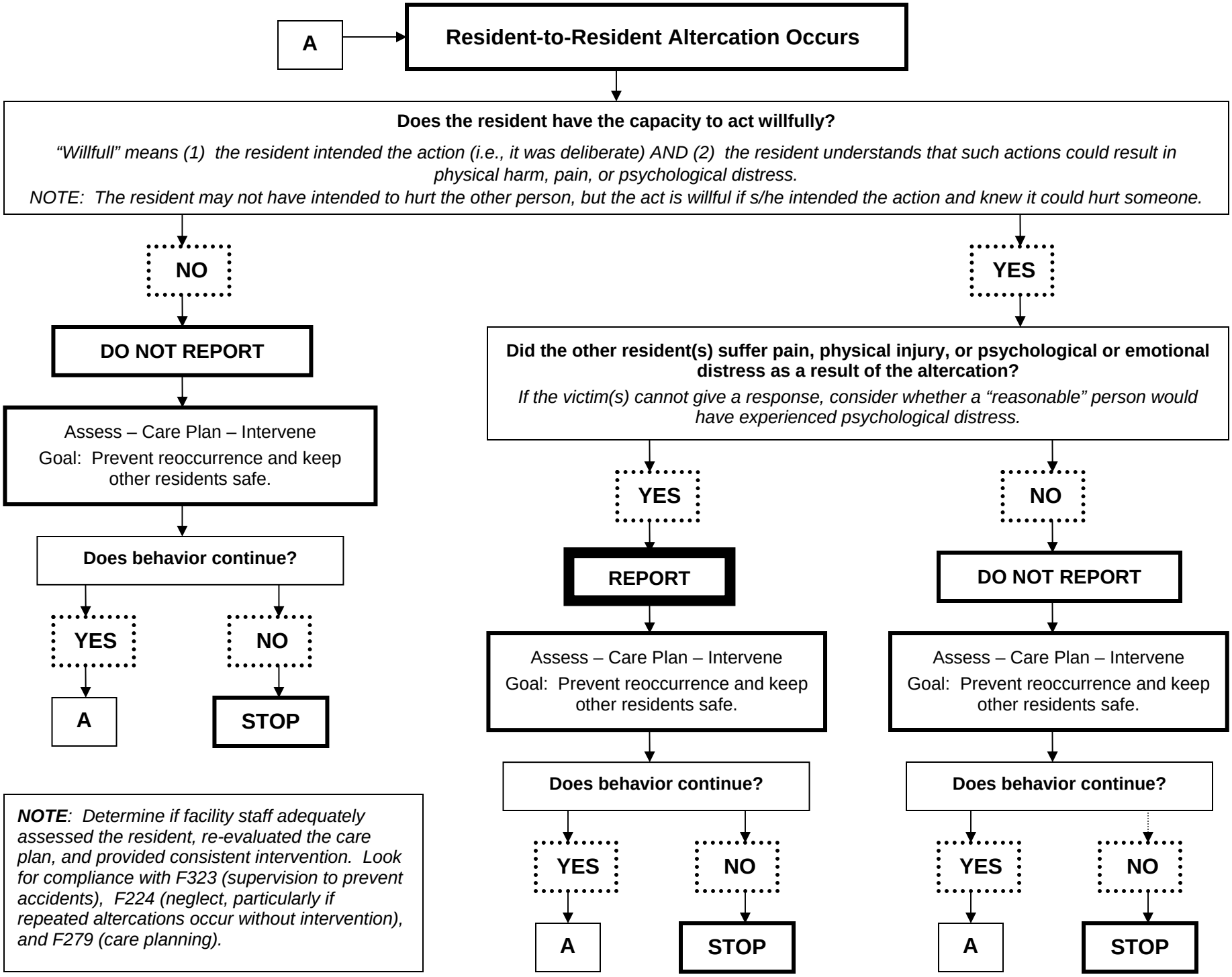
Analysis: The facility could not immediately determine what had happened to the money because the staff who were questioned denied any knowledge of the missing money. This is reportable. The money was in a locked drawer and only the staff had a key to the drawer.

Resources

See the following investigation resources:

- Wisconsin Caregiver Abuse and Neglect Prevention Project
- Investigation Protocol
- Conducting Internal Investigations of Caregiver Misconduct Training – Webcast Series
- Suggested Sexual Assault Response Protocol

Attachment: Resident-to-Resident Altercation Flowchart


A
Resident-to-Resident Altercation Occurs
Does the resident have the capacity to act willfully?
"Willfull" means (1) the resident intended the action (i.e., it was deliberate) AND (2) the resident understands that such actions could result in physical harm, pain, or psychological distress.
NOTE: The resident may not have intended to hurt the other person, but the act is willful if s/he intended the action and knew it could hurt someone.
NO
DO NOT REPORT
Assess – Care Plan – Intervene
Goal: Prevent reoccurrence and keep other residents safe.
Does behavior continue?
YES
A
NO
STOP
YES
Did the other resident(s) suffer pain, physical injury, or psychological or emotional distress as a result of the altercation?
If the victim(s) cannot give a response, consider whether a "reasonable" person would have experienced psychological distress.
YES
REPORT
Assess – Care Plan – Intervene
Goal: Prevent reoccurrence and keep other residents safe.
Does behavior continue?
YES
A
NO
STOP
NO
DO NOT REPORT
Assess – Care Plan – Intervene
Goal: Prevent reoccurrence and keep other residents safe.
Does behavior continue?
YES
A
NO
STOP
NOTE: Determine if facility staff adequately assessed the resident, re-evaluated the care plan, and provided consistent intervention. Look for compliance with F323 (supervision to prevent accidents), F224 (neglect, particularly if repeated altercations occur without intervention), and F279 (care planning).