VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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Memorandum

To: Nursing Home Administrators

From: Suzanne Leavitt, RN, MS
State Survey Agency Director

Date: Revised October 1, 2015 (originally distributed April 18, 2013)

Subject: Resident to Resident Incident Reporting for Nursing Homes

This memorandum is intended to provide clarification to nursing homes regarding Resident to Resident incidents/altercations and how the reporting requirements (under federal CMS regulations (42 C.F.R. 483.13(c)(2) - (4)), the Affordable Care Act, and Vermont Licensing and Operating Rules for Nursing Homes) apply to these incidents. This memorandum does NOT include specific guidance about Adult Protective Services reporting requirements.

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*Refer also to Memo dated **January 10, 2013 (also revised 10/1/15)** for more general information regarding required reports to the State Agency (DLP).

1. Vermont State Requirements:

(1) The facility must ensure that all alleged violations involving mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and the licensing agency and Adult Protective Services in accordance with 33 V.S.A. Chapter 69. [Regulation 3.17(f)]

*The Federal requirements are stricter regarding reporting of resident to resident abuse, so this document will focus on Federal reporting requirements.

2. Federal CMS Requirements:

As specified in F225 (42 CFR 483.13(c)(2) - (4)), the following alleged violations must be reported immediately to the administrator of the facility, other officials in accordance with state law, and the state survey and certification agency.

> ***Note:** The requirement that all alleged violations must be reported immediately is interpreted by CMS to mean as soon as possible, but not to exceed 24 hours. In order to prevent unnecessary calls to your facility, this report should identify the nature of the incident, the name of all residents involved, and the name of all staff members involved and any immediate actions taken by the facility.

(1) Abuse - The willful infliction of injury, unreasonable confinement, intimidations, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. §488.301).

> ***Note** that the federal definition of abuse indicates that the act needs to be "willful" and that it needs to have resulted in pain, mental anguish, or physical harm to the resident, or would be expected to have caused pain, mental anguish, or harm to a "reasonable person" if the resident cannot provide a response.
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> "Willful" means that the individual intended the action itself. Examples include intentional hitting, slapping, pinching, kicking, pushing, etc. Even though a resident may have a cognitive impairment, he/she could still commit a willful act.

***Note:** in the interpretive guidance, CMS prohibits states from eliminating the obligation to report abuse, prohibits states from establishing longer time frames for reporting, and prohibits states from overriding the obligation of Nursing Homes to fulfill these requirements so long as the facility is Medicare/Medicaid Certified.

3. How the Federal Requirements Pertain to Resident to Resident incidents:

When a resident abuses another resident it falls under these requirements for reporting abuse. This was recently verified with CMS staff in our Regional Office. As noted above, even though a resident may have cognitive impairment, they can still commit willful acts. The resident does not have to know the consequences of his/her action for it to be willful. Examples of willful acts include, but are not limited to:

- hitting, punching, slapping, pinching or kicking another resident
- verbally assaulting another resident
- purposeful pushing or another resident (i.e. not as a result of an accident or an involuntary bodily movement)
- threatening another resident
- non-consensual sexual acts or sexual harassment

CMS states in its definition of abuse that the actions or words need to result in **physical harm, pain or mental anguish**. When a resident is a victim of resident to resident abuse, she/he needs to be assessed not only for physical harm, but should be assessed by a qualified person for psychosocial or mental harm. Some examples of ways to assess for psychosocial or mental harm by a qualified person include ongoing monitoring for at least 24 - 48 hours and documentation of monitoring for signs of:

- increased anger/aggression/combativeness
- increased anxiety (or increased use of, or requests for anti-anxiety medication)
- apathy
- depressed mood
- exhibiting fear of others
- withdrawing from social interactions
-change in sleep patterns

When cognitive impairment or other circumstances prohibit an accurate assessment of pain, psychosocial or mental harm, CMS states in Appendix P of the State Operations Manual that the "reasonable person" concept should be used to determine the actual or potential outcome to the resident. To apply the reasonable person concept, the facility should assess what degree of actual or potential harm one would expect a reasonable person in a similar situation to suffer as a result of the incident.

4. Affordable Care Act Requirements regarding Reporting of Crimes

Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act:

> Reporting Suspicion of a Crime: Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility.
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> Reporting to State Survey Agencies (SAs) and Law Enforcement: Reports must be submitted to at least one law enforcement agency of jurisdiction **and** the State Survey Agency (DLP – S&C).
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> Section 1150B establishes **two time limits** for the reporting of reasonable suspicion of a crime, depending on the seriousness of the event that leads to the reasonable suspicion.
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> a. *Serious Bodily Injury* – ***2 Hour Limit***: If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion;
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> b. *All Others* – ***Within 24 Hours***: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion.

5. How the Reporting of Crimes pertains to Resident to Resident incidents:

All Nursing Homes were required to work with local law enforcement to establish what constitutes a crime in their local area when this law and information was distributed to Nursing Homes in 2011.

If a Resident to Resident incident meets the definition of a crime, then the crime must be reported to the State Survey Agency (DLP – S&C) in addition to local law enforcement within **2 hours** if serious bodily injury occurred and within **24 hours** if the result is not serious bodily injury as defined above.

The policies of the facility should reflect the agreement between the local law enforcement agency and the facility in terms of what constitutes a crime.

6. Decision-Making Tips on how to know when a report to DLP is required under F225 (these are only tips to assist, call with questions):

1. If any resident hits, punches, slaps, pinches, kicks or pushes another resident on purpose (i.e. the action is willful and not as a result of an accident or involuntary bodily movement).

1.a. If the victim is cognitively impaired and cannot report if the action caused pain or mental anguish, put yourself in the victim's position and ask yourself if it would hurt or cause you mental anguish if it happened to you in your home or place of work (applying the reasonable person concept).

2. If any resident verbally abuses another resident, meaning that they threaten to harm the resident or they use oral, written, or gestured language that willfully includes disparaging and derogatory terms.

2.a. If the victim is cognitively impaired and cannot report if the words/language caused mental anguish, put yourself in the victim's position and ask yourself if it would cause you mental anguish if it happened to you in your home or place of work.

3. Any resident to resident sexual abuse, which includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.

3.a. If the victim is cognitively impaired and cannot report if the actions/language caused pain or mental anguish, again put yourself in the victim's position and ask yourself if it would hurt or cause you mental anguish if it happened to you in your home or place of work.

4. If a resident alleges they have been abused, mistreated, neglected, or allege that their property has been stolen.

5. If there is an injury of unknown source (bruising, fractures, etc.) discovered.
An injury should be classified as an "injury of unknown source" when both of the following conditions are met:

-The source of the injury was not observed by any person **or** the source of the injury could not be explained by the resident or after assessment by the staff

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.

7. Tips on How to Maintain Compliance and Prevent Further Abuse:

1. Report to the State Survey Agency per CMS requirements (within 24 hours) and within the timeframes outlined in the reporting of crimes (within 2 hours if serious bodily injury occurred as the result of a crime). *After the initial report, the facility has 5 working days to complete the thorough investigation and send the results to S&C.

2. Thoroughly investigate the incident and prevent further potential abuse while the investigation is in progress.

2.a. Tips on a thorough investigation of Resident to Resident incidents (root cause analysis):

- Follow facility policies and procedures for investigating abuse or injuries of unknown source;

- Interview all residents and staff involved or who may have witnessed the incident, to determine what occurred prior to the incident to try to determine the contributing factors leading up to the incident;

- Determine whether the Resident's care plan was being implemented correctly by staff regarding level of supervision, behavior monitoring, and/or interventions required for any known behaviors and determine whether staffing levels contributed to any failures to implement the care plan;

- If the facility is investigating an injury/bruise of unknown source, it is very important to interview all staff members that provided care to the resident for a sufficient period of time prior to the discovery of the injury/bruise. Also, when investigating an injury/bruise of unknown source, it may be useful to perform re-creations of certain situations or care scenarios.

- Document all of the above to be able to show evidence of a thorough investigation.

3. Send the results of the investigation to the State Survey Agency **within 5 working days of the incident**, and if the alleged violation is verified, appropriate corrective action must be taken.

4. Per CMS interpretive guidance, if any resident, at the time of admission, has a history that puts them at risk for abusing other residents, the facility is required to develop intervention strategies to prevent occurrences of abuse. Also, the facility should monitor the resident for changes that would trigger abusive behavior and should reassess the interventions to prevent abuse on a regular

basis. *Regardless of history, it is the obligation of the facility once they admit a resident to protect that resident from abuse by anyone, including other residents.

5. If there is an incident of resident to resident abuse, the facility is responsible for preventing further abuse from happening. The care plan should address what interventions staff are to utilize to prevent further abuse.

5.a. For the alleged perpetrator, the care plan should address what interventions the facility is utilizing to prevent further abuse since the resident now has a known history of abusive actions/behavior.

5.b. For the alleged victim, the facility should investigate whether the victim's condition or actions put them at increased risk of being a victim of abuse (such as wandering into other resident's rooms). If there are conditions or actions that put them at increased risk, interventions should be put in place to prevent further abuse of that resident.

6. The facility is also responsible for providing Social Services related to residents with behavioral issues, as well as providing Social Services to address the mental, psychosocial, emotional needs of residents who are victims of abuse. (Refer to CMS regulation F250 for requirements related to Social Services)

8. Explanation of the differences between APS and S&C:

There have been many questions regarding APS and S&C. Both programs are housed in the Division of Licensing and Protection, but the programs are very separate. The 2 programs have different definitions of abuse and different statutory requirements when it comes to investigating abuse. There is often confusion about the various stages of investigation by both programs.

When a facility submits a self report of a resident to resident incident, S&C staff will ALWAYS contact the facility to confirm receipt and will often request further information from the facility to be able to review the incident using the guidelines in Chapter 5 of the CMS State Operations Manual.

You may get a letter from APS saying that they are closing the case, but that does not reflect any S&C decision on the case.

APS staff may investigate independent from S&C before, during, or after the S&C investigation. Our investigations are kept separate due to the difference in abuse definitions and the way the APS statute is interpreted. Examples of resident to resident abuse where there have been both APS and S&C investigations include – incidents involving death or serious injury, sexual abuse, or a pattern of resident to resident abuse involving the same resident.

*Please contact Pamela Cota, RN, BS, if you have any further questions.