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HEALTH & WELFARE

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INFORMATIONAL LETTER #2014-04
Replaces Informational Letter #2005-1

DATE: May 23, 2014

TO: ALL LONG TERM CARE FACILITIES IN IDAHO

FROM: DEBBY RANSOM, R.N., R.H.I.T., Chief
Bureau of Facility Standards

SUBJECT: **RESIDENT ABUSE REPORTING IN SNF/NF'S**

State law and federal regulations require that SNF/NF's report certain events to the survey agency. This guidance includes updated reporting direction for facilities. This replaces Informational Letter #2005-1. Regulatory references include §483.13(b) and (c), 483.25(h) and IDAPA 16.03.02.100.12.c. and f. Failure to comply with these reporting requirements may result in serious citation(s) at one or more of these regulations.

Types of Abuse that must be Reported:

- Physical abuse. This is non-accidental contact with a resident including hitting, kicking, slapping, biting, pinching. Report all such occurrences even if no mark is left on the resident.

- Sexual abuse. This includes sexual harassment or sexual assault. This further includes sexual behavior between two individuals, at least one of whom cannot make informed consent. For example, sexual behavior between two residents with Alzheimer's dementia, who are not able to form a rational decision or legal consent (Brief Interview for Mental Status (BIMS) = 0-12), would be an incident of sexual abuse, even though the residents may be calm and agreeable.

If any resident alleges he/she was raped, it must be treated as a serious allegation of sexual abuse regardless of the resident's cognitive status. The police should be notified and an exam should be performed by qualified emergency room staff.

- Verbal or mental abuse. Examples include humiliation, threats of physical abuse or deprivation, or use of derogatory names. Resident-to-resident verbal/mental abuse need only be reported if it results in psychological harm, severe distress, or if it is a pattern of behavior (occurs three times or more).

- Involuntary seclusion. This includes separating a resident from other residents through confinement in a room against the resident's wishes. The Guidance to Surveyors at F223 explains special times when involuntary seclusion may be used as a last resort to keep residents safe.

Incidents that must be Reported:

- Resident-to-resident abuse incidents.

- Staff-, family-, visitor-to-resident abuse incidents. For incidents where a licensed nurse was the perpetrator, also notify the Board of Nursing at 208 / 334-3110.

- Resident injuries of unknown origin. These are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; **and**, the injury includes bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities need not be reported. Injuries found immediately after a fall need not be reported as "unknown origin".

- Misappropriation of resident property by staff or others. This is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

- Mistreatment – The negligent commission or omission of acts that result in harm.

- Neglect – Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Specific Possible Neglect Situations that must be Reported:

- *Staff mistakes* that result in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death. Some examples of staff mistakes include failure to adhere to the care plan, failure to

notify the physician timely of a significant change, failure to implement nursing standards. (See **Staff Management** below.)

- Accidents involving facility-sponsored transportation resulting in resident injury. Examples: falling from the facility's van lift, wheel chair belt coming loose during transport, accident with another vehicle, etc.

- Resident elopement of any duration. Elopement is defined as when a resident who is unable to make sound decisions (Brief Interview for Mental Status (BIMS) = 0-12) "leaves the premises or a safe area without authorization and/or necessary supervision to do so".

- Resident suicide or attempted suicide.

Other Situations that must be Reported and Investigated:

- Accidental death of a resident from any cause. This includes accidents that result in injury for which the resident is hospitalized and subsequently dies in the hospital.

- Any resident death, from any cause, that occurs while the resident is physically restrained.

- Any occurrence that causes any resident(s) to be evacuated from any portion of the licensed facility.

- Power outage of more than one hour.

- Planned admission of a registered (from any state) sex offender. Please be prepared to provide a detailed care plan showing how residents and/or vulnerable visitors will be kept safe from potential abuse.

For all of the above incidents: All allegations must be immediately reported to the facility's Administrator and to the Department's hotline, 1-208-364-1899. 'Immediately' means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident. Fax the completed investigation to the survey agency within five (5) working days, 1-208-364-1888. All investigation reports must include the facility's **conclusions** and **actions taken to prevent a repeat occurrence of abuse, neglect, or misappropriation**.

All investigations must be signed by the Administrator within five (5) working days of the allegation/incident. This signature indicates the administrator has reviewed the

investigation, approves it as complete, and has ensured that appropriate measures have been taken. If the Administrator is out of the facility, his/her designee may sign the investigations. When the Administrator is on duty, this responsibility cannot be delegated to other staff.

It is not necessary to call and speak to a supervisor directly when reporting any of the above incidents. You are still welcome to call if you have questions.

Idaho's Adult Protection law, IC 39-5303(b) further requires that when the facility has reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult, the facility must report this to law enforcement within four (4) hours.

Idaho's Skilled Nursing Facilities/Nursing Facilities do not need to report incidents of resident abuse, neglect, or exploitation to Adult Protection. IDAPA 39-5303 (1) directs SNF/NF's to report these incidents to the Department.

Staff Management:

- If the facility determines that a staff member abused a resident, F225 requires the facility to terminate the staff member.

- If a staff member makes an error that meets the definition of neglect (above), the incident must be reported to the survey agency. However, the regulations do not require the termination of the staff member unless the facility concludes the neglect was intentional (willful or deliberate). The Bureau will not open a CNA case on reported incidents of CNA neglect unless the facility's investigation provides evidence the neglect was intentional.

Investigation Guidance:

A thorough investigation is critical to developing effective prevention strategies. Each facility is required to have a policy/procedure related to incident investigation. Every incident is unique. Facility investigators must ask probing questions to get to the root cause. While no guidance can identify every aspect of a good investigation, some essential components of a thorough investigation include:

- Date and time of the incident.

- A clear and legible description of exactly what occurred.

- All pertinent staff, resident(s), and other witnesses must be interviewed and the results of the interview documented in some form. Whenever possible, have witnesses sign a written statement.

- If a staff person is accused of any of the above, that person must be interviewed regarding the allegations and that interview must be documented. The facility must attempt to get a signed, written statement from the accused. If the accused refuses to give a signed written statement, the facility must document that refusal along with the interview. The accused staff person must be suspended until the investigation is completed, in order to protect residents from further abuse. The accused staff person may not be reassigned to another department in the facility or to a sister facility.

- Interview the resident(s) involved.

- All visible injuries must be **measured** and described in detail.

- In cases of injury of unknown source, all staff having possible contact with the resident over the 24 hours prior to injury discovery must be interviewed.

- In cases of unwitnessed incidents, the facility needs to determine when the resident was last observed by staff and what the resident was doing at that time.

The facility must determine whether specific care plan approaches intended to prevent incidents (such as observation at designated intervals), were being implemented as planned.

If you have any questions, please contact Lorene Kayser, LSW, QIDP, or David Scott, RN, Co-Supervisors of the Long Term Care unit at 208/334-6626, option 2.

Debby Ransom

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DR/nm
c: Idaho Health Care Association