Abuse and Neglect Implementation Checklist (F600)

On June 29, 2022, the Centers for Medicare & Medicaid Services (CMS) updated Appendix PP of the State Operations Manual. New and revised guidance covers significant sections of the Requirements of Participation and must be implemented by October 24, 2022.

LeadingAge has developed implementation checklists to assist members as they work toward compliance. The checklists and other resources are not exhaustive and LeadingAge strongly encourages members to review the CMS guidance to ensure compliance with all required elements.

Excerpts from the guidance and suggested action items are organized according to the headings provided by CMS in the State Operations Manual, Appendix PP. Excerpts are italicized, with new/revised guidance noted in red text.

483.12 Freedom from Abuse, Neglect, and Exploitation – F600 Free from Abuse and Neglect

Resident to Resident Abuse of Any Type (p. 70)

New Guidance (in red):

A resident to resident altercation should be reviewed as a potential situation of abuse. The surveyor should not assume that every resident to resident altercation results in abuse. For example, infrequent arguments or disagreements that occur during the course of normal social interactions (e.g., dinner table discussions) would not constitute abuse. The surveyor must determine whether the incident would meet the definition of abuse. Also, 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.

Action Items:

- ☐ Review abuse prevention policies, including any policies on resident to resident altercations and resident to resident abuse.

- ☐ Discuss with staff how to distinguish between resident to resident altercations and resident to resident abuse. Pay particular attention to the definition of "willful" as it relates to abuse.
- ☐ Identify and review care plans of residents with known histories of distressed behavior including physical, sexual, or verbal aggression to ensure appropriate interventions.

Capacity and Consent (p. 74)

New Guidance (in red):

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 take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity.

Action Items:

- ☐ Review "Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists - © American Bar Association Commission on Law and Aging – American Psychological Association, located at http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf for information related to capacity to consent.
- ☐ Review abuse prevention policies and any policies on resident sexual activity to ensure policies, procedures and protocols, 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.
- ☐ Consider establishing an ethics committee, that includes legal consultation, in order to assist in the development and implementation of policy related to aspects of quality of life and/or care, advance directives, intimacy and relationships.
- ☐ Provide information and education to staff, residents, and resident representatives related to capacity to consent.
- ☐ Review care plans regularly related to capacity to consent and intimate relationships.

Determination of Past Noncompliance (p. 79)

New Guidance:

NOTE: When a facility has identified abuse, the facility must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. Facilities that take immediate action to correct any issues can reduce the risk of further harm continuing or occurring to other residents, thereby potentially preventing the scope and severity of the deficiency from increasing. Failure to take steps could result in findings of current noncompliance and increased enforcement action, including, but are not limited to, the following:

- *Taking steps to prevent further potential abuse [See F600, 483.12(a) and F610- § 483.12(c)(3)];*
- *Reporting the alleged violation and investigation within required timeframes [See F609- § 483.12(c)(1) and (c)(4)];*
- *Conducting a thorough investigation of the alleged violation [See F610 – § 483.12(c)(2)];*
- *Taking appropriate corrective action [See F610 –§ 483.12(c)(4)]; and*
- *The facility must revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse [See Tag F656- §483.21(b)].*

Action Items:

- ☐ Review abuse prevention policies including policies related to:
  - Responding to allegations of abuse
  - Investigating allegations of abuse
  - Reporting alleged violations
  - Notification of changes
- ☐ Discuss with staff ways to ensure resident safety following allegations of abuse or potential incidents of abuse, including immediate safety and medical care for resident victim and ensuring the safety of other residents, staff, and visitors if an alleged perpetrator has been identified.
- ☐ Review policies for documenting response to allegations and care plan review following allegations of abuse. Include referrals for evaluation and support related to resident's medical, nursing, physical, or psychosocial needs following an allegation or incident of abuse.

<u>Neglect (p. 80)</u>

New Guidance (in red):

"Neglect," is defined at §483.5 as "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." Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.

Action Items:

- ☐ Review abuse prevention policies related to neglect.

- ☐ Review policies related to notification of changes, care plan review, and provision of care according to the plan of care.
- ☐ Ensure staff are trained on resident care needs and provision of care according to Facility Assessment and plan of care including any applicable training related to care equipment.
- ☐ Review staffing and staffing patterns to ensure timely and adequate care provision.

Identification of Goods and Services Required by the Resident (p. 83)

New Guidance (in red):

The cumulative effect of different individual failures in the provision of care and services by staff leads to an environment that promotes neglect. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in, or may result in, physical harm, pain, mental anguish, or emotional distress. Examples of individual failures include, but are not limited, to the following:

- *Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;*

Action Items:

- ☐ Review process for communicating care needs across shifts and between staff, practitioners, and resident representatives.
- ☐ Review policies for notification of changes.

Deficiency Categorization (p. 86)

New Guidance:

As the Psychosocial Outcome Severity Guide, located in the Nursing Home Survey Resources Folder, describes, to apply the reasonable person concept, the survey team should determine the severity of the psychosocial outcome or potential outcome the deficiency may have had on a reasonable person in the resident's position (i.e., what degree of actual or potential harm would one expect a reasonable person in the resident's similar situation to suffer as a result of the noncompliance). Generally, when applying the reasonable person concept, the survey team should consider the following as it determines the outcome to the resident, which include, but is not limited to:

- *The resident may consider the facility to be their "home," where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.*
- *The resident trusts and relies on facility staff to meet his/her needs.*
- *The resident may be frail and vulnerable.*

Determining the severity of psychosocial outcomes for abuse can present unique challenges to surveyors. Given that the psychosocial outcome of abuse may not be apparent at the time of the survey, it is important for the survey team to apply the reasonable person concept in evaluating the severity of psychosocial outcomes. It is important for the surveyor to gather and document any information that identifies any psychosocial outcomes resulting from the noncompliance; for abuse, surveyors should also consider that the psychosocial outcome of abuse may not be apparent at the time of the survey. For example, a resident who was raped may demonstrate indifference to the incident at the time of the survey. In addition, residents may not be able to express themselves due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), not be able to recall what has occurred, or may not express outward signs nursing home residents of physical harm, pain, or mental anguish. However, when a nursing home resident is treated in any manner that does not uphold a resident's sense of self-worth and individuality, it dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive situation for the resident(s).

There are situations that are likely to cause psychosocial harm which may sometimes take months or years to manifest and have long-term effects on the resident and his/her relationship with others. Therefore, during a survey, "Immediate Jeopardy" or "Actual Harm," may be supported when there is not an observed or documented negative psychosocial outcome, or a description of resident impact from the resident's representative or others who know the resident. Numerous situations involving abuse are likely to cause serious psychosocial harm (i.e. Immediate Jeopardy) to a resident who is a victim of these types of actions; these situations include, but are not limited to:

- *Sexual assault (e.g., rape)*
- *Unwanted sexual touching*
- *Sexual harassment*
- *Any staff to resident physical, sexual, or mental/verbal abuse [NOTE: Sexual abuse does not include the rare situation where a nursing home employee has a pre-existing and consensual 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]*
- *Staff posting or sharing demeaning or humiliating photographs or videos of nursing home residents*
- *When facility staff, as punishment, threaten to take away the resident's rights, privileges, or preferred activities, or withhold care from the resident*
- *Any resident to resident physical abuse that is likely to result in fear or anxiety*

Action Items:

- ☐ Review Psychosocial Outcome Severity Guide (available here in Downloads).

- ☐ Review policies related to investigating abuse allegations and consider integrating Psychosocial Outcome Severity Guide.