Revised 2014

Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property

Principle

Nursing facility residents shall be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident personal property.

Introduction

This guideline has been developed to assist facilities in determining when an incident of misconduct, such as abuse, neglect, or misappropriation of resident personal property has occurred. **This guideline, however, is not a replacement for adhering to the law and/or regulation regarding incidences of misconduct and cannot be used to avoid a citation of noncompliance.**

Incidences of mistreatment, abuse, neglect, and misappropriation of resident personal property are to be reported to the Adult Protective Services Unit of the Va. Department of Aging and Rehabilitative Services (DARS) as required by § 51.5-148 of the Code of Virginia. All alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriate of resident property are reported immediately to the OLC as required by 42 CFR § 483.15.

OLC recommends that each facility review and revise, where appropriate, their policies, protocols and practices annually to ensure compliance with state and federal laws and regulations regarding the investigation of misconduct towards residents.

It is expected that facility management will follow and exceed these measures to assure that residents are protected from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion and misappropriation of personal property.

A glossary of Misconduct Terms used in this guideline **begins on page 6.**

General Rules

A. A facility shall implement written policies and procedures prohibiting misconduct towards residents.

Policies and procedures should include, <u>but are not limited to:</u>

- How and to whom staff are to report occurrences, within the facility and to state and local authorities such as OLC, APS/DARS, DHP or local law enforcement, as required by law;

- How internal investigations will be conducted and completed;
- How staff will be trained on the procedures; and
- How residents will be informed of the procedures.

Every facility must ensure that its employees, contractors, volunteers, residents and nonresident personnel are knowledgeable about its misconduct investigation and reporting procedures and requirements.

B. Immediately upon learning of an incident, the facility must take the necessary steps to protect the resident(s) from subsequent incidences of misconduct while the matter is pending. A facility can learn of an incident from a:

- Staff member observing an incident;
- Verbal or written statement by a resident;
- Verbal or written statement by someone in a position to have knowledge of the incident through direct or indirect observation;
- Staff observing injuries to or behavioral changes in a resident; or
- Otherwise becoming aware of an incident.[1]

C. Within 24 hours of learning of an incident the facility must report it to the OLC. Incidents shall be submitted to the OLC complaint Department via fax at (804)527-4503.

D. Facilities must conduct an internal investigation and document their findings for all alleged incidences at the facility within 5 days of the incident. A thorough internal investigation should include, <u>but is not limited to</u>*:*

- Collecting physical and documentary evidence;
- Interviewing victims and witnesses;
- Collecting other corroborating/disproving evidence;
- Involving other regulatory authorities[2] who can assist; and
- Documenting each step taken during the internal investigation.

These steps are taken as part of the facility's effort to determine what, if anything, happened, and the complete factual circumstances surrounding the alleged incident.

NOTE: Absence of the facility administrator, or designated alternate, from the facility cannot be used to delay implementation of the facility investigative protocols.

E. A timely and thorough facility investigation, which is recorded in an investigative report, is critical to substantiate a finding of misconduct. An investigative report provides:

[1] This list is NOT intended to be inclusive, but to give examples of how a facility can become of aware of misconduct incidents.

[2] For example, the Adult Protective Services Unit of the Va. Department of s Aging and Rehabilitative Services or the appropriate local law enforcement authority (i.e., police or sheriff's office).

- A record of the facility investigator's activities and findings so that nothing is left to memory;
- A permanent official record of the facility investigator's actions, observations and discoveries;
- A basic reference of the case;
- Information on what has been done concerning the case;
- A basis for deciding further action;
- A method to communicate the findings of the case; and
- Information that can be evaluated to detect and identify patterns of misconduct.

F. Investigative reports should contain the following basic elements:

- Individuals involved, i.e., all persons connected in any way with the incident under investigation such as, residents, complainant, suspected individual, witnesses, any others with firsthand knowledge. Individuals should be identified in such a manner that they cannot be confused with any other individual;
- Description of the incident in a precise and accurate manner, including observable facts and statements from witnesses;
- Time and date of the incident;
- Specific location of all persons and things related to the incident, including room numbers, wing/corridor locators, objects in the space, noise, furnishings, clothing of victim; and
- Effect on the resident or resident's reaction.

Staff Misconduct

No facility shall employ individuals who have been convicted of abusing, neglecting, or mistreating residents by a court of law or have had a finding of abuse, neglect, mistreatment or misappropriation of resident property from the applicable board of the Virginia Department of Health Professions. The facility administrator is required to report any knowledge he or she has of actions by a court of law against an employee that indicates unfitness for service to the applicable board of the Department of Health Professions.

Injuries of Unknown Source or Origin

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

The facility must establish a protocol or procedure for determining when injuries such as skin tears, bruises, abrasions or other injuries are the result of abuse, neglect, corporal punishment, or involuntary seclusion. Injuries of unknown origin are to be reported and investigated the same as an incident of mistreatment.[3]

> NOTE: The facility is not relieved of its responsibility to report and investigate the occurrence, regardless of the circumstances, and complete a report.

Resident to Resident

Resident to resident altercations do not have to be reported[4] *if the facility takes immediate and appropriate actions* to intervene in the situation and provides sufficient supervision and monitoring to limit the probability of recurrence.

> NOTE: Resident to resident altercations in which a resident is injured and requires physician intervention and/or transfer or discharge to a hospital *must* be reported to the OLC regardless of the actions taken by the facility.

Residents who are abusive to other residents must be monitored and must have a care plan that addresses the abusive behavior. Those who are victims of abuse must be protected from further injury or mental anguish.

Visitor to Resident Abuse

Visitors who mistreat or are abusive to residents must be monitored and the resident or residents protected to assure that further abuse or mistreatment does not occur in all cases of visitor to resident misconduct. The facility must report such occurrences to OLC, APS/DARS, and local law enforcement.

Unusual Occurrences

Facility procedures and protocols should include unusual incidents or occurrences to their reporting criteria and report any such occurrences immediately, if applicable. Examples of unusual occurrences include but are not limited to:

- Any event involving a resident that is likely to result in legal action;
- Medication errors that result in the resident being hospitalized or dying;
- Suicides - attempted or successful;

[3] If a staff member is involved, facilities shall follow the reporting criteria of other agencies, such as APS/DARS or DHP, which may vary from this guideline.

[4] Facilities shall follow the reporting criteria of other agencies, such as APS/DSS or DHP, which may vary from this guideline.

- Death or serious injury associated with the use of restraints;
- Ingestion of toxic substances requiring medical intervention;
- Accidents or injuries of known origin that are unusual, e.g., a resident falling out of a window, a resident exiting the facility and sustaining an injury on facility property, or a resident being burned;
- A resident procuring and ingesting enough medication to result in an overdose; and
- Any unusual event involving a resident or residents that may result in media coverage.

Glossary of Misconduct Terms

"ABUSE" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish including deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain a resident's physical, mental, and psychosocial well-being. This includes but not limited to:

1. An act or repeated acts by staff, including but not limited to restraint, isolation or confinement[5], contrary to a facility's policies and procedures, and not part of a resident's care plan, and intentionally causes harm, which does any of the following:

a. Causes, or could reasonably be expected to cause, pain or injury to a resident or the death of a resident and the act does not constitute self-defense;

b. Substantially disregards a resident's rights under § 32.1-138 of the Code of Virginia, or the facility's duties and obligations to a resident;

c. Causes, or could reasonably be expected to cause, mental or emotional damage to a resident, including harm to the resident's psychological and intellectual functioning exhibited by: anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or fear of harm or death, or a combination of these behaviors.

2. An act or acts of sexual intercourse or sexual contact by staff and involving a resident;

3. The forcible administration of medication or the performance of psychosurgery, electroconvulsive therapy or experimental research on a resident with the knowledge that no lawful authority exists for the administration or performance; and

4. A course of conduct, or repeated acts by staff, which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten or frighten a resident causes, or could reasonably be expected to cause, the resident to feel harassed, intimated, humiliated, threatened, or frightened.

"**INCIDENT**" means an occurrence or episode of possible misconduct towards a resident and/or injuries of unknown origin.

"**INVOLUNTARY SECLUSION**" means a separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents is not considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. Placement in a specialized unit for the cognitively impaired does not constitute involuntary seclusion as long as care and services are provided in accordance with the resident's individual needs and preferences and not for staff convenience.

[5] This does not apply to restraint, isolation or confinement permissible by law or regulation.

"**MENTAL ABUSE OR ANGUISH**" includes but is not limited to humiliation, harassment, and intimidation with threats of punishment or threats of depriving care or possessions, malicious teasing, not giving reasonable consideration to a resident's wishes, unreasonably restricting contact with family, friends or other residents, ignoring resident needs for verbal and emotional contact, and violation of a resident's right to confidentiality by discussing a resident's condition, treatment of personal affairs with anyone who does not have a right to such information.

"MISAPPROPRIATION OF PROPERTY" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent, including but not limited to:

1. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a resident's movable property without the resident's consent and with the intent to deprive the resident of possession of the property.
2. Obtaining property of a resident by intentionally deceiving a resident with a false representation[6] which is known to be false, made with the intent to defraud, and which does defraud the person to whom it is made.
3. By virtue of his or her office, business or employment, or as a trustee or bailee, having possession or custody of money or of a negotiable security, instrument, paper or other negotiable writing of a resident, intentionally using, transferring, concealing, or retaining possession of money, security, instrument, paper or writing without the resident's consent, contrary to his or her authority, and with the intent to convert it to his or her own use or the use of another person or persons except the resident.
4. Intentionally using or attempting to use a resident's personal identifying information, or a resident's birth certificate or financial transaction card, to obtain credit, money, goods, services or anything else of value without the authorization or consent of the resident and by representing that he or she is the resident or is acting with the authorization or consent of the resident. Examples of misappropriation include:

- Theft, or attempted theft, of a resident's medication, money, credit cards, financial transaction card, jewelry, or personal property.
- Inappropriate use of resident funds or property.
- Use of a resident's telephone without their expressed permission.

"**MISCONDUCT**" means(i) mistreatment or abuse of a resident, (ii) neglect of a resident, (iii) incidences of corporal punishment, (iv) involuntary seclusion or (v) misappropriation of a resident's property, by facility staff, other residents, or family and friends visiting a resident.

"NEGLECT" means a failure to provide timely and consistent services, treatment or care to a resident or residents which are necessary to obtain or maintain the resident's health, safety or comfort; or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness, including but not limited to, acts that:

[6] False representation means a promise made with the intent not to perform if the promise is a part of a false or fraudulent scheme.

1. Cause, or could reasonably be expected to cause, pain or injury to a resident or the death of a resident;
2. Substantially disregards a resident's rights under § 32.1-138 of the Code of Virginia, or the facility's duties and obligations to a resident;
3. Cause or could reasonably be expected to cause, mental or emotional damage to a resident, including harm to the resident's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, fear of harm or death, or a combination of these behaviors.

Neglect is the intentional carelessness, negligence, or disregard of policy, or care, that causes, or could reasonably be expected to cause, pain, injury, or death. The major difference between abuse and neglect is that in a case of abuse, harm was intended; in neglect, the staff person did not intend to harm the resident.

Examples of neglect include, <u>but are not limited to</u>:

- Failure to provide adequate nutrition and fluids
- Failure to take precautionary measures to protect the health and safety of the resident
- Intentional lack of attention to physical needs including, but not limited to, toileting and bathing
- Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed
- Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program
- Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize
- Failure to notify a resident's legal representative and physician in the event of an occurrence involving the resident, such as failure to report a fall or a conflict between residents that result in injury or possible injury
- Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities
- Failure to adequately supervise a resident known to wander from the facility without staff knowledge

NOTE: Such things as failure to comb a resident's hair on occasion would not necessarily constitute a reportable incidence of neglect. However, continued omission in providing personal grooming and/or failure to address and resolve the omission could constitute neglect.

"**PHYSICAL ABUSE**" means hitting, slapping, pinching, kicking, shoving, pushing, non-therapeutic pulling or twisting any part of the resident's body, burning, sticking a resident with an object, or striking a resident with a part of the body or with an object; controlling a resident's behavior through corporal punishment; physical contact intentionally or through carelessness that

results in, or is likely to result in, pain or psychological harm, physical injury, or death to the resident. Indications of psychological harm include a noticeable level of fear, anxiety, agitation or emotional distress in the resident; use of any restraints, involuntary seclusion, or isolation of a resident as a method of punishment.

> NOTE: Accidental injury due to self-defense or to prevent injury to another resident would not normally be considered abuse. An example would be a skin tear occurring when a staff member *grabbed a resident's wrist to prevent the resident from striking another resident or the staff member.*

"**SEXUAL ABUSE**" means harassment, inappropriate touching, assault, sexual coercion or allowing a resident to be sexually abused by another.

"**STAFF**" means any employee, or contractor of the facility such as facility administrators, administrative staff, physicians, RNs, LPNs, nurse aides, podiatrists, dentists, vocational therapists, beauticians, housekeepers, dietary, laundry, maintenance staff, and laboratory personnel. This also applies to volunteers.

"**VERBAL ABUSE**" means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples include, but are not limited to threats of harm, saying things to frighten a resident, statements that result in ridicule or humiliation

"WILLFUL" means the individual intended an action that he or she knew or should have known could case physical harm, pain or mental anguish. Even a cognitively impaired resident may commit a willful act. The act needs to have resulted in physical or psychosocial harm to a resident or would be expected to have caused harm to a "reasonable person" if the resident cannot provide a response.