# BIG Survey Issues

## Life Services Network
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advocate educate innovate

# Faculty

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# Immediate Jeopardy

**Immediate Jeopardy –**

"A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

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# Immediate Jeopardy

- Only **ONE INDIVIDUAL** needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.
- **Serious harm, injury, impairment, or death** does **NOT** have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Individuals must not be subjected to abuse by **anyone** including, but not limited to, entity staff, consultants or volunteers, family members or visitors.

# Immediate Jeopardy

- Serious harm can result from both abuse and neglect.
- Psychological harm is as serious as physical harm.
- When a surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the entity due to the entity's failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
- Any time a team cites abuse or neglect, it should consider Immediate Jeopardy.

# Immediate Jeopardy

- Upon recognizing a situation that may constitute Immediate Jeopardy, the investigation process must proceed until it confirms or rules out Immediate Jeopardy.
- The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the jeopardy situation.

# Immediate Jeopardy – Triggers

**A. <u>Failure to protect from abuse.</u>**

- 1. Serious injuries such as head trauma or fractures;
- 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault;
- 3. Unexplained serious injuries that have not been investigated;
- 4. Staff striking or roughly handling an individual;
- 5. Staff yelling, swearing, gesturing or calling an individual derogatory names;
- 6. Bruises around the breast or genital area; or Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.

# Immediate Jeopardy – Triggers

**B. Failure to Prevent Neglect**

- 1. Lack of timely assessment of individuals after injury;
- 2. Lack of supervision for individual with known special needs;
- 3. Failure to carry out doctor's orders;
- 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention;
- 5. Access to chemical and physical hazards by individuals who are at risk;
- 6. Access to hot water of sufficient temperature to cause tissue injury;
- 7. Non-functioning call system without compensatory measures;

# Immediate Jeopardy – Triggers

**B. Failure to Prevent Neglect (cont.)**

- 8. Unsupervised smoking by an individual with a known safety risk;
- 9. Lack of supervision of cognitively impaired individuals with known elopement risk;
- 10. Failure to adequately monitor individuals with known severe self-injurious behavior;
- 11. Failure to adequately monitor and intervene for serious medical/surgical conditions;
- 12. Use of chemical/physical restraints without adequate monitoring;
- 13. Lack of security to prevent abduction of infants;
- 14. Improper feeding/positioning of individual with known aspiration risk; or
- 15. Inadequate supervision to prevent physical altercations.

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# Immediate Jeopardy – Triggers

**C. Failure to protect from psychological harm**

- 1. Application of chemical/physical restraints without clinical indications;
- 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or
- 3. Lack of intervention to prevent individuals from creating an environment of fear.

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# Immediate Jeopardy – Triggers

**D. <u>Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.</u>**

- 1. Administration of medication to an individual with a known history of allergic reaction to that medication;
- 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions;
- 3. Administration of contraindicated medications;
- 4. Pattern of repeated medication errors without intervention;
- 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or
- 6. Lack of timely and appropriate monitoring required for drug titration.

# Immediate Jeopardy – Triggers

**E. <u>Failure to provide adequate nutrition and hydration to support and maintain health.</u>**

- 1. Food supply inadequate to meet the nutritional needs of the individual;
- 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values;
- 3. Withholding nutrition and hydration without advance directive; or
- 4. Lack of potable water supply.

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# Immediate Jeopardy – Triggers

**F. <u>Failure to protect from widespread nosocomial infections; e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections</u>**

- 1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease;
- 2. High number of infections or contagious diseases without appropriate reporting, intervention and care;
- 3. Pattern of ineffective infection control precautions; or
- 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.

# Immediate Jeopardy – Triggers

**G. Failure to correctly identify individuals.**

- 1. Blood products given to wrong individual;
- 2. Surgical procedure/treatment performed on wrong individual or wrong body part;
- 3. Administration of medication or treatments to wrong individual; or
- 4. Discharge of an infant to the wrong individual.

# Immediate Jeopardy – Triggers

**H. <u>Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.</u>**

- 1. Nonfunctioning or lack of emergency equipment and/or power source;
- 2. Smoking in high risk areas;
- 3. Incidents such as electrical shock, fires;
- 4. Ungrounded/unsafe electrical equipment;
- 5. Widespread lack of knowledge of emergency procedures by staff;
- 6. Widespread infestation by insects/rodents;
- 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk;

# Immediate Jeopardy – Triggers

**H. Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations. (cont.)**

- 8. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas;
- 9. Improper handling/disposal of hazardous materials, chemicals and waste;
- 10. Locking exit doors in a manner that does not comply with NFPA 101;
- 11. Obstructed hallways and exits preventing egress;
- 12. Lack of maintenance of fire or life safety systems; or
- 13. Unsafe dietary practices resulting in high potential for food borne illnesses.

# Spotting Immediate Jeopardy

- Allegation of abuse
- Incidents of abuse
- Failure to conduct background checks
- Elopements
- Med Errors
- “Excessive” falls
- Pain Management
- Blood Glucose Testing
- Stage IV pressure sores
- High incidence of pressure sores
- Failure to report significant change in condition (diabetic)
- Failure to properly respond to code situation
- Equipment failure /head entrapment
- Excessive water temperatures
- Comprehensive failure to train staff

# Immediate Jeopardy: What to do?

- Develop the Plan of Removal Immediately.
- Implement the Plan of Removal immediately.
- Prepare any additional Plan of Correction(s) requested.
- Prepare for the re-visit.

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# Guidelines for Plan of Removal

- Completion date for each action.
- As quickly as possible.
- If can't inservice all staff immediately, state that no staff will be allowed to work until they have been inserviced and use today's date.
- Focus on addressing problem not full blown plan of correction.
- If the IJ issue is unclear ask for clarification.
- Push for a decision on whether the IJ is removed.

# Managing the Survey Cycle

- Read all cover letters
- Denial of payments will be imposed 90 days from the beginning of the survey unless you are deemed back in compliance
- IJ may speed up the DOPNA
- Removal of IJ does not mean compliance
- You are not in compliance until you are notified that you are in compliance

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# IDFPR

- New mandate to “crack down” on administrators
- Virtually all IJ’s are now resulting in complaints against the administrator
- Managing the situation early is key
- Fortunate that the Board understands the challenges faced by administrators

# IDFPR

- Want to know that administrator understands and appreciates the problem.
- Confirm that administrator did not cause problem.
- Confirm that administrator was aggressive in addressing the problem.

# IDFPR

- Step one – Letter requesting information.
- Step two – Interview with investigator.
- Step three – In person meeting with IDFPR attorney and Board Members.
- Step four – Complaint.
- Step five - Hearing.

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# Disciplinary Actions

- The range of disciplinary actions includes:
  - License Revocation
  - License Suspension
  - Probation
  - Reprimand
  - Administrative Warning
  - Dismissal

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# Hot Survey Issues

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# Current Hot Issues

- Pain Management
- Falls
- Med Errors
- Abuse

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# F309 – Pain Management

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# Pain Management

- Failure to address recurring pain.
- Failure to complete a root cause analysis.
- Failure to be proactive with pain management.
- Failure to document effectiveness of pain medications.

# Pain Management - Check

- All residents with PRN pain meds
- Are staff documenting pain scaling?
- If there is no relief, are they contacting attending for new orders?
- Are we addressing predictable pain episodes?
- Who is experiencing chronic pain?

# Pain Management – Plan of Removal

- Consult with resident's doctor.
- Change pain meds.
- Inservice staff on assessing pain.
- Determine root cause.
- Assess all residents with PRN pain meds.

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# Pain Management Survey Response File

- Facility medication/pain policies.
- Physicians' orders.
- Care plans.
- Medication Administration Record.
- Documentation of in-servicing.

# F331 – Med Error Unnecessary Medications

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# Med Error

- Staff give resident A resident B's medications.
- Staff give incorrect dosage.
- Staff give medications at incorrect time.
- Staff give medications incorrectly.

# Med Error

- If a medication error occurs:
  - Contact physician immediately;
  - Follow all physician orders for monitoring;
  - Follow internal policy;
  - Contact family;
  - Monitor;
  - Inservice staff.
- If the outcome is bad assume that the family will call in a complaint.

# Med Error

- Two measures for significant medication errors:
  - Errors in greater than 5% of medication administration opportunities; or
  - Due to type of medication or condition of resident there is the potential for significant harm.

# Med Error Plan of Removal

- Review med administration system to identify cause of error.
- Inservicing for staff.
- Review residents with orders for similar medications.
- May be necessary to review MARs for all residents to identify potential problems.

# Med Error Survey Response File

- Resident's nurses notes showing follow up.
- Medication record.
- Documentation of monitoring.
- Facility policy on medication errors.
- Documentation of inservicing.

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# Unnecessary Medications

- Psychotropics
- Documentation that the physician made an educated decision regarding the drug.
- Documentation that staff are monitoring side effects.
- This will be a big one.

# F309, F323 Excessive Falls

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# Excessive Falls

- Any resident experiencing a significant number of falls will be looked at.
- Could be frequency over time (one fall every other month).
- Could be recent episodes of frequent falls.
- Focus is on the facility's response to the falls.

# Excessive Falls

- ALJs will assume that if a resident has a history of falls that the provider should assume that as a result of any fall the resident has broken a hip.
- ALJ says that the fact that resident was noted to be “weaker on her feet” indicated a probable fracture (despite no complaints of pain).

# Excessive Falls

- R2 has 7 falls after care plan.
- "It should have been obvious to Petitioner that the care plan adopted for R2 was not working. I find that once R2 had shown a risk for falling, the facility had an obligation to do everything practicable to keep her safe from further falls. Petitioner failed to submit evidence that additional practicable measures to better ensure R2's safety were unavailable."

# Excessive Falls

- “Several of R2’s falls occurred when she tried to get out of bed.  Yet, Petitioner submitted no evidence that it considered switching her to the use of a low bed or placing soft mats beside her bed…I find it amazing that the facility made no changes in care planning to prevent further falls after this resident broke her hip .”

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# Excessive Falls

- Key to avoiding or contesting a citation:
  - For EVERY FALL - Documentation that you assessed issue.
  - For EVERY FALL - Documentation that you were communicating with MD.
  - For EVERY FALL - Documentation that you were constantly trying new approaches.

# Excessive Falls Plan of Removal

- Update of care plan for each resident identified.
- Review of care plans for all residents with falls in the past three months to ensure that they are up to date and adequately address risk.
- Review of all falls within the past two months by DON and administrator.
- Inservice staff.

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# Excessive Falls Survey Response File

- Care Plan showing that new approaches were considered and/or implemented following each fall.
- Documentation showing that the falls were reviewed to determine if there was a trend and to identify possible causes.
- Policy on falls.

# Abuse

- **Defining Abuse**
- Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.  42 C.F.R. 488.301
  - This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

# Abuse

- “Verbal abuse” is defined as 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 of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
- “Sexual abuse” includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

# Abuse

- “Physical abuse” includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
- “Mental abuse” includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.
- “Involuntary seclusion”

# Abuse

- **State regulations (IDPH Code)**

  **77 Ill. Admin Code 300.330:**

- **Abuse means:**
  - **Physical abuse** refers to the infliction of injury on a resident that occurs other than by accidental means and that requires (whether or not actually given) medical attention.

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# Abuse

- **Mental injury arises from the following types of conduct:**

  **Verbal abuse** refers to the use by a licensee, employee or agent of oral, written or gestured language that includes disparaging and derogatory terms

  **Mental abuse** includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by a licensee, employee or agent.

  Sexual harassment or sexual coercion perpetrated by a licensee, employee or agent.

- **Sexual assault.**

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# What to do with abuse?

- 483.13(c)(2), The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

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# What to do with abuse?

- 483.13(c)(3), The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
- 483.13(c)(4), The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

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# What to do with abuse?

- **"Injuries of unknown source" –** 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; **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.
- **"Immediately"** means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement. Conformance with this definition requires that each State has a means to collect reports, even on off-duty hours (e.g., answering machine, voice mail, fax).

# What to do with abuse?

- **State law and regulations (Nursing Home Care Act and IDPH Code):**

- A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.
- A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.
- A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.

# What to do with abuse?

- **Employee as perpetrator of abuse.** When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

# What to do with abuse?

- **Resident as perpetrator of abuse.** When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

# Top Five Errors with Abuse

- Staff fail to identify an incident or allegation of abuse.
- Staff fail to report an allegation of abuse.
- Once a report has been made, staff are not suspended pending investigation.
- Failure to conduct a thorough investigation.
- Failure to dig deeper.

# F323 – Resident on Resident Abuse

- Will be considered abuse if staff are aware of danger.
- Facility “knew or should have known.”
- Responsibility to protect other residents.
- Discharge of resident – “Any effort to transfer R11 did not diminish the facility’s obligation to protect other residents as long as she remained in the facility.” Western Care Management Corp. v. CMS

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# F324 – Resident on Resident Abuse

- In response to the argument that the facility staff "did the best that they could do with a difficult situation" an ALJ stated:
- "The facility does not have the option of throwing up its hands in despair on the theory that acute episodes are inevitable. Rather, it must provide treatment and services aimed at preventing those episodes."

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# Abuse Plan of Removal

- Alleged perpetrator suspended or barred from facility.
- All staff inserviced on abuse policy and reporting responsibility.
- Report to SSA.
- Initiate comprehensive investigation.
- Contact family and physician.
- Discharge of perpetrator resident.
- Repeat inservicing.

# Abuse Survey Response File

- Initial report to IDPH
- Facility Abuse Policy
- Summary of investigation
- 5-Day Follow-Up report to IDPH
- In-servicing Documentation
- Copies of updated care plans if applicable

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# Three Golden Rules

- Treat every allegation as if it were true and as if it were abuse.
- Treat every allegation as if it were true and as if it were abuse.
- Treat every allegation as if it were true and as if it were abuse.

# Which means

- **Immediately report it to the administrator.**
- **Immediately <u>suspend</u> staff pending the investigation.**
- Initial report to SSA within 24 hours.
- Conduct a thorough investigation.
- Send 5-Day Follow-Up Report.
- Discipline any staff as necessary.

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# Allegations

- Even (especially) if from the surveyor.
- Even if the incident was witnessed.

# Reporting it to Administrator

- Staff should be hypersensitive.
- Proactively asking about concerns on a regular basis (e.g., weekly).
- Make it clear that the report will be investigated.
- Make sure that staff don't get the impression that any staff member is getting a pass.

# Suspension

- **<u>Immediate suspension means immediate</u>**.
- Maintain suspension during investigation.
- If abuse is substantiated, terminate the staff and report the staff.
- If abuse is not substantiated, determine whether other discipline or actions are justified.

# Disciplining

- Reprimand
- Suspension
- Termination
- Reporting to registry

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# Initial Report to IDPH

- Keep it factual and keep it simple.
- Verify as much as possible before reporting.
- Include a description of measures taken.
- Over report rather than under report.
- Report to family and physician.

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# Conduct a Thorough Investigation

- Must be more than your determination as to what was the most likely cause.
- Interview:
  - Staff on duty at the time;
  - Room mate;
  - Family;
  - Other residents.
- Review prior notes.
- Interview staff for any other concerns.

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# Send 5 Day Follow-Up Report

- Be factual.
- Include actions taken.
- Be aware that it doesn't end there.

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# Training

- Orientation
- Inservicing
- One to one training
- Common Problems
  - Not meaningful
  - Only addresses physical abuse
  - Fails to stress reporting aspect

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# Other types of reporting

- Compare IDPH regulations on “Incidents and Accidents” reporting (77 Ill. Admin. Code 300.690)
- IDPH regulations for “Contacting local law enforcement” (77 Ill. Admin. Code 300.695)
- Reports to the Illinois Department on Aging
- Reports required under new federal law PPACA

# “Incidents and Accidents” reporting

- a)  The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process.  A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.
- b)  The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

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# “Incidents and Accidents” reporting

- c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. **If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only.**
  - For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline.

    **[NEW REQUIREMENT AS OF 2/3/13]**
- The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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# “Contacting local law enforcement”

- The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:
  1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor;
  2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability;
  3) Sexual abuse of a resident by a staff member, another resident, or a visitor;
  4) When a crime has been committed in a facility by a person other than a resident; or
  5) When a resident death has occurred other than by disease processes.

# “Contacting local law enforcement”

- For the purpose of this Section, the following definitions shall apply:

  "911" − an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue.

  Physical abuse − same as IDPH regulations

  Sexual abuse − sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).

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# “Contacting local law enforcement”

- The facility shall develop and implement a policy concerning local law enforcement notification, including:
  1) Ensuring the safety of residents in situations requiring local law enforcement notification;
  2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;
  3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;
  4) Seeking advice concerning preservation of a potential crime scene;
  5) Facility investigation of the situation.

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# Elder Abuse and Neglect Act, 320 ILCS 20/1

"**Mandated reporter**" means any of the following persons while engaged in carrying out their professional duties:

(i) **social services**, (ii) law enforcement, (iii) education, (iv) **the care of an eligible adult or eligible adults**, or (v) **any of the occupations required to be licensed**, *i.e.*, Clinical Psychologist, Social Work, Dental, Dietitian Nutritionist, Marriage and Family Therapy Licensing, Medical, Naprapathy, Nurse, Nursing Home Administrators, Occupational Therapy, Optometry, Pharmacy, Physical Therapy, Physician Assistant, Podiatry, Respiratory Care, Professional Counselor, Speech-Language Pathology and Audiology, Veterinary, and Public Accounting.

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# Elder Abuse and Neglect Act, 320 ILCS 20/1

- If any mandated reporter has reason to believe that an eligible adult, who because of dysfunction is unable to seek assistance for himself or herself, has, within the previous 12 months, been subjected to abuse, neglect, or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to an agency designated to receive such reports under this Act or to the Department on Aging.

# Elder Justice Act, §6703(3) of PPACA

- Requires reporting any reasonable suspicion of a crime within either 2 hours or 24 hour
  - If the reasonable suspicion relates to an incident *causing serious injury*, it must be reported **within 2 hours**.
  - If the reasonable suspicion relates to an incident that did NOT cause serious injury, it must be reported within 24 hours.
- "Clock time" – not "business hours"

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# Elder Justice Act, §6703(3) of PPACA

Reports must be made to:

- Local law enforcement; *and*
- State Survey Agency (*i.e.*, state department of public health)

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# Elder Justice Act, §6703(3) of PPACA

- A Covered Individual must report any reasonable suspicion of a crime committed against an individual who is a resident of, or is receiving care from, the facility.
- Who are the "Covered Individuals"?: Owner; Operator; Employee; Agent; and Contractor

# Elder Justice Act, §6703(3) of PPACA

## Considerations about reporting . . .

- **Group reporting**
  - Permitted, but best to identify all individuals within group
- **Chain reporting**
  - Permitted, if covered individual has clear assurance that supervisor is reporting it
- **Covered Individual required to notify facility of report?**
  - No, could discourage reporting for fear of retaliation

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# Elder Justice Act, §6703(3) of PPACA

- ***Advisable*** actions:
  - Coordinate with local law enforcement
  - Develop policies and procedures for compliance with the Elder Justice Act
  - Understand and coordinate reporting pursuant to Elder Justice Act and long-standing CMS/State regulations on reporting abuse, neglect, misappropriate, injuries of unknown origin

# “Abuse” Scenario 1

- CNA John has been an outstanding CNA for ten years.  One day CNA John “loses it” and hits a resident.

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# “Abuse” Scenario 2

- Spouse slaps resident to “encourage” her to do therapy.

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# “Abuse” Scenario 3

- Resident with dementia says that she has had sex with a staff member.  Resident is known by staff to be unreliable.
- Resident reports that she had a consensual relationship with staff.

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# “Abuse” Scenario 4

- Resident 1 has dementia and is aggressive when others come near. Resident 2 has dementia and wanders into her room.  Resident 1 hits resident 2 with drawer.

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# “Abuse” Scenario 5

- Resident 1 is admitted and is hostile and resistive to care. Resident continually refuses body check. Staff repeatedly try to conduct body check. Resident 1 subsequently tells a nurse that other lesbian nurses assaulted her.

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# “Abuse” Scenario 6

- Demented resident has history of aggressive behaviors. Resident’s physician has an order for Ativan PRN. Resident becomes hostile and aggressive, two staff hold the resident while a nurse administers Ativan.

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# “Abuse” Scenario 7

- Resident goes out to hospital tells hospital staff that staff abused him. Three staff were present during the alleged incident and clearly there was no abuse.

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# “Abuse” Scenario 8

- Demented resident repeatedly unplugs ventilator of another resident.

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