What Should be reported to Licensure & Certification?

Presenters:
Marilynn, Winborne, Bureau Director
Ranessa Maberry, Division Director
Jane McNally, RN Surveyor
Lauree Chase, BSN, MHS, RN Surveyor/Nurse Evaluator
Angelan Walker, LMSW/Hotline Coordinator

Objectives

Attendees will have the knowledge to:

- Define and describe and to assist in the development of a strategy to assure that all resident are free from abuse and neglect.
- Identify the conditions in which an incident is classified as an “injury of unknown source” and know when to report.
- Promote efficiency and quality and to ensure complaints and incidents are reported to the appropriate agency for follow up and investigation.
- Protect residents from abuse, neglect, exploitation, inadequate care/supervision.

Duty to Report

- Duty To Report
- Licensure Requirement 100.04
- Adopted by the Board – July 13, 2011
- Effective August 13, 2011

Duty To Report

- What to Report:
- Shall be Reported

  Fires, Explosions, Natural Disasters as well as Avoidable Deaths or Avoidable Serious, or Life-Threatening injuries to Residents resulting from Fires, Explosions, and Natural Disasters

Duty To Report

- How/When To Report
- By Telephone to the LSC Division with the Bureau of HFLC (601-364-1111)
- By the Next Working Day after the occurrence
- Appropriate form provided by the Bureau of HFLC and sent within 15 calendar days of occurrence

Duty to Report

- What to include in the report:
- Reports shall be complete and thorough
- Shall include the causal factors, date/time of occurrence, exact location of occurrence within or without the facility
- Police, fire, or other official reports shall be attached

S&C Letter 11-30-NH

- Section 1150 B of the SSA as established by Section 6703 (b) (3) requires specific individuals in applicable LTC facilities to report any reasonable suspicion of crimes committed against a resident of that facility

S&C Letter 11-30 NH

- Reports must be submitted to SSAs and Law Enforcement
- Reports must be submitted to at least one law enforcement agency of jurisdiction and the SA

S&C Policy Letter 11-30 NH

- Applicability of this Memo:
- Nursing Facilities
- Skilled Nursing Facilities
- Hospices that provide services to LTC facilities
- ICFs-MR

S&C Policy Letter 11-30 NH

- Processing reports about Suspected Crimes –
- SA should process reports in accordance with existing CMS and State policies and procedures for reporting incidents and complaints to SAs.

S&C Policy Letter 11-30 NH

- LTC Policies and Procedures
- LTC facilities should have policies and procedures to comply with this law
- The obligations of the facility are different than the obligations of a covered individual.

Duty to Report/S&C Policy Letter

This concludes this part of the presentation.

Thank You!

Abuse and Neglect

Presented by:

Jane McNally, RN

Abuse and Neglect

- REGULATIONS F223, F224, F225, F226
- 483.13(b) F223 ABUSE
- THE RESIDENT HAS THE RIGHT TO BE FREE FROM VERBAL, SEXUAL, PHYSICAL AND MENTAL ABUSE, CORPORAL PUNISHMENT AND INVOLUNTARY SECLUSION.

Abuse and Neglect

- Intent: Each Resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents MUST NOT be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

Abuse and Neglect

- “ABUSE” MEANS THE WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMIDATION, OR PUNISHMENT WITH RESULTING PHYSICAL HARM, PAIN OR MENTAL ANGUISH.

Abuse and Neglect

- QUESTION: Resident A, who has dementia, traps Resident B in her room, pushes her on the bed against her will and shoves his hands down her pants. Her screaming alerts staff who open the door and pull Resident A away. Has Resident B been abused?

Abuse and Neglect

- “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.

Abuse and Neglect

- 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.

Abuse and Neglect

- “PHYSICAL ABUSE” includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

Abuse and Neglect

- MENTAL ABUSE” includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

Abuse and Neglect

- “INVOLUNTARY SECLUSION” is defined as separation of a resident from other residents or from his/her room or confinement to her/his room (with or without a roommate) against the resident’s will or the will of the resident’s legal representative.

Abuse and Neglect

- F224 THE FACILITY MUST DEVELOP AND IMPLEMENT WRITTEN POLICIES AND PROCEDURES THAT PROHIBIT MISTREATMENT, NEGLECT, AND ABUSE OF RESIDENT AND MISAPPROPRIATION OF RESIDENT PROPERTY.

Abuse and Neglect

- QUESTION: Resident A has dementia and has a history of wandering into resident rooms and physically threatening residents. The facility monitored him sporadically, but not in a manner that enabled them to protect the resident. In his last incident, he went into a female resident's room and broke her wrist. Should you cite the facility under F224?

Abuse and Neglect

- NEGLECT means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Abuse and Neglect

- “Misappropriation of resident property” means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Abuse and Neglect

- Intent: Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing other residents, and development of intervention strategies.

Abuse and Neglect

- F225 – Part 1 – Can't employ abusers, must report unfitness: The facility must not employ individuals who have been found guilty of abusing, neglecting or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property

Abuse and Neglect

- Part 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 (including to the state survey and certification agency.).

Abuse and Neglect

- Part 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. The RESULTS of all investigations must be reported to the administrator and to other officials in accordance with State Law AND IF THE ALLEGED VIOLATION IS VERIFIED APPROPRIATE corrective action must be taken.

Abuse and Neglect

- F226: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

Abuse and Neglect

- Facilities HAVE these policies. Identify the SPECIFIC policy/procedure(s) that were not implemented.

Abuse and Neglect

- THE PURPOSE OF THE SURVEY IS TO DETERMINE THAT CARE AND SERVICES ARE PROVIDED ACCORDING TO FACILITY POLICY AND PROCEDURE, STANDARDS OF PRACTICEAND COMPLIANCE WITH FEDERAL AND STATE REGULATIONS.

Abuse and Neglect

- SYSTEMIC FAILURE: Conditions that encourage would-be abusers to abuse residents:

- Explicit tolerance of intimidation by staff and other residents
- Administration apathy
- Fearful/underpowered residents

Abuse and Neglect

- A DEFICIENCY IS DEFINED AS A FACILITY'S FAILURE TO MEET A PARTICIPATION REQUIREMENT SPECIFIED IN THE SOCIAL SECURITY ACT OR IN PART 483, SUBPART B –
- REGULATIONS HAVE BEEN DEVELOPED FROM THE SOCIAL SECURITY ACT.

Abuse and Neglect

- SURVEYORS LOOK AT THE REGULATORY LANGUAGE WHEN MAKING A DECISION:

- EACH RESIDENT MUST RECEIVE
- THE FACILITY MUST PROVIDE

*The nursing home owns the actions of their employees

Abuse and Neglect

- STATUTORY REQUIREMENT OF PRINCIPAL LIABILITY FOR THE ACTS OF AGENTS:

Abuse and Neglect

- Section 1819 of the SS Act, which gives CMS THE AUTHORITY TO IMPOSE SANCTIONS INCORPORATES THE PROVISIONS OF SECTION 1128 OF THE ACT, WHICH STATES AT SUBPART (L) “A PRINCIPAL IS LIABLE FOR PENALTIES…FOR THE ACTIONS OF THE PRINCIPAL’S AGENT ACTING WITHIN THE SCOPE OF THE AGENCY”.

Abuse and Neglect

- Many abuse and neglect concerns are reported to the state by way of complaints or self-reported incidents. Chapter 5 of the SOM (State Operational Manual) defines an allegation as an assertion of improper care or treatment that could result in the citation of a deficiency.

Abuse and Neglect

- COMPLIANCE DETERMINATIONS OF “AVOIDABLE” AND “”UNAVOIDABLE” ARE DETERMINED TO MAKE THOSE DETERMINATIONS.

Abuse and Neglect

- "AVOIDABLE" MEANS THAT THE RESIDENT DEVELOPED A CONDITION (OR HAD AN EVENT), OR FAILED TO IMPROVE ADEQUATELY, AND THAT THE FACILITY FAILED TO DO **ONE** OR MORE OF THE FOLLOWING:

Abuse and Neglect

- EVALUATE RESIDENT'S CLINICAL CONDITION AND RISK FACTORS
- DEFINE AND IMPLEMENT INTERVENTIONS CONSISTENT WITH RESIDENT'S NEEDS, GOALS AND RECOGNIZED STANDARDS OF PRACTICE
- MONITOR AND EVALUATE IMPACT OF INTERVENTIONS
- REVISE INTERVENTIONS TIMELY AND AS APPROPRIATE

Abuse and Neglect

- **“UNAVOIDABLE” MEANS THAT RESIDENT EITHER DEVELOPED CONDITION “OR HAD EVENT” OR EXPERIENCED FAILURE TO IMPROVE AND FACILITY HAD:**

Abuse and Neglect

- **EVALUATED RESIDENT'S CLINICAL CONDITION AND IDENTIFIED RISK FACTORS**
- **DEFINED AND IMPLEMENTED INTERVENTIONS CONSISTENT WITH RESIDENT'S NEEDS, GOALS AND RECOGNIZED STANDARDS OF PRACTICE**
- **MONITORED AND EVALUATED IMPACT OF INTERVENTION**
- REVISED APPROACHES AS APPROPRIATE AND IN A TIMELY FASHION

Abuse and Neglect

- IMMEDIATE JEOPARDY: Definition at 42 CFR 488.301: “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.

Abuse and Neglect

- The SOM states that: “serious harm injury, impairment or death does NOT have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ”.

Abuse and Neglect

- The American Heritage Dictionary defines likely as:

  POSSESSING OR DISPLAYING THE QUALITIES OR CHARACTERISTICS THAT MAKE SOMETHING PROBABLE.

This concludes this part of our presentation.

Thank You!

Injury of Unknown Source

Presented by:

Ranessa Maberry, Division Director

Injuries of Unknown Source

- S&C 05-09

Reiterates the reporting of alleged violations and the results of the investigation by nursing homes to the SA.

Injuries of Unknown Source

- The facility has an obligation to report allegations and the results of the investigation of these alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

Injuries of Unknown Source

- 42 C.F.R. 483.13

Resident behavior and facility practices:

Injuries of Unknown Source

- 483.13©(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 the other officials in accordance with State law through established procedures.

Injuries of Unknown Source

- CMS believes “immediately” means:

  As soon as possible.

  But ought not exceed 24 hours after discovery of the incident

Injuries of Unknown Source

- 483.13©(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.

Injuries of Unknown Source

- 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 within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Injuries of Unknown Source

- An injury should be classified as an “injury of unknown source” when both of the following conditions are met:

Definitions

The source of the injury was not observed by any person

or

The source of the injury could not be explained by the resident;

Definitions

- And,

Definitions

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)

Definitions

or the number of injuries observed at one particular point in time or the incidence of injuries over time.

Injuries of Unknown Source

- It is not always possible to determine the cause of the injury.

Injuries of Unknown Source

- Injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to determine the cause,
- and appropriate action must be taken.
- Documentation of the assessment must be in the resident's clinical record.

Types of Injuries of Unknown Source

- Superficial injury
- Substantial injury

Superficial Injury

- Superficial injury of unknown source include injuries limited to the surface layers of the skin, easily treated with first aide/not requiring physician's orders for treatment **and** located in areas generally vulnerable to trauma.

Superficial Injury

- Superficial injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to determine the cause and appropriate corrective action must be taken.
- Documentation of the assessment must be in the resident's clinical record.

Examples of Superficial Injury

- May include, but are not limited to, the following:
- Small abrasions,
- Lacerations, or
- Bruises limited to the surface layers of the skin, occurring in areas generally vulnerable to trauma, such as hands, forearms, and shins.

Substantial Injury

- Substantial injury of unknown source include injuries that are more than superficial.
- Substantial injury require more than first aide and may require close assessment and monitoring by nursing or medical staff.
- They also include injuries occurring in areas not generally vulnerable to trauma.

Substantial Injury

- All substantial injuries of unknown source must be thoroughly investigated.
- All injuries (regardless of the extent) occurring in non-vulnerable areas will be considered substantial injuries.

Examples of Substantial Injury

- May include, but are not limited to:
- Abrasions,
- Burns,
- Deep lacerations,
- Bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
- All fractures.

Injuries of Unknown Source

This concludes this part of our presentation.

Thank You!

Complaints and Incidents

Presented by:

Lauree Chase, BSN, MHS
RN/Nurse Evaluator

Purpose of the Complaint/Incident Process

- Mission:

. To protect Medicare/Medicaid beneficiaries from abuse, neglect, exploitation, inadequate care or supervision.

Purpose of the Complaint/Incident Process

- 1st: Protective Oversight
- 2nd: Prevention
- 3rd: Promote Efficiency and Quality

Purpose of the Complaint/Incident Process

- 1st: Protective Oversight

Purpose of the Complaint/Incident Process

- 2nd: Prevention

Purpose of the Complaint/Incident Process

- 3rd: Promote Efficiency and Quality

Complaint

- Complaint
  - A report that alleges noncompliance with federal and/or state law and regulations received by the survey agency or the CMS regional office from anyone other than the administrator or designee.

Incident

- Incident
  - An official notification to the state survey agency or the CMS regional office from a self-reporting provider or supplier, such as the administrator or authorized official for the provider or supplier.

Incidents

- All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations.
- All such investigations attempt to determine if such injury results from abuse or neglect.
- It may not always be possible to determine the cause of the incident.

Allegation

- An allegation is a statement or a gesture made by someone (regardless of capacity or decision-making ability) that indicates that abuse, neglect, exploitation, or misappropriation of resident property may have occurred and requires a thorough investigation.

Allegation

- To suspect means to have reason to believe without conclusive proof that someone may have abused, neglected, exploited a resident, or misappropriated a resident's property.

Documentation

- Documentation of the investigation for all incidents must be kept and readily available for review.

Examples of Incidents

- Any occurrence that is not consistent with standards of care and practice;
- Any allegation of mistreatment, neglect or abuse; and
- Any misappropriation of resident property or exploitation of a resident.

Accidents

- 42CFR 483.25(h) states:

  The facility must ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

Accidents

- Accident

  - Unexpected, unintended event that can cause a resident bodily injury.

Accidents

- Failure to adequately supervise the whereabouts and/or activities of a resident is NEGLECT.

Accidents

- NEGLECT may be determined even if no apparent negative outcome has occurred.

Examples of Accidents

- May include, but are not limited to, the following:

- A self-propelling resident catches a finger in wheelchair spoke and fractures the finger.

Examples of Accidents

- An independent resident who becomes dizzy fails to use call light for help and falls while getting out of bed. The resident sustains a fracture right hip.

Examples of Accidents

- Resident pinches hand in doorjamb and sustains a skin tear.
- Resident hits arm on the head of the bed and sustains a bruise on forearm.

Examples of Accidents

- A resident with a known risk for wandering ambulates through the front doors of the facility without staff supervision. The resident is gone for 45 minutes. He is picked up by staff and returned to the facility without injury.

Accidents

- Any of the above examples may become examples of **NEGLECT** if repeated without facility intervention, **or** if the prior risk of such an event was identified and no action was taken to prevent the occurrence.

This concludes this part of our presentation.

Thank You!

Reporting Process

Presented by:

Angelan Walker, LMSW/Hotline Coordinator

Reporting Process

The facility is required to:

Protect residents, and to investigate and report certain events.

Reporting Process

- First Priority:

Protect the victim(s)/resident(s) from further harm.

Reporting Process

- Second Priority:

Perform a thorough investigation, and report to the department and law enforcement as required.

Reporting Process

- Facilities are required to report to:

The MS State Department of Health.

Attorney General's Office.

Law Enforcement.

Appropriate licensing agency.

When to Report

- Oral or Telephonic report within 24 hours of discovery of the event (excluding week-ends and holidays)
- Written report within 72 hours of discovery of the event
- And results of all investigations must be reported to the administrator or designee and to other officials in accordance with state law within 5 working days of the incident

When to Report

- Keep in mind Time Period for Individual Reporting according to Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility:

- Serious Bodily Injury – 2 Hour Limit

- All Other - Within 24 Hours

Report Content

5 Ws + 1 H

- Who?
- What?
- When?
- Where?
- Why?
- How?

Report Content

- Who

Report Content

- What

Report Content

- When

Report Content

- Where

Report Content

- Why

Report Content

- How

Where to Report

- **Complaint Hotline Phone Numbers:**

  1-800-227-7308 or 601-362-2194

- **Mailing Address:**

  Angelan Walker, Hotline Coordinator
  Division of Health Facilities
  Licensure and Certification
  P.O. Box 1700
  Jackson, MS 39215-1700

- **Complaint Unit Fax Number:**

  601-364-5050

Questions & Answers

Thank You!!

The End!

We Thank You for Your Time and Attention.