F600

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§483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must—

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

INTENT §483.12(a)(1)

Each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone.

NOTE: Refer to tag F602 for misappropriation of resident property and exploitation, and F603 for cases of involuntary seclusion.

DEFINITIONS §483.12(a)(1)

"**Abuse**," is defined at §483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse 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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology."

"**Neglect**," as defined at §483.5, means "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."

"**Sexual abuse**," is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

"**Willful**," as defined at §483.5 in the definition of "abuse," and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

GUIDANCE §483.12(a)(1)

NOTE: For purposes of this guidance, "staff" includes employees, the medical director, consultants, contractors, and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.

ABUSE

Sections §§1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii) of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse.

Staff to Resident Abuse of Any Type

Nursing homes have diverse populations including, among others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences, speech/language challenges, and generational differences. When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's responsibility to ensure that all staff are trained and are knowledgeable in how to react and respond appropriately to resident behavior. All staff are expected to be in control of their own behavior, are to behave professionally, and should appropriately understand how to work with the nursing home population. A facility cannot disown the acts of staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment. CMS does not consider striking a combative resident an appropriate response in any situation. It is also not acceptable for an employee to claim his/her action was "reflexive" or a "knee-jerk reaction" and was not intended to cause harm. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited.

NOTE: It should not be assumed that every accident or disagreement that occurs between an employee and a resident should be considered to be abuse. Accidents that may not be considered to be abuse include instances such as a staff member tripping and falling onto a resident; or a staff member quickly turning around or backing into a resident that they did not know was there.

Resident to Resident Abuse of Any Type

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. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term "willful". The word "willful" means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate ("willful") action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident

who is nearby. If it is determined that the action was not willful (a deliberate action), the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible and that each resident receives adequate supervision (See F689).

The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse. For example, redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected.

Staff should monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to:

- Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;
- Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
- Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;
- Taking, touching, or rummaging through other's property; and
- Wandering into other's rooms/space.

Also, resident to resident abuse could involve a resident who has had no prior history of aggressive behaviors, since a resident's behavior could quickly escalate into an instance of abuse. For example, a resident pushes away or strikes another resident who is rummaging through his/her possessions.

Visitor to Resident Abuse of Any Type

Allegations of abuse have been reported between spouses, or residents and their parents or children, in addition to visitors who are not members of a resident's immediate family. The surveyor may obtain information from the resident's social history, to the extent possible that identifies concerns or issues regarding relationships between the resident and relatives, friends, and/or visitors. The surveyor should interview the social worker and review the resident's assessment and care plan to determine whether the facility identified and provided interventions on how to address the concerns. (Also see F745-Medically Related Social Services).

In addition, the survey team must review whether the facility has developed and implemented policies and procedures related to visitor access. This would include safety restrictions, such as denying access or providing limited and supervised access to a visitor who has been found to be abusing, exploiting, or coercing a resident or who is suspected of abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed. Any such restriction should be discussed with the resident or resident representative first. Also, the

resident maintains the right to deny visitation according to his/her preferences. See guidance at F563- Visitation Rights and F564- Resident Right to Visitors.

TYPES OF ABUSE

Identified facility characteristics[1,2] that could increase the risk for abuse include, but are not limited to:

- Unsympathetic or negative attitudes toward residents;
- Chronic staffing problems;
- Lack of administrative oversight, staff burnout, and stressful working conditions;
- Poor or inadequate preparation or training for care giving responsibilities;
- Deficiencies of the physical environment; and
- Facility policies operate in the interests of the institution rather than the residents.

In addition, the risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction by staff, residents, or others, such as[3]:

- Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;
- Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
- Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;
- Taking, touching, or rummaging through other's property;
- Wandering into other's rooms/space; and
- Resistive to care and services.

Some situations of abuse do not result in an observable physical injury or the psychosocial effects of abuse may not be immediately apparent. In addition, the alleged victim may not report abuse due to shame, fear, or retaliation. Other residents may not be able to speak due to a medical condition and/or cognitive impairment (e.g., stroke, coma, Alzheimer's disease), cannot recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred.

Abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to, the following:

- Fear of a person or place, of being left alone, of being in the dark, and/or disturbed sleep and nightmares;
- Extreme changes in behavior, including aggressive or disruptive behavior toward a specific person; and

- Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts.

The guidance below identifies some characteristics of specific types of abuse.

Physical Abuse

Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking.

Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object.

Possible indicators of physical abuse include an injury that is suspicious because the source of the injury is not observed, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time.

Examples of injuries that could indicate abuse include, but are not limited to:

- Injuries that are non-accidental or unexplained;
- Fractures, sprains or dislocations;
- Burns, blisters, or scalds on the hands or torso;
- Bite marks, scratches, skin tears, and lacerations with or without bleeding, including those that are in locations that would unlikely result from an accident;
- Bruises, including those found in unusual locations such as the head, neck, lateral locations on the arms, or posterior torso and trunk, or bruises in shapes (e.g., finger imprints); and
- Facial injuries, including but not limited to, broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks.

Deprivation of Goods and Services by Staff

Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s).

Mental and Verbal Abuse

Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.

Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.

Examples of mental and verbal abuse include, but are not limited to:

- Harassing a resident;
- Mocking, insulting, ridiculing;
- Yelling or hovering over a resident, with the intent to intimidate;
- Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; and
- Isolating a resident from social interaction or activities.

NOTE: Although a finding of mental abuse indicates that a facility is not promoting an environment that enhances a resident's dignity, surveyors must cite a finding of mental abuse at F600 at the appropriate severity level with consideration of the psychosocial outcome to residents.

Mental abuse includes abuse that is facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident(s), regardless of whether the resident provided consent and regardless of the resident's cognitive status, the surveyor must consider non-compliance related to abuse at this tag. This would include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. Depending on what was photographed or recorded, physical and/or sexual abuse may also be identified.

Sexual Abuse

"Sexual abuse" is non-consensual sexual contact of any type with a resident, as defined at 42 CFR §483.5. Sexual abuse includes, but is not limited to:

- Unwanted intimate touching of any kind especially of breasts or perineal area;
- All types of sexual assault or battery, such as rape, sodomy, and coerced nudity;
- Forced observation of masturbation and/or pornography; and
- Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident.

Generally, sexual contact is nonconsensual if the resident either:

- Appears to want the contact to occur, but lacks the cognitive ability to consent; or
- Does not want the contact to occur.

Other examples of nonconsensual sexual contact may include, but are not limited to, situations where a resident is sedated, is temporarily unconscious, or is in a coma.

Any investigation of an allegation of resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent, or consent is obtained through intimidation, coercion or fear, whether it is expressed by the resident or suspected by staff. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. A facility is required to conduct an investigation and protect a resident from non-consensual sexual relations anytime the facility has reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent.

Non-Sexual Physical Contact with Residents
Nothing in this guidance is intended to limit a resident's ability to receive non-sexual contact, such as holding a resident's hand. It is not the intent of this guidance for facilities to foster "no contact of any type" policies/procedures/practices between staff and residents or residents and others, assuming such contact is consistent with the resident's preferences. It should also not be assumed that all physical contact involving a resident would constitute sexual abuse.

Capacity and Consent
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.*

NOTE: For information related to determining consent, refer to "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 This resource includes a discussion on determining issues related to determining consent including:

> The legal standards and criteria for sexual consent vary across states (Lyden, 2007; Stavis et al., 1999). The most widely accepted criteria, which are consistent with those applied to consent to treatment, are: (1) knowledge of relevant information, including risks and benefits; (2) understanding or rational reasoning that reveals a decision that is consistent with the individual's values (competence); and (3) voluntariness (a stated choice without coercion) (Grisso, 2003; Kennedy, 1999; Stavis, 1991; Stavis et al., 1999; Sundram et al., 1993).

When investigating an allegation of sexual abuse, the facility must conduct a thorough investigation to determine the facts specific to the case investigated, including whether the resident had the capacity to consent and whether the resident actually consented to the sexual activity. A resident's voluntary engagement in sexual activity may appear to mean consent to the activity; in these instances, if the facility has reason to suspect that the resident may not have the capacity to consent, the facility must protect the resident from potential sexual abuse while the investigation is in progress *[See §483.12(c)(3)]*.

Determinations of capacity to consent depend on the context of the issue and one determination does not necessarily apply to all decisions made by the resident. For example, the resident may not have the capacity to make decisions regarding medical treatment, but may have the capacity to make decisions on daily activities (e.g., when to wake up in the morning, what activities to engage in). Determinations of capacity in this context are complex and cannot necessarily be based on a resident's diagnosis alone. Capacity on its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation. Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with State law, if applicable. The facility's policies, procedures and protocols, should 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. See also 42 CFR §483.10(f) [F561] for concerns related to the resident's right to self-determination through support of resident choice, and 42 CFR §483.10(b)(3)-(7) [F551] for concerns related to the exercise of the resident's rights by the resident representative.

NOTE: CMS is not requiring facilities to adopt a specific approach in determining a resident's capacity to consent. However, the facility administration, nursing and medical director may wish to 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.

Cognitive functioning may change due to health issues such as, but not limited to stroke, dementia, depression/psychiatric illnesses or other impacts such as medication(s), hearing/visual loss, and stress. Therefore, the facility should continue to monitor and re-evaluate a resident's capacity to consent over time, as needed, based on the individual resident's physical, mental and psycho-social needs. See also 42 CFR §483.10(g)(14) [F580-Notification of Changes].

Residents with Designated or Legally Appointed Representatives

A resident may have a representative that has been appointed legally under State law through, for example, a power of attorney, guardian, limited guardian, or conservatorship. These legal appointments vary in the degree that they empower the appointed representative to make decisions on behalf of the resident. While a legal representative may have been empowered to make some decisions for a resident, it does not necessarily mean that the representative is empowered to make all decisions for the resident. The individual arrangements for legal representation will have to be reviewed to determine the scope of authority of the representative on behalf of the resident.

A resident may also have designated an individual to speak on his/her behalf for decisions for care or other issues. However, it is necessary for the resident, his/her representative and the facility to have a clear understanding of the types and scope of decision- making authority the representative has been delegated.

Any decision-making power that is not legally granted to a representative under state law is retained by the resident. It is the responsibility of the facility to ascertain what decisions the representative is legally empowered to make on behalf of the resident.

More specifically, regarding consent for sexual activity, State law and the legal instruments setting up resident representation may be silent on that topic. The facility must be aware of the representative's scope of authority regarding resident decision-making.

When a resident with capacity to consent to sexual activity and his/her representative disagree about the resident engaging in sexual activity, the facility must honor the resident's wishes irrespective of that disagreement if the representative's legal authority does not address that type of decision-making for sexual activity. If the resident representative's legal authority addresses decision-making for sexual activity, then the facility must honor the resident representative's decision consistent with 42 CFR §483.10(b).

NOTE: See F551 at 42 CFR §483.10(b)(6)- If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.

Indicators of Potential Sexual Abuse

In addition to reports from residents and others that sexual abuse occurred, possible physical indicators of sexual abuse that would require investigation by the facility and survey team include, but are not limited to:

- Bruises around the breasts, genital area, or inner thighs;
- Unexplained sexually transmitted disease or genital infections;
- Unexplained vaginal or anal bleeding; and/or
- Torn, stained, or bloody underclothing.

Literature indicates that the most prevalent psychosocial outcomes of abuse are depression, anxiety, and posttraumatic disorder[4]. Other possible outcomes of sexual abuse [5,6] may include SUDDEN OR UNEXPLAINED CHANGES in the following behaviors and/or activities such as fear or avoidance of a person or place, of being left alone, of the dark, nightmares, and/or disturbed sleep.

Allegations of Sexual Abuse

There are additional considerations when investigating allegations of sexual abuse involving:

- Sexual abuse by a staff member;
- Resident to resident sexual abuse; and

- Sexual abuse by a spouse or visitor.

For any alleged violation of sexual abuse, the facility must:

- Immediately implement safeguards to prevent further potential abuse;
- Immediately report the allegation to appropriate authorities;
- Conduct a thorough investigation of the allegation; and
- Thoroughly document and report the result of the investigation of the allegation.

See Tags F609*[See §§ 483.12(b)(5), 483.12(c)(1) and (c)(4)]*, and F610 *[See §§ 483.12(c)(2), (c)(3), and (c)(4)]*.

Allegations of Staff to Resident Sexual Abuse

Nursing home staff are entrusted with the responsibility to protect and care for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff member's role as a caregiver and will be considered an abuse of power. Also, for some health care professionals, it is prohibited by licensure or certification requirements for professionals to have a relationship with a resident (or patient).

NOTE: Refer to applicable State professional licensure/certification requirements and/or scope of practice.

Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed before the resident was admitted to the facility, such as a spouse or partner, and must be thoroughly investigated. However, in a rare situation, it may not be considered to be sexual abuse when a nursing home employee has a pre-existing 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.

Allegations of Resident To Resident Sexual Abuse

Studies show that a considerable amount of unwanted sexual contact in nursing homes may be initiated by a resident who is sexually aggressive as a result of disease processes such as brain injuries or dementia. In addition, a resident may have a pre-occupation for sexual activity, or have had a prior history of sexual abuse. The resident who is sexually aggressive may target a resident who is unable to protect him/herself, and may involve various types of sexual aggression such as fondling both over and under clothing, masturbation in the presence of another resident and is unwanted by that other resident, forcing oral sex, or sexual intercourse.

If there is an allegation that a resident did not wish to engage in sexual activity with another resident or may not have the capacity to consent, the facility must respond to it as an alleged violation of sexual abuse.

Allegations of Visitor to Resident Sexual Abuse

In certain situations, sexual activity between a resident and a visitor (e.g., spouse, partner) may not be considered to be abuse, if there was a pre-existing sexual relationship, the resident has the capacity and ability to consent, and the resident wishes to continue with the sexual relationship. Regardless, the nursing home must ensure that a visitor(s) is not subjecting any resident(s) to sexual abuse. In addition, the nursing home staff must immediately act on any allegation or suspicion that a visitor is engaging in improper sexual activity with a resident (See F609 and F610).

Response to Alleged Violations of Sexual Abuse

If an allegation of sexual abuse has been reported, the facility must immediately protect the alleged victim(s) involved, report the alleged violations to the Administrator and appropriate State and local authorities, and begin an investigation of the allegation. See 42 CFR §483.12 (c)(1)-(4), F609-Reporting of Alleged Violations and F610-Response to Alleged Violations. As the facility conducts its investigation, the facility must not tamper with evidence. Tampering with evidence would impede completion of a thorough investigation by the facility and other investigating authorities. Examples of tampering include, but are not limited to: washing linens or clothing, destroying documentation, bathing or cleaning the resident until the resident has been examined (including a rape kit, if appropriate), or otherwise impeding a law enforcement investigation. If the surveyor identifies that the facility has tampered with evidence, the surveyor should investigate whether the facility is in compliance with F607 and F610.

Determination of Findings and Potential to Foresee Abuse

It has been reported that some facilities have identified that they are in compliance with F600-Free from Abuse and Neglect because that they could not foresee that abuse would occur and they have "done everything to prevent abuse," such as conducted screening of potential employees, assessed residents for behavioral symptoms, monitored visitors, provided training on abuse prevention, suspended or terminated employment of the perpetrator, developed and implemented policies and procedures to prohibit abuse, and met reporting requirements. However, this interpretation would not be consistent with the regulation, which states that "the resident has the right to be free from verbal, sexual, physical, and mental abuse…" Therefore, if the survey team has investigated and collected evidence that abuse has occurred, it is appropriate for the survey team to cite the current or past noncompliance at F600-Free from Abuse and Neglect.

Determination of Past Non-Compliance

Past noncompliance occurs when noncompliance has occurred in the past, but the facility corrects the deficiency and is in substantial compliance at the time of the current survey. *Prior to citing a deficiency as past-noncompliance, surveyors should investigate each instance thoroughly to determine if the facility took all the appropriate actions to correct the noncompliance, and determine the date on which the facility had returned to substantial compliance.*

More specifically, a deficiency citation at past noncompliance meets the following three criteria:

1. The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;
2. The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and
3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

The surveyors must document the facility's corrective actions in the CMS-2567; the facility is not required to submit a plan of correction. Refer to SOM Section *7510.1 and* 7510.2 for *additional guidance and* information on findings of past noncompliance.

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)].*

NEGLECT

NOTE: For purposes of this guidance, "staff" includes employees, the medical director, consultants, contractors, volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.

The Link between Noncompliance at Resident's Rights/Quality of Care/Quality of Life and Neglect of Goods and Services

Neglect at F600 should not automatically be cited in addition to the Resident's Rights/Quality of Care/Quality of Life tags. While the latter citations identify potential or actual negative outcomes in the areas of resident's rights, quality of care, and quality of life, neglect identifies the facility's failure to provide the required structures and processes in order to meet the needs of one or more residents. This may include, but is not necessarily limited to, the facility's failure to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident's needs.

Noncompliance at tags such as F686 and F689, do not automatically indicate noncompliance at F600 for neglect. For example, a survey team identifies that a facility had failed to perform a skin assessment for a resident, resulting in failure to implement interventions to prevent the development of an avoidable Stage 2 pressure ulcer for a resident. Upon further investigation, the survey team finds that the facility identified the pressure ulcer and treated it with no further worsening. While the survey team would identify noncompliance at F686, the facility would not generally be cited at F600 as well. Another example is when a resident requires supervision when ambulating and a staff member fails to provide assistance to the resident, resulting in a fall. In this scenario, the survey team would identify noncompliance at F689; however, the facility would not be cited at F600 for neglect. In both of these examples, a citation for neglect would require additional evidence that identifies that the facility knew, or should have known, to provide the staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident's needs, but continued to fail to take action necessary to avoid the potential for harm, or actual harm to the resident.

Identifying Neglect

"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.

Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances, such as lack of training to perform an intervention (e.g., suctioning, transfers, use of equipment), lack of sufficient staffing to be able to provide the services, lack of supplies, or staff lack of knowledge of the needs of the resident. Examples include, but are not limited to:

- A nurse aide was assigned to care for several residents, who required, assistance to eat, drink, dress, bathe, toilet, walk, and positioning in bed or chair. Due to the workload and resident care requirements, the nurse aide is unable to respond to call lights or complete the assignments for all of the residents that she is assigned to provide care for. In addition, due to insufficient numbers of staff in the facility, there is no other nurse aide available to assist her. This inability of the nurse aides in this unit to respond to call lights and to complete resident care assignments occurs throughout the shift, resulting in omissions in delivery of services to meet the resident's needs. Physical harm occurred as a result of the lack of sufficient staff to implement the care plan as ordered and inadequate supervision to assure that care was provided as ordered and/or as planned. In addition, staff had reported to administration their concerns about not meeting the residents' needs, but administration failed to respond.

- The nursing home utilizes temporary staffing agencies, but does not have processes in place to provide orientation, or medical or care plan information for the temporary staff regarding the individual resident's needs on the unit to which the temporary employee is assigned.

- The nursing home failed to respond to residents refusing to bathe/shower, based on complaints of cold water during bathing/showering. Maintenance staff identified equipment failures and reported them to the facility's administrator with recommendations to replace the water heating system. However, the administrator did not address these failures, resulting in the diminished quality of life for residents.

Identification of Goods and Services Required by Residents

When a resident is admitted to a nursing home, the nursing home has determined that it has the capability and capacity to provide goods and services to meet the needs of the resident by its staff.*See, for example, requirements at §483.10-Resident Rights, §483.24-Quality of Life, and §483.25-Quality of Care.* In addition, other services as needed by the resident must be assessed and addressed by the nursing home. This does not mean that all services must be directly provided by the nursing home, but the nursing home must assist and/or make referrals for the resident to receive necessary services. Examples of structures and processes in the facility include but are not limited to, the following:

- Structures - The nursing home's capability and capacity to provide needed care and services such as:

    - A facility's assessment to determine what resources are necessary to care for its residents competently;
    - The provision of sufficient numbers of qualified, trained staff based upon the facility's assessment and as needed to meet resident needs;
    - An effective orientation, training, and evaluation program, which includes, but is not limited to, nursing home resident care policies specific to resident's identified

care needs, resident care requirements based upon assignments and duties including types of services and treatments required for each resident, and other interventions necessary to meet a resident(s) needs;
    - Oversight and monitoring of staff performance including conducting performance evaluations for direct care staff (nurse aides), and how weaknesses or training needs are addressed;
    - Oversight and monitoring of contracted services or services provided under arrangement;
    - Resident care policies and procedures to ensure that the facility provides care and services in accordance with current standards of practice, that address resident's diagnosis, and that provide clinical and technical direction to meet the needs of each resident admitted;
    - Sufficient amounts of food to meet dietary needs;
    - Availability of medications and supplies necessary to provide care;
    - Implementation of an infection control and prevention program that includes staff procedures for care including hand hygiene, standard and transmission based precautions, including use of PPE;
    - A safe and sanitary environment;
    - Provision of sufficient clean linens;
    - Adequate and appropriate equipment and devices and other available technology, including procedures for how to use, clean, maintain and store equipment; and
    - If admitted, the provision of specialized services for residents who require rehabilitation services, dialysis, respiratory therapy (mechanical ventilation or oxygen therapy), IV therapy, and hospice.

- Processes so that the needs of each resident are met, based upon:
    - Initial and ongoing assessments of the clinical needs of the resident including any acute changes in condition, such as cardio/respiratory failure, choking, hemorrhaging, poor glycemic control, onset of delirium, behavioral emergencies, or falls resulting in head injuries or fractures;
    - The provision and implementation of a resident-specific care plan including the ongoing evaluation and revision of the care plan as necessary; and
    - Ongoing monitoring and supervision of staff to assure the implementation of the care plan as written.

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 provide sufficient, qualified, competent staff, to meet resident's needs;
- Failure to provide orientation and/or training to staff;

- Failure to provide training on new equipment or new procedures or medications required for the care of a specified resident or required due to changes in acceptable standards of practice;
- Failure to oversee the implementation of resident care policies;
- Failure to provide supervision and/or monitoring of the delivery and implementation of care;
- Failure of staff to implement resident interventions, even when residents are assessed and interventions are identified in the care plan;
- Failure to identify, assess, and/or contact a physician and/or prescriber for an acute change in condition, and/or a change in condition that requires the plan of care to be revised to meet the resident's needs in a timely manner;
- Failure to ensure staff respond correctly to medical or psychiatric emergencies;
- *Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives;*
- Failure to monitor and/or provide adequate supervision to assure that environmental hazards are not present including but not limited to:
    - Access to hot water of sufficient temperature to cause tissue injury;
    - Non-functioning call system without a compensatory action;
    - Improper handling/disposal of hazardous materials, chemicals and waste;
    - Infestation by insects/rodents;
- Failure to provide adequate monitoring and supervision, if smoking is allowed;
- Failure to meet financial obligations for the delivery of care and the maintenance of the facility (e.g. payment for staff, utilities, contractors);
- Failure of the Quality Assurance and Assessment committee to develop and implement appropriation action plans to correct identified quality deficiencies;
- Failure of administration to effectively and efficiently use its resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being; and
- Failure to provide oversight of medical services that are provided in the facility.

The failure to provide necessary care and services resulting in neglect may not only result in a negative physical outcome, but may also impact the psychosocial well-being of the resident, with outcomes such as mental anguish, feelings of despair, abandonment, and fear. (Refer to Psychosocial Outcome Severity Guide)

INVESTIGATIVE SUMMARY FOR ABUSE AND NEGLECT INVESTIGATION OF ALLEGATIONS OF ABUSE

The process to review concerns are outlined in the Abuse Critical Element Pathway (Form CMS- 20059).

Summary of Procedures

Identify if there is an alleged violation of abuse, physical punishment or allegations of an individual depriving a resident of care or services.

- Refer to the Neglect Critical Element Pathway (form CMS-20130) to investigate concerns about structures or processes leading to a resident(s) failing to receive required care and services.
- Refer also to the Investigative Protocol for *F607 – Policies and Procedures Related to Allegations of Retaliation by the Facility Against a Covered Individual, for an allegation of retaliation and*F*609* -Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime.

NOTE: If you receive an unreported allegation of abuse, report this immediately to the facility administrator or person in charge.

Use observations, interviews, and record review to gather and corroborate information related to:

- The alleged abuse, including anything that could have placed the alleged victim at risk for abuse, who was involved, what happened, and when and where did it happen;
- Any injuries and/or physical/psychosocial outcomes, including whether interventions/medical treatment was required;
- Details of actions taken, including protecting the resident(s), reporting, investigating, and corrective actions;
- Whether there is any indication that retaliation may have occurred; and
- What types of training and/or orientation staff may have received related to abuse.

For specific allegations of abuse, the surveyor should review:

- For allegations of staff to resident abuse, staffing rosters to determine staffing at the time of the alleged abuse, timecards for staff on duty at the time, and conduct staff interviews to determine whether there was adequate monitoring and supervision of staff at the time of the allegation. The surveyor should also review staff training logs to determine whether staff was trained on abuse prevention, and review the alleged perpetrator personnel records, including screening and disciplinary records, if any.

- For allegations of resident to resident abuse, whether there is a history of distressed behaviors that could place residents at risk, whether resident assessments identified concerns related to behavior, mood, cognitive status, communication, and mobility and whether care planning addressed the concerns identified with specific interventions, whether interventions were implemented, and whether there was adequate monitoring and supervision of the resident(s).

- For allegations of visitor to resident abuse, whether there was any indication of risk to the resident(s) and whether adequate monitoring and supervision were provided as appropriate.

If Tag F600 is cited for abuse, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from [Type(s) of abuse: mental abuse/verbal abuse/physical abuse/sexual abuse/deprivation of goods and services] by [Perpetrator type: staff/a resident/a visitor]…."

INVESTIGATION FOR ALLEGATIONS OF NEGLECT

The process to review concerns are outlined in the Neglect Critical Element Pathway (Form CMS-20130).

Use

Use the Neglect Critical Element (CE) Pathway, and the above Guidance when investigating concerns related to structures or processes that have led to resident outcome such as unrelieved pain, avoidable pressure injuries, avoidable dehydration, lack of continence care, or malnourishment.

Utilize appropriate Critical Element Pathways for care issues, in order to identify whether noncompliance for a care concern exists first and determine whether further investigation is needed as to whether the facility has the structures and processes to provide necessary to provide goods and services to residents.

Summary of Procedures

Interview staff and review facility policies and procedures to determine:

- How the facility monitors and provides oversight of the provision of care and services; and
- How the facility responds when there are concerns that a resident(s) is not receiving necessary goods and services.

If Tag F600 is cited for neglect, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from neglect…."

KEY ELEMENTS OF NONCOMPLIANCE FOR ABUSE AND NEGLECT §483.12(a)(1)

To cite deficient practice at F600, the surveyor's investigation will generally show that the facility:

- Failed to protect a resident's right to be free from any type of abuse, including corporal punishment, and neglect, that results in, or has the likelihood to result in physical harm, pain, or mental anguish; or

- Failed to ensure that a resident was free from neglect when it failed to provide the required structures and processes in order to meet the needs of one or more residents.

POTENTIAL TAGS FOR ADDITIONAL INVESTIGATION

During the investigation, the surveyor may have determined that concerns may also be present with related outcome, process and/or structure requirements. The surveyor is cautioned to investigate these related requirements before determining whether non-compliance may be present. Some examples of related requirements that should be considered include the following:

- 42 CFR §483.10(f)(4)(ii) -(v), F563 - Visitation Rights
  - Determine if the facility provided immediate access and visitation by family, designated representatives or other individuals, subject to reasonable restrictions and the resident's right to deny or withdraw consent.
- 42 CFR §483.10(f)(4)(vi), F564- Resident Right to Visitors
- 42 CFR §483.10(g)(1), F572 - Notice of Rights and Rules
- 42 CFR §483.10(h), F583- Personal Privacy/Confidentiality of Records
- 42 CFR §483.12(a)(3) -(4), F606 - Not Employ/Engage Staff with Adverse Actions
- 42 CFR §483.12(b)(1) -(4), §483.12(b)(5), F607 – Develop/Implement Abuse/Neglect, etc. Policies
- 42 CFR §483.12(c)(1), (4), §483.12(b)(5), F609 – Reporting of Alleged Violations
- 42 CFR §483.12(c)(2) - (4), F610 – Alleged Violations-Investigate/Prevent/Correct
- 42 CFR §483.24, F675 - Quality of Life
- 42 CFR §483.25(d), F689- Free of Accident Hazards/Supervision/Devices
  - Determine if the facility ensured that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision to prevent accidents related to resident-to-resident altercations where the resident's action is not willful.
- 42 CFR §483.35, 483.35(a), and §483.35(c)- F725 and F726 – Sufficient and Competent Staff
- 42 CFR §483.35(a)(3) and (a)(4), §483.35(c), F726 – Competent Staff
- 42 CFR §483.40(b) -(b)(1), F742- Treatment/Svc for Mental/Psychosocial Concerns
- 42 CFR §483.75 (g)(2)(ii)- F867- QAA Activities
- 42 CFR§483.95(c), F942- Abuse, Neglect, and Exploitation Training
- 42 CFR §483.95(g), F946-Required In-Service Training for Nurse Aide

DEFICIENCY CATEGORIZATION §483.12(a)(1)

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Psychosocial Outcome Severity Guide).

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 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*

According to the Social Security Act [Sections §§1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii)], every resident has the right to be free from mental or physical abuse. A reasonable person would not expect that they would be harmed in his/her own "home" or a health care facility and would experience a negative psychosocial outcome (e.g. fear, anxiety, anger, humiliation, a decline from former social patterns). In incidents in which one resident abuses another resident, if a reasonable person would likely suffer actual harm as a result of the incident, the incident should not be cited below Severity Level 3 (Actual Harm).

NOTE: Surveyors should refer to the guidance related to physical, mental/verbal, and sexual abuse and deprivation of goods and services by staff.

Examples of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety include, but are not limited to:

- *The facility failed to protect a resident from sexual abuse when Resident 1 was found in Resident 2's bedroom. Resident 1 was holding Resident 2, whose clothes had been partially removed and her breasts were exposed. Resident 2 was severely cognitively impaired. Resident 1 had a known history of sexually inappropriate behaviors, but there was no evidence that the facility had assessed and revised the care plan to identify the potential risks to other residents related to the behaviors; there was no evidence that Resident 2 could consent to sexual activity with other residents. Based on interview with Resident 2's daughter, the daughter described her shock about the incident and how her mother would have been upset. Because this type of inappropriate, unwanted sexual contact would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in the resident's position would have experienced severe psychosocial harm- dehumanization, and humiliation- as a result of the sexual abuse.*

- *The facility failed to ensure that a resident was free from physical abuse. A resident, who required 1:1 supervision due to physical aggression, was observed to have escalating behaviors, resulting in striking out at staff and residents in the vicinity. The staff failed to ensure that residents in the vicinity were safe, and the resident pushed another resident who was walking to his/her room while unsupervised by staff, as described by housekeeping staff who witnessed the incident. The victim fell to the floor with a resulting fracture to her arm that required treatment at the hospital, placement of a cast, and was in moderate pain due to the fracture. Even though there was no significant decline in mental or physical functioning, it can be determined that the reasonable person would have experienced severe psychosocial harm as a result of the physical abuse, since a reasonable person would not expect to be injured in this manner in his/her own home or a health care facility.*

- *The facility failed to ensure that a resident was free from mental abuse and corporal punishment. A resident who had a cognitive disability carried a doll around with her throughout the day. During an activity, the resident placed the doll in a chair next to*

her and refused to allow another resident to use the chair. The staff slapped the resident's hand and removed the doll so the other resident could sit down. The staff told the resident she could not attend any more activities with the doll, or he would get rid of it and the resident would never see it again. The resident began to scream, cry for her doll, and left the room. The resident will not leave her room to attend any activities for fear that the staff person will take her doll. The resident's behavior has declined and now cries and expresses fear when taken for bathing and meals without her doll. Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the mental abuse and corporal punishment.

- *The facility deprived residents of care related to the failure of staff to respond timely to residents' requests and treat residents with dignity and respect which resulted in ongoing embarrassment, humiliation, and the failure to provide incontinence care as needed to meet the needs of several residents. Based on family and resident group interviews, other residents and their family members complained that residents often waited a long time (up to an hour) before staff took them to the bathroom, resulting in residents urinating in their beds and lying in urine for long periods of time. Residents indicated that this is a problem, especially on the night shift. Residents were told by nurse aides to just urinate on their beds and staff would change the sheets in the morning. Two night-shift staff members confirmed that they had seen other staff disconnect call lights in residents' rooms so that they were not functioning. After investigation, it was determined that the nursing home failed to provide the necessary care. [**NOTE**: In this example, the surveyor had already identified noncompliance at dignity (F550) and urinary incontinence (F690)] It can be determined that the reasonable person in the residents' position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation) as a result of the abuse.*

- *The facility deprived a resident of care by failing to provide access for resident communication and response to resident's requests for necessary care resulting in the resident's ongoing fear and anxiety. During a survey, the surveyor observed that a resident's call light was pinned to a privacy curtain that was out of reach of the resident. The resident stated that the staff removes the call light at night because the nursing staff said he used it too much and they did not have time to answer the light all the time. The resident began crying and expressed fear that something would happen and he would have no way of getting assistance as staff would not come if he called out for help. Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the deprivation of care.*

- The facility failed to protect a resident from sexual abuse resulting in serious psychosocial harm. A resident, with moderate confusion and who was dependent on staff for care, reported to staff that she was "touched down there" and identified the alleged perpetrator. However, staff, who thought the resident was confused, did not report her allegation to facility administration and failed to provide protection for the resident allowing ongoing access to the resident by the alleged perpetrator. The resident expressed recurring fear whenever the perpetrator approached the resident,

exhibited crying and agitation, and declined to leave her room. *Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the sexual abuse.*

- The facility failed to protect two residents from mental abuse and extreme humiliation perpetuated by two staff who posted videos and photographs on social media, of the residents during bathing, using the bathroom, and grooming, which included nude photos and photos of genitalia. In addition, on the videos, the two staff verbally taunted and made cruel remarks to the residents including making fun of the way the resident looked and acted. One resident who was cognitively impaired was shown on the video to be crying in response to the remarks made to her by the staff. One resident, who was cognitively intact, told surveyors that he was extremely humiliated and angry when he found out that these items were posted. *Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the mental abuse.*

- The facility failed to ensure that a resident was free from neglect when it did not have the structures to provide necessary goods and services to residents. During facility tour, the surveyor noted a strong urine odor. Residents were observed to be in bed with soiled clothes and linens. Residents told the surveyor that they did not get out of bed or dressed since there were not enough nurse aides to assist them. During interviews with nurse aides, it was reported that the facility lacked supplies, such as incontinence briefs, laundry/housekeeping supplies, gloves and food. Interview with the Director of Nurses revealed that the medical supply vendor was suspended and no longer providing supplies to the facility due to non-payment. Multiple staff also reported not receiving their last paychecks. During interviews with residents, residents reported mice in their rooms. During observation of the kitchen and interview with the dietary manager, there was evidence of rodent infestation, including staff seeing rodents eating and finding torn bags and crumbs on the floor. The administrator reported that the pest control company had visited the facility recently, but there was no record of the visit or proposal for remediation. Also, there was no sanitizer for the dishwasher and no alternative method for sanitizing dishes. *It can be determined that the reasonable person in the residents' position would have experienced severe psychosocial harm (e.g., embarrassment, humiliation, anxiety) as a result of neglect.*

Examples of Severity Level 3 Noncompliance Actual Harm that is not Immediate Jeopardy include, but are not limited to:

- *The facility failed to protect a resident from physical abuse when Resident 1 slapped Resident 2 in the face. Based on resident and staff interviews, Resident 1 had previously exhibited an aggressive tone towards other residents. Based on the interview with the nurse aide, Resident 2 was talking loudly to Resident 1 in the hallway. Resident 1 shouted profanity to Resident 2, followed by: "If you say one more word, you're going to be sorry." The nurse aide was the only staff present in the area and was transferring another resident; the nurse aide could not intervene and did not call for assistance from other staff. Resident 2 continued to talk loudly. Resident 1*

then reached out, slapped Resident 2 on the left side of his face, and backed his wheelchair away from Resident 2. Based on the assessment of Resident 2, his left cheek exhibited some redness in the area that was slapped, but there were no other physical injuries. Based on the survey team's interview with Resident 1, Resident 1 was also able to recall the incident and said, "He [Resident 2] just won't stop talking…I don't know what came over me." Resident 2 was moderately cognitively impaired and when interviewed, could not recall the incident. The survey team interviewed Resident 2's son, who said that his father would have been mad after an incident like this. Therefore, by using the reasonable person concept, the survey team would conclude that Resident 2 would have experienced psychosocial harm (e.g. anger directed at the action or at a person) as a result of the physical abuse since there is an expectation that the resident would not be slapped in the face in the facility.

- The facility neglected to provide supervision and monitoring to assure that continence care is provided with dignity, respect and meets the needs of a resident. During a complaint survey, the investigation revealed that a cognitively-impaired resident had been left with his body *partially* uncovered, and unattended for several hours. Also, the investigation also identified that his catheter bag had been left lying flat on the bed so that urine could not flow freely or drain, resulting in expressions of pain and *distress*. Interview with the charge nurse revealed that she was the only nurse in the building during the night shift and stated that the she was unable to monitor the nurse aides' provision of care because she was providing treatments on other units. It was identified that insufficient nurse staffing has been reported to the administration and that this was an ongoing concern. *Based on the resident's behavior, it can be determined that the resident experienced psychosocial harm as a result of neglect.*

Examples of Severity Level 2 Considerations Noncompliance No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include, but are not limited to:

- *The facility failed to protect Resident 2 from verbal abuse. During the interview with Resident 2, she mentioned that she does not get along with Resident 1. Based on an interview with staff, Resident 1 previously demanded Resident 2 to sit up at the table and that there was something wrong with her. However, staff would re-direct the residents to separate tables to prevent any situation from escalating. According to interviews with other residents, one weekend, residents recall that temporary staff had placed Resident 1 and 2 at the same table for a group activity. Resident 1 yelled to Resident 2 to sit up straight a few times. However, staff in the room would not intervene. Resident 1 called Resident 2 a derogatory name. Upon review of Resident 1 and 2's records, there was no documentation related to altercations. Even though Resident 2 did not have a reaction, it can be determined that the reasonable person would experience no actual harm with the potential for more than minimal psychosocial harm as a result of the verbal abuse.*

Severity Level 1: No Actual Harm with Potential for Minimal Harm

The failure of the facility to prevent abuse or neglect is more than minimal harm. Therefore,

Severity Level 1 does not apply for this regulatory requirement.

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[1] World Health Organization. 2016. Adapted from*Elder Abuse Fact Sheet*. September. Accessed March 21, 2017. https://www.who.int/mediacentre/factsheets/fs357/en.

[2] CDC. 2016.*Elder Abuse: Risk and Protective Factors*. June. Accessed March 21, 2017. http://www.cdc.gov/violenceprevention/elderabuse/riskprotectivefactors.html.

[3] Adapted from Lachs, Mark S, Tony Rosen, Jeanne A Teresi, Joseph P Eimicke, Mildred Ramirez, Stephanie Silver, and Karl Pillemer. 2013. "Verbal and physical aggression directed at nursing home staff by residents." *Journal of General Internal Medicine*660-667.

[4] Dong, XinQi, RuiJia Chen, E-Shien Chang, and Melissa Simon. 2013. "Elder Abuse and Psychological Well-Being: A Systematic Review and Implications for Research and Policy--A Mini Review."*Gerontology*132-142.

[5] Adapted from Burgess, Ann W, Elizabeth B Dowdell, and Robert A Prentky. 2000. "Sexual Abuse of Nursing Home Residents."*Journal of Psychosocial Nursing & Mental Health Services*10-18.

[6] Adapted from Burgess, Ann W, and Paul T Clements. 2006. "Information Processing of Sexual Abuse in Elders." *Journal of Forensic Nursing*113-120.