F603

(Rev. 208; Issued:10-21-22; Effective: 10-21-22; Implementation:10-24-22)

§483.12(a)(1) 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.

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**involuntary seclusion**.

DEFINITIONS §483.12(a)(1)
"**Involuntary seclusion**" is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative.

GUIDANCE §483.12(a)(1)
NOTE: During a situation in which a resident's behavior has escalated and immediate interventions are required for the safety of the resident, staff and/or other residents), the facility must immediately consult with the resident's physician about the behavioral symptoms and the resident's designated representative; and provide necessary supervision of the resident to ensure that the resident and other residents are protected.

Involuntary seclusion may take many forms, including but not limited to the confinement, restriction or isolation of a resident. Involuntary seclusion may be a result of staff convenience, a display of power from the caregiver over the resident, or may be used to discipline a resident for wandering, yelling, repeatedly requesting care or services, using the call light, disrupting a program or activity, or refusing to allow care or services such as showering or bathing to occur.

Involuntary seclusion includes, but is not limited to, the following:

- A resident displays disruptive behaviors, such as yelling, screaming, distracting others (such as standing and obstructing others viewing abilities for the TV or programs) and staff remove and seclude the resident in a separate location such as in an office area or his/her room, leaving and closing the door and without providing interventions to address the behavioral symptoms;

- In an attempt to isolate a resident in order to prevent him/her from leaving an area, the resident(s) is involuntarily confined to an area by staff placing furniture, carts, chairs in front of doorways or areas of egress;

- Staff hold a door shut, from the opposite side of the door, in order to prevent egress;

- Staff place a resident in a darkened room, office, or area secluded from other staff and residents for convenience or as punishment;

- A resident is physically placed in an area without access to call lights, and/or other methods of communication creating an environment of seclusion and isolation for the resident; and

- A resident placed in a secured area of the facility, but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress.

Considerations Involving Secured/Locked Areas
If a resident resides in a secured/locked area that restricts a resident's movement throughout the facility, the facility must ensure that the resident is free from involuntary seclusion.

A resident in a secured/locked area would not be considered to be involuntarily secluded if all of the following are met:

- The facility has identified the clinical criteria for placing a resident in the secured/locked area;

  Placement in a secured/locked area is not:

  1. Used for staff convenience or discipline;
  2. Based on the resident's diagnosis alone since the determination for placement in the area must be made on an individualized basis; and/or
  3. Based on a request from the resident's representative or family member without clinical justification;

  For example, if the POA requests placement in the secured/locked area but the resident declines placement and placement does not meet the clinical criteria and is not in the best interest of the resident, then placement of the resident in the secured/locked area would be involuntary seclusion.

- The facility involves the resident/representative in care planning, including the decision for placement in a secured/locked area and the development of interventions based upon the resident's comprehensive assessment and needs; and

- The facility provides immediate access and visitation by family, resident representative or other individuals, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent.

It is expected that each resident's record would include:

- Documentation of the clinical criteria met for placement in the secured/locked area by the resident's physician along with information provided by members of the interdisciplinary team;
- Documentation that reflects the resident/representative's involvement in the decision for placement in the secured/locked area;
- Documentation that reflects whether placement in the secured/locked area is the least restrictive approach that is reasonable to protect the resident and assure his/her health and safety;
- Documentation by the interdisciplinary team of the impact and/or reaction of the resident, if any, regarding placement on the unit; and
- Ongoing documentation of the review and revision of the resident's care plan as necessary, including whether he/she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continue to meet the needs of the resident.

NOTE: A resident who chooses to live in the secured/locked unit (e.g., the spouse of a resident who resides in the area), and does not meet the criteria for placement, must have access to the method of opening doors independently. The chosen method for opening doors (e.g., distribution of access code information) is not specified by CMS. Staff should be aware of which residents have access to opening doors and monitor their use of the access to ensure other residents' safety.

NOTE: See also Tags at Resident Rights for guidance related to justice-involved individuals.

Transmission Based Precautions

When used appropriately, transmission-based precautions (i.e., isolation due to infection) is not to be considered involuntary seclusion. The facility's policies must identify the type and duration of the transmission-based precautions required, depending upon the infectious agent or organism involved; and the precautions should be the least restrictive possible for the resident based on his/her clinical situation. Furthermore, the resident's record must contain the rationale for the selected transmission-based precautions. However, once the resident is no longer a risk for transmitting the infection, the removal of transmission-based precautions is required in order to avoid unnecessary involuntary seclusion. See also 42 CFR §483.65 – Infection Control (Tag F880).

INVESTIGATIVE PROTOCOL FOR INVOLUNTARY SECLUSION USE §483.12(a)(1)

Use this protocol for investigating:

- An alleged violation of involuntary seclusion during a standard survey and abbreviated surveys (complaint investigations, onsite investigations of self-reported incidents, and/or revisits); and
- An allegation of involuntary seclusion involving a resident who resides in a secured/locked area or who is/was on temporary transmission-based precautions.

If a surveyor determines that an act of involuntary seclusion has occurred or is occurring, he/she must immediately report this to the Administrator, or his/her designated representative if the Administrator is not present. The survey team should determine whether the facility then takes appropriate action in accordance with the requirements at F607, F609, and F610, including implementing safeguards to prevent further potential involuntary seclusion.

Review of Facility Policies and Procedures
Obtain and review the facility's policies and procedures related to the allegation under investigation.

Observations
Observe the physical environment in which the alleged involuntary seclusion may have occurred. This may include observations of the following, which include, but are not limited to:

- Room configuration;
- Location of the alleged involuntary seclusion in relation to supervised areas; and
- Objects that may have been used to obstruct residents.

Observe whether staff members make remarks and behave in a manner that may indicate concerns with staff treatment of residents.

Interview:

Alleged Victim/Resident Representative and Witness Interviews

Interview the alleged victim/resident representative to determine as much information regarding the alleged involuntary seclusion that he/she may be able to provide. Interview the alleged victim privately; however, the alleged victim may request that another person be present. If so, be aware that the alleged victim may not be comfortable speaking openly in the presence of another person, and another interview may be necessary to follow up on any discrepancies identified. A resident with a cognitive impairment and/or mental illness may mistakenly be assumed to be an incompetent witness. In those situations, interview the alleged victim, to the extent possible, and corroborate statements with other observations, interviews and record review. During the interview, observe the resident's emotions and tone, as well as any nonverbal expressions or gesturing to a particular body area, in response to the questions.

Interview witnesses, including but not limited to, the assigned staff, staff in the immediate area, staff from the shifts prior to or after the alleged involuntary seclusion; the victim's roommate (if any), other residents, and/or visitors. Make every attempt to maintain the confidentiality of witnesses. It may not be appropriate to interview the person who reported the allegation first, as that may unintentionally identify the person. The surveyor may ask the witness to re-create or re-enact the alleged incident, to better understand the sequence of events.
Interview the alleged victim/resident representative and witnesses to determine:

- What happened, when, where, and how often;

- Whether he/she can identify the alleged perpetrator and any witnesses;
- What occurred prior to, during and immediately following the alleged involuntary seclusion;
- Whether he/she reported the allegation to anyone within the facility or to an outside agency (e.g., other staff, ombudsman); if so, to whom, when and what was the response;
- For the alleged victim,
  - Whether he/she feels safe, is afraid of anyone, or is fearful of retaliation; and
  - Whether the alleged victim has had past encounters with the alleged perpetrator.

Staff Interview

Review staff schedules to determine who was working at the time of the alleged involuntary seclusion. Interview staff from any department who has direct contact with the resident(s), as appropriate, to collect information about:

- Whether he/she had knowledge of the alleged involuntary seclusion and what actions, if any, he/she took in response to the allegation;
- Any changes in the alleged victim's behavior as a result of the alleged involuntary seclusion;
- How the alleged perpetrator and alleged victim related to one another prior to and after the incident;
- Whether the alleged perpetrator had exhibited inappropriate behaviors to the alleged victim or other residents in the past, such as using derogatory language, rough handling, or ignored residents while giving care;
- Whether he/she reported the alleged involuntary seclusion to management/administrative staff, or any State or local agencies, such as Adult Protective Services or local law enforcement, and if so, to whom was the alleged involuntary seclusion reported and when;
- If not reported, what prevented him/her from reporting;
- If he/she reported the allegation, whether he/she feels that retaliation has occurred as a result of reporting the allegation, and if so, what actions were taken against staff; and
- Whether he/she has received training related to involuntary seclusion from the facility.

NOTE: If the staff member was a witness, refer also to the questions above under Witness Interview.

Alleged Perpetrator Interview:

The alleged perpetrator may or may not be in the facility or may refuse to be interviewed. If the alleged perpetrator is a staff member, the staff member may have been suspended or re-assigned until the investigation is completed and in some situations, the facility may have terminated the employment of the individual. If possible, interview the alleged perpetrator either in person or by phone to determine:

- What position he/she holds and how long the alleged perpetrator has worked in the facility;

- What type of orientation, training, work assignments, and supervision he/she receives;
- Whether he/she was present in the facility at the time of the alleged involuntary seclusion;
- What information he/she can provide regarding the alleged involuntary seclusion such as what happened, why was the resident separated/secluded, how often does it occur;
- What is his/her relationship to the alleged victim; and
- If he/she has any other information that he/she wishes to share in regard to the investigation.

Other Health Care Professionals Interview

Interview the director of nursing, social worker, and physician/practitioner, as necessary, to determine:

- Whether he/she was notified by staff of the alleged involuntary seclusion and if so, the response;
- Whether he/she conducted an assessment of the resident for potential injuries and/or changes in mental status, and if identified, what interventions or treatment (e.g., counseling) were provided and when; and
- If a resident is under transmission-based precautions, the reason why the resident is under transmission-based precautions and when transmission-based precautions are to be removed.

Record Review-Resident

It may be necessary to obtain copies of any relevant information in the resident's record. Review the alleged victim's record to obtain necessary information, as applicable, such as:

- The diagnosis and physician orders including medications;
- The RAI, to include the resident's cognitive status, functional status (independent ambulation, transfer status, uses a wheelchair, using an assistance device or requires staff assistance for ADL's);
- Care plan and interventions/goals;
- Physician's, nurse's, social worker's and other staff members progress notes, as applicable;
- Social and psychological history; and
- Hospital transfer/discharge information, if applicable (**NOTE**: the surveyor may follow up with an interview with the treating practitioner at the hospital).

Review interdisciplinary notes within the timeframe of the alleged involuntary seclusion for documentation that supports, clarifies, or verifies the allegation. Determine if the record reflects:

- The date/time of the allegation and/or the date/time when the allegation was first discovered and reported; and

- Any change in the alleged victim's mood and demeanor before and after the alleged incident, such as, but not limited to: Distrust, fear (e.g., fear of being left alone), angry outbursts, tearfulness, agitation, trembling, cowering, panic attacks, withdrawal from social interaction, changes is sleeping patterns, or symptoms similar to PTSD symptoms.

Record Review-Alleged Perpetrator's Personnel File Review, if Staff
If staff is identified as the alleged perpetrator, review the staff member's personnel file for information related to:

The allegation being investigated or history of other allegations;
- Adverse personnel actions taken;
- Screening that occurred prior to and during employment; and
- Training and orientation related to abuse and neglect prevention.

Additional Activities for Investigating Possible Involuntary Seclusion for Residents in Secured/Locked Areas

If a resident lives in an area that restricts free movement throughout the facility, the survey team must determine the following:

- Whether the facility has developed and implemented policies and procedures related to secured/locked areas, including criteria for placement and ongoing assessment to assure that the resident meets the criteria;
- Whether the facility attempted alternatives prior to placement in a secured/locked area; if so, what alternatives, and what the resident's response was to the alternative interventions;
- Why the resident is placed in the secured/locked area;
- Whether the resident/resident representative was involved in the placement decision; whether the resident/resident representative agreed with the decision or not; if not, how did the facility address this; and

- Whether the secured/locked area is accessible to other residents in the facility and visitors, and if so, how.

Facility Investigator Interview
If the facility has investigated the alleged involuntary seclusion, identify the staff member responsible for the initial reporting and the overall investigation of the alleged involuntary seclusion. This may be the administrator in some facilities. Obtain a copy of the investigation report, if any.

NOTE: Refer to F609 for further investigation if the facility does not have a copy of the investigation report available.

Interview the facility investigator to determine:

- When he/she was notified of the allegation and by whom;

- When and what actions were taken to protect the alleged victim(s) while the investigation was in process;
- Steps taken to investigate the allegation and a timeline of events that occurred;
- What happened as a result of the investigation;
- When and who received the results of the investigation; and
- Whether there is any related information regarding the allegation that may not be included in the investigation report.

Administrator Interview

The administrator is responsible for the overall implementation of the facility policies/procedures, including to prohibit involuntary seclusion. This includes the obligation to report, investigate, protect the alleged victim, and take corrective actions, as necessary, based upon the outcome of the investigation. Note that some of this information may have already been obtained from the facility investigator.

Interview the administrator to determine:

- When he/she was notified of the alleged involuntary seclusion, and when the initial report was made to the required agencies;
- Who was/is responsible for the investigation, whether it has been completed and the outcome, or whether the investigation is ongoing;
- When the results of the investigation were reported to the administrator and to the required agencies;
- How the alleged victim and other residents at risk were protected during the investigation;
- If the alleged violation is verified, what corrective actions are being taken;
- Whether any changes were necessary to the facility's policies and procedures;
- Whether the alleged perpetrator had previous warnings or incidents at the facility; and
- What information has been provided to staff and residents related to involuntary seclusion, including reporting requirements.

Interview with Person Responsible for Quality Assurance

Interview the person responsible for quality assurance activities. Determine how the committee is providing monitoring and oversight of potential and/or actual reported allegations of involuntary seclusion. Evaluate whether the committee has made recommendations such as policy revision and/or training to prohibit involuntary seclusion.

KEY ELEMENTS OF NONCOMPLIANCE §483.12(a)(1)

To cite deficient practice at F603, the surveyor's investigation will generally show that the facility separated or secluded a resident against the resident's will or the resident representative's will without clinical justification.

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, §483.10(a)(1)-(2), §483.10(b)(1)-(2), F550- Resident Rights and Dignity
- 42 CFR §483.10(c)(1),(4),(5), F552- Right to be Informed/Make Treatment Decisions
- 42 CFR §483.10(c)(2)-(3), F553- Right to Participate Planning Care
- 42 CFR §483.10(g)(14), F580-Notify of Changes (Injury/Decline/Room,Etc)
- 42 CFR §483.10(j), F585- Grievances
- 42 CFR §483.12(a)(3)-(4), F606- Not Employ/Engage Staff with Adverse Actions
- 42 CFR §483.12(b)(1)-(5), F607– Develop/Implement Abuse/Neglect, etc. Policies
- 42 CFR §483.12(b)(5), (c)(1), (4), F609 – Reporting of Alleged Violations
- 42 CFR §483.12(c)(2)-(4), F610– Alleged Violations-Investigate/Prevent/Correct
- 42 CFR §483.20(b)(1)-(2)(i),(2)(iii), F636-Comprehensive Assessments & Timing
- 42 CFR §483.20(b)(2)(ii), F637-Comprehensive Assess After Significant Change
- 42 CFR §483.21(b)(1), F656- Develop/Implement Comprehensive Care Plan
- 42 CFR §483.21(b)(2), F657- Care Plan Development and Revision
- 42 CFR §483.24, F675 - Quality of Life
- 42 CFR §483.95(c), F942- Abuse, Neglect, and Exploitation Training
- 42 CFR §483.95(g), F946-Required In-Service Training for Nurse Aide
- Life safety code requirements
  - If there are concerns with life safety code requirements, the survey team should notify its SA supervisor that a life safety code concern has been identified and may require a life safety code survey.

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).

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

- The facility failed to assure that a resident was free from involuntary seclusion. The resident with a history of suicidal ideation and displaying behavioral symptoms which included episodic periods of yelling and screaming, especially towards the end of the day and during the night. According to the resident's record, after dinner last evening, the resident was placed by staff in her recliner with a tray attached by the nurse's station. It was documented and corroborated by staff interviews that they heard the resident yell and scream loudly, pounding on her tray. Several residents began complaining about the noise. A nurse aide transferred the resident to a wheelchair, and placed the resident, who was at risk for suicidal ideation, in a housekeeping supply room, which was used for storage of chemicals. The nurse aide closed the door and went back to the floor. The

resident began crying loudly, banging on the doors and yelling for help. Another staff person thought that she heard a resident yelling, but was busy completing tasks for another resident. Afterwards, she heard the yelling continue, found the resident, and removed the resident from the room, the resident was sweating profusely, her face was reddened, and was shaking and sobbing incoherently. Upon interview, the nurse aide who had secluded the resident stated that she did not have the time to deal with the yelling, and she had to get other residents to bed. She moved the resident to the supply room to quiet her down.

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

- The facility failed to assure that a resident was free from involuntary seclusion. A resident was admitted to a secured area at the request of his representative. After admission, the resident requested the security codes in order to go in and out of the area, but staff refused to provide the codes. The resident then requested to be transferred, but staff refused his request. The staff then contacted the resident's attending physician, who made the determination that was not any clinical reason for the resident to be located in the secured area; once the physician made this determination, he notified the facility, which immediately transferred the resident to a room not located in the secured area. During interview with the resident, he stated that he was still angry that he had been placed in the secured area against his will for his first day in the facility, and felt afraid to leave his room except for meals or else staff would place him again in the secured area, even though staff attempted to regain his trust.

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

- The facility failed to assure that a resident was free from involuntary seclusion. Based on resident and staff interviews, it was stated that a nurse aide was transporting him to an activity. The resident, who was dependent on staff for mobility in his wheelchair, said that he was annoyed that he was late to the activity. He began to insult the nurse aide. The nurse aide transported the resident in his wheelchair to an unused shower room, instead of to the activity room and the nurse aide told the resident that when he stopped insulting her, she would take him to the activity. The nurse aide stood outside the door to supervise the resident and when the resident became quiet, she took the resident back to the activity. Afterwards, the resident reported what had happened to the activity director and said that he did not want the aide working with him anymore. During interview, the resident stated that this was the only time something like this happened.

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

The failure of the facility to prevent involuntary seclusion is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.