



June 14, 2009

The Abuse F-tags: Are You in Compliance?

Recently a number of facilities have been cited under one or more of the Abuse-related F-tags during annual or other survey visits while other facilities continue to have questions regarding what situations do and/or do not have to be reported.

- Surveyors continue to identify situations that they believe meet the criteria for being reported and/or investigated to rule in/out the possibility of abuse as a result of incident reports, complaint/grievance logs and employee personnel records reviews, resident interviews, etc., even in those cases in which the surveyor doesn't really suspect that abuse may have occurred.
- Even in those cases in which the facility did conduct an investigation and the known facts did not substantiate an abuse/neglect/theft, failure to report the process to The State has resulted in survey deficiencies.
- Investigations that did not meet the surveyor's interpretation of comprehensive and/or comprehensively documented have resulted in survey deficiencies.
- With increasing frequency, licensure surveys are including abuse/neglect language in conjunction with serious findings.

This article will review the regulations and discuss ways to address surveyor application of the standards.

Reporting Requirements:

F223 defines 'Abuse' as the *willful* infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

Forms of abuse are further defined as:

Verbal = any use of oral, written, or gestured language that *willfully* includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of ... their ability to comprehend...

Sexual = includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

Physical = includes hitting, slapping, pinching, and kicking.

Mental = includes but is not limited to humiliation, harassment, threats of punishment or deprivation.

F224 defines 'Neglect' as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. 'Misappropriation of resident property' means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

F225 requires that:

- Facilities ensure that ***all alleged*** (or potential) violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are ***reported immediately*** to the administrator and to other officials in accordance with State law through established procedures (***including to the State survey and certification agency***).
- Facilities have evidence that ***all alleged*** (or potential) violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
- ***The results of all investigations*** must be reported to the administrator or his designated representative and to other officials in accordance with State law (***including to the State survey and certification agency***) within **5** working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Some facilities have misinterpreted the above, believing that only substantiated allegations are to be reported to The State.

THIS IS NOT CORRECT!

In some cases, the allegation of the resident/family includes clear potential for an abuse situation, i.e. the CNA hit me, the Nurse threatened to give me a shot if I didn't eat my dinner, I saw the Housekeeper take my gold ring, etc., and the facility's obligation to report the initiation of an investigation, followed by an investigation summary/conclusion within 5 days, is equally clear. However, when a situation is reported involving resident/family concern or upset or dissatisfaction with the way in which a caregiver has verbally interacted or physically cared for resident, i.e., the CNA transferred me roughly, the Nurse's tone of voice sounded harsh, I am missing \$10 from my purse, etc., it may be uncertain at the outset whether or not the allegation and facts/circumstances of the interaction potentially meet the abuse/neglect definition. *Bruises or other injuries for which there has been no cause or probable cause identified after/despite comprehensive incident investigation* also potentially meet the abuse/neglect definition.

If the situation requires investigation to determine its exact nature, then the situation requires immediate reporting to The State that an investigation has been initiated with follow-up of the completed investigation and conclusions within 5 working days.

In many cases the facts and circumstances are not commensurate with the definition of abuse in that the actions of staff were not *willful*, had an unintentional affect on the resident, resulted in a misunderstanding by the resident, etc. The State does not typically pursue an on-site follow-up

investigation of every preliminary report nor does it necessarily conduct an on-site review when the facility's summary/conclusion report reflects a *comprehensive investigation* that supports a logical conclusion that no abuse was involved.

The moral of the story is: If you need to investigate a situation to determine what exactly transpired, then you need to report it.

A Comprehensive Investigation:

When submitting the initial/immediate notification to The State it is recommended that the following information be included:

- An allegation has been received or a situation has been identified that may or may not involve one of the following reportable offenses (indicate the possible offense)
- The individual allegedly involved: include name, address, phone, social security number, date of hire, position title, and status at time of report, i.e. on administrative leave pending the outcome of the investigation, terminated, etc.
- Name of resident, age, diagnoses and mental status.
- Date, time, place, circumstances, etc. surrounding the alleged occurrence or identified situation.
- Resident status, i.e. injuries, etc.
- Based upon the initial investigation, review of the medical record and interview of witnesses during the first 24 hours after the allegation was received or potential situation was identified, the following are the known facts at this time:
- Include that the investigation is ongoing and a final report will be submitted within 5 working days; include all other notifications made, i.e. family, attending physician, police (if applicable), etc.

When submitting the final summary report to The State it is recommended that the following information be included:

- Restate the original allegation or identified situation, including day, time, location, by whom, witnesses, and any injuries or other affects upon the resident.
- Describe the process of the investigation including re-interview of the involved resident and/or family, the names/position titles, etc. of all witnesses (staff, residents, others) interviewed, relevant results of medical record and other document reviews, etc.
- Summarize the known facts identified as a result of the aforementioned investigation process.
- Attach a summary of all interviews conducted with the names, addresses, phone numbers and willingness to testify of all those interviewed.
 - Either have the interviewees write, sign and date their own responses to questions asked by the investigator or the investigator may record the interviewees responses which should then be reviewed, signed and dated by the interviewee.
 - It is frequently ineffective to have employees independently write a statement. Key points may not be addressed, time frames may not be identified, etc. and these factors can either prolong the investigation or fail

to yield valuable information. All too often the facility may be unaware of crucial pieces of information which then is discovered by the surveyor who subsequently interviews the employee. Surprise!

- Attach a police report if applicable.
- Document the conclusions drawn based upon the known facts as determined by the investigation.
- Indicate the facility's actions taken (if any/if applicable) as a result of the above conclusions, i.e. employee terminated/returned to duty, inservice training, policy/procedure changes, etc.
- Include all other notifications being made of the facility's conclusions.

When the Abuse/Neglect/Theft allegation is substantiated:

There are those extremely unfortunate times when the facility's investigation determines that an abuse/neglect/theft actually occurred. The State will hold the facility responsible and a survey finding will likely be cited *unless* the facility can demonstrate that it has done everything possible in advance to prevent the abuse/neglect/theft from occurring through its comprehensive implementation of the F-tag requirements including: written and operationalized policies and procedures to prevent and detect, screening, training, identification, protection, investigation, reporting and follow-up. The burden of proof is on the facility and documentary evidence is required to be successful, i.e., policies and procedures, evidence of pre-employment screening, frequent and timely inservices with sign-in sheets (hopefully/ideally including attendance by the perpetrator), a supervision structure, strategies to identify trends and patterns possibly indicative of potential abuse/neglect/theft, immediate actions to protect the resident during the investigation, quality assurance follow-up. While there is recognition that a facility cannot control the actions of all of its employees all of the time, the facility is expected to go to great lengths to try!

About the Author:

Dorrie J. Seyfried is Vice President of Method Management, Risk Management & LTC Consultants, now part of Insurance Program Managers Group, based in St. Charles, Illinois. Under her directions, the Method Management team provides the risk management services to LSN's Workers Compensation Trust and LSN's liability insurance Risk Retention Group as well as a comprehensive array of consultation services to long to term care providers including mock surveys, plan of correction & informal dispute resolution development, incident management, and leadership development and a 24-hour risk management hotline exclusively for LSN members.

For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.

