31. Bill of Rights, Resident Rights, Abuse, Neglect, Mistreatment and Reporting

BILL OF RIGHTS

Each resident has the right to:

1. Be informed and receive in writing a copy of the Resident Bill of Rights.
2. Be informed of facility services and related charges.
3. Be informed of bed reservation policy.
4. Receive appropriate medical care, obtain diagnosis and prognosis, etc. from the physician. Self-medicate if desired and deemed appropriate.
5. Take part in any room transfer or discharge plans prior to a move.
6. Voice concerns, have complaints resolved, invite advocates and be involved in a resident council to discuss concerns and interests of the resident.
7. Participate in the established resident council.
8. Be advised of complaint procedures.
9. Manage personal finances and/or be given at least a quarterly accounting of transactions made.
10. Be free from physical/chemical abuse, mistreatment or neglect as well as the use of physical measure/safety devices unless indicated by a physician.
11. Security in storing personal possessions and confidential treatment of medical records.
12. Dignity, independent decision making and respect
13. Receive assistance in obtaining guardianship or conservatorship.
14. Freedom from performing services not included in the plan of care.
15. Communicate privately with persons of his/her choice, send and receive mail unopened.
16. Take part in social, religious and community activities.
17. Be informed of visiting hours.
18. Keep and use personal clothing.
19. Privacy in personal care and visitation with spouse.
20. Civil and religious liberty.
21. Be provided with kosher foods as required per religious beliefs.
22. Inquire as to his/her specific assignment to category under RUG classification. (If you wish to know your PRI score, please contact your social worker).
23. Be informed of Advance Directives (Do Not Resuscitate Order, Living Will, and Health Care Proxy) and the right to implement advance directives.
24. Right to refuse to serve as a medical research subject.
25. To use tobacco in accordance with applicable policy, rules and laws.
26. To consume a reasonable amount of alcoholic beverages.
27. Right to review results of the facility’s annual survey and corrective action plan.

Attestation Reading

RESIDENT ABUSE SUMMARY

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

A. **Involuntary Seclusion** – The 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's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

   Examples:

   1. Locking a resident in a bathroom.
   2. Leaving a resident alone in the dining room after a meal when he/she has been combative during a meal.

B. **Mental Abuse** – Humiliation, harassment, threats of punishment or deprivation. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).

   Examples:

   1. The staff member records a resident making unusual faces and comments and posts it on social media.
   2. Taking explicit pictures of a resident receiving incontinent care and using it to coerce a resident into following the staff member's directions.

C. **Misappropriation of Resident Property** – The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

   Examples:

   1. Throwing a resident's new clothing items into the trash because the staff member does not want to label them.
   2. Taking resident's Buffalo Bills sweatshirt because the staff member wants it for himself.
   3. The staff member puts the five dollar bill in his/her pocket when it is found in a resident's room.

D. **Mistreatment** – Isolation, unnecessary physical restraints, chemical restraints or any improper use of medication.

Examples:

1. Tying a resident up with a restraint or sheet.
2. Overuse of drugs to sedate the resident for staff convenience.
3. Giving the wrong drug.

E. **Neglect** – Failure to provide timely, safe, consistent and adequate services, care and treatment to residents. These services include food, drugs, therapies, clean clothing and surroundings and help with daily living activities such as eating, using the bathroom and moving around

Examples:

1. Failure to follow the doctor's orders or the resident's care plan.
2. Leaving the resident lying in a wet bed or leaving a resident is on the toilette for a long period of time, even if you got busy and forgot.
3. Refusing to clean or feed a resident.

F. **Physical Abuse** – Striking, pinching, kicking, shoving, or bumping. It also includes controlling behavior through corporal punishment.

Examples:

1. Physically forcing a resident to get out of bed against his/her wishes.
2. The resident is physically abusive during care. After care, she stops. The caregiver retaliates and strikes the resident.

G. **Sexual Abuse** – Sexual harassment, sexual coercion, or sexual assault.

H. **Verbal Abuse** – The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Examples:

1. Threats of harm; anything said to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
2. If you do not eat – you cannot have dessert or go to bed.

I. **Failure to Follow a Care Plan** – Failure to follow a care plan must be reported if one or both of the following have occurred.

Examples:

1. There are repeated failures by staff to follow a resident's care plan.
2. Resident harm has occurred because staff did not follow the care plan.
3. A resident is injured by a 1 assist transfer when it is written on the care plan that the resident is a 2 assist transfer.

<u>Public Health Law Requires Facilities to Report</u>:

1. All Physical Abuse
2. All Mistreatment
3. Neglect that results in a negative outcome

<u>Who Must Report Abuse</u>?

- All caregivers are responsible to report immediately to their supervisor anything that appears to be abuse of any nature.

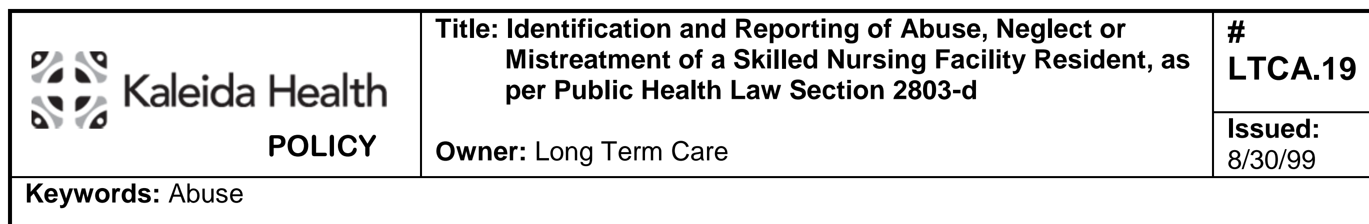
- Failure to report is a violation of the Public Health Law and may be punishable by a fine of up to $2,000 and further, the Licensing Board will be notified and disciplinary action may result.

<u>Kaleida Health's Procedure for Reporting Abuse *(Policy: LTCA.19)*</u>:

A. <u>All staff, volunteers, consultants, etc.</u> must report witnessed or suspected resident abuse, neglect, or mistreatment to their immediate supervisor.

B. When a verbal report or written incident report is received, the principal manager of the department shall initiate the investigative process and notify the Administrator/designee. Each staff member will be asked to complete a written statement regarding his or her knowledge of the incident. This will become a part of the investigative record.

C. Supervisory staff must <u>investigate all allegations</u> of suspected or witnessed abuse, neglect, or mistreatment of residents.



Kaleida Health POLICY	Title: Identification and Reporting of Abuse, Neglect or Mistreatment of a Skilled Nursing Facility Resident, as per Public Health Law Section 2803-d	# LTCA.19
	Owner: Long Term Care	Issued: 8/30/99

Keywords: Abuse

I. Statement of Purpose

Resident abuse, neglect, exploitation, involuntary seclusion or misappropriation of property will not be tolerated within any of the Skilled Nursing Facilities of Kaleida Health. Any staff member or volunteer shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator or designee.

II. Audience

This policy applies to all employees and volunteers of the Skilled Nursing Facilities within the Kaleida Health system.

III. Instructions – (Outline necessary steps for consistent completion of process/ procedure)

Federal (42 CFR 483.13) and state (10NYCRR 415.4) require the facility to report alleged violations involving mistreatment, neglect and abuse, including injuries of unknown origin and misappropriation of resident property, immediately to the Administrator of the facility and to other officials in accordance with State law.

The Elder Justice Act Section 1150B of the Social Security Act as established by section 6703 (b)(3) of the Patient Protection and Affordable Care Act of 2010 requires specific individuals in applicable long term care facilities to report any reasonable suspicion of a crime against a resident of the facility to at least one local law enforcement agency of jurisdiction and the NYSDOH.

The Patient Abuse Reporting Law, Public Health Law Section 2803-d requires every nursing home employee and all licensed professionals to report to the NYSDOH when there is a reasonable cause to believe that a resident has been physically abused, mistreated or neglected.

A. **Definition of Abuse & Neglect**

Abuse is 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 and services that are necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful as used in this definition of abuse, means the individual must have acted deliberately not that the individual intended to inflict injury or harm.

1. **Verbal** Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend, or disability. Staff yelling, swearing, gesturing or calling an individual derogatory names. Examples of verbal abuse

include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

2. **Sexual** Abuse is non-consensual sexual contact of any type with a resident.
3. **Mental** Abuse includes, but not limited to, abuse that is facilitated or caused by nursing home staff or using photographs or recordings in any manner.
4. **Physical** Abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
5. **Neglect** is 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.
6. **Involuntary seclusion** is defined as the separation of a resident from other residents or her/his room or confinement to her/his room (with or without roommates) against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and not be permitted if used for a limited period as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.
7. **Exploitation** is defined as unfair treatment or use of a resident or taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
8. **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.
9. **Mistreatment** means inappropriate treatment or exploitation of a resident.
10. Injuries of Unknown Origin - An injury should be classified as an "injury of unknown source" when both of the following conditions are met:
    a. The source for the injury was not observed by any person or the source of the injury could not be explained by the resident.
    b. The injury is suspicious because of the extent of the injury, the location of the injury (i.e. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.
11. **Immediately** means as soon as possible but not to exceed 24 hours after discovery of the incident. (State operations manual, Appendix PP, Interceptive Guidelines, Section 483.13 (c)(2) and (4)).

B. **Investigation**

The facility begins an investigation immediately upon discovery of an incident. The investigation is the process used to try to determine what happened. Further potential abuse is prevented while the investigation is in process.

1. **Investigation of "abuse":** When an incident or suspected incident of "abuse" is reported, the Administrator or designee will investigate the incident with the assistance of the appropriate personnel. The investigation will include:
    a. Who was involved?
    b. Residents statements

       For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident; complete an evaluation

of resident behavior, affect and response to interaction, and document findings.

c. Resident roommate statements (if applicable)
d. Involved staff and witness statements of events
e. Resident specific information including: resident medical record, care of plan and diagnose, resident cognition evaluation
f. Observation of resident and staff behaviors during the investigation
g. Environmental considerations (if applicable)

Keypoint: All staff must cooperate during the investigation to assure the resident is fully protected.

2. **Investigation of Injuries of Unknown Origin:** must be immediately investigated to rule out abuse. Injuries include, but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an usual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable trauma.

3. **Investigation regarding misappropriation:** complete an active search for missing item(s) including documentation of investigation.
The investigation will consist of at least the following:
   a. A review of completed complaint report
   b. An interview with the person or persons reporting the incident
   c. Interviews with any witnesses to the incident
   d. A review of the resident medical record if indicated
   e. A search of resident room (with resident permission)
   f. An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident.
   g. Interviews with the residents roommate, family members, and visitors
   h. A root-cause analysis of all circumstances surrounding the incident

4. **Investigation of Involuntary seclusion should include:**
   a. Symptoms that led to the consideration of the separation
   b. Investigation into whether the symptoms were caused by failure to meet resident needs, provide meaningful activities or manipulation of the resident environment
   c. Was the cause of the symptom removed?
   d. Were alternatives attempted prior to separation?
   e. Was the separation for the least amount of time necessary?
   f. Was the family/legal representative involved in the care to reduce negative outcomes and attempt to determine less restrictive alternatives?

C. **Additional Investigation Protocols**
   1. While the investigation is being conducted accused individuals will be denied access to the resident(s).
   2. The Administrator or designee will keep the resident or his/her resident representative informed of the progress of the investigation.
   3. The administrator or designee will assemble a complete copy of investigation materials.

4. The Administrator or designee will keep the resident or his/her representative informed of the progress of the investigation.
5. The Administrator or designee will inform the resident and/or his/her representative of the findings of the investigation and corrective action taken.

D. **Procedure**

1. All staff, volunteers, consultants, etc. must report witnessed or suspected resident abuse, neglect, or mistreatment to their immediate supervisor.

2. When a verbal report or written incident report is received, the principal manager of the department shall initiate the investigative process and notify the Administrator/designee. Each staff member will be asked to complete a written statement regarding his or her knowledge of the incident. This will become a part of the investigative record.

3. Supervisory staff must investigate all allegations of suspected or witnessed abuse, neglect, or mistreatment of residents.

4. If staff is called in for investigative interviews, they shall be paid for their time as per SNF policy or union contract.

5. Each staff member will be interviewed individually when applicable, union representation may be present if employee requests.

6. A summary of investigation shall be forwarded to the appropriate SNF site Administrator/ designee for review and final decision regarding the allegation.

7. The resident's family, physician and the Kaleida Health SNF Medical Director, where applicable, shall be notified of the incident and investigation.

8. All materials collected during the investigation will be safeguarded.

9. Upon receipt of questionable incident report, the following steps will be taken:
   a. Director of Nursing/ Nursing Supervisor or Designee shall assess resident and interview resident about incident. Document the statement.
   b. Interview all staff involved or having witnessed the incident. Document the statement. Review staffing schedules to include timeframe that is applicable to incident, to ensure capturing statements from personnel who might be from a department outside of nursing, or on vacation, DBL, COMP or FMLA. Document the statements on the investigation summary form.
   c. Based upon incident report and interviews determine whether a reportable incident has occurred.
   d. Report findings and conclusions to Administration along with all documentation for indicated action.
   e. Upon notification of incident Administrator or designee shall:
      1) See resident, if possible, and speak with resident about incident

2) Review incident report
3) Review chart notes
4) Review Resident's Comprehensive Interdisciplinary Care Plan
5) Make determination of obvious violation of abuse, neglect and mistreatment regulations

f. If no obvious determination:
1) Review statements of all staff and residents
2) Re-interview staff whose statement is inconsistent or indicates need for further questioning
3) Speak with resident's M.D. or N.P. for their evaluation of incident and reliability of resident's statements
4) Consult other professionals for additional opinion/evaluation
5) Confer with Department Director for other circumstances not apparent by documentation: assure documentation of such criteria in statement of policy above to determine reportability.

10. In the absence of the Administrator, the Director of Nursing in conjunction with the Administrator in charge shall be responsible to contact Kaleida Health Administration to consult with and/or notify them of the incident.

IV. Approved by - (Include date)
Vice President, Long Term Care 10/00, 12/04, 11/05, 8/07, 7/17

V. References (Include evidence based research, Kaleida Health policy, and regulation as applicable)
NYS: 415.4
Federal: 42 CFR 483.13
Elder Justice Act: section 1150B of Social Security Act
DOH: 8-16: Nursing Home Incident Report Manual
CMS 10-16: Medicare and Medicaid Requirements of Participation

Version History:

Effective Date:	Reviewed/ Revised
8/30/17	Revised
8/11	Reviewed no changes
8/07	Revised
11/05	Revised
6/05	Reviewed no changes

Kaleida Health developed these Policies, Standards of Practice, and Process Maps in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team, hospital administration and staff in making clinical and non-clinical decisions about our patients' care and the environment and services we provide for our patients. These documents should not be construed as dictating exclusive courses of treatment and/or procedures. No one should view these documents and their bibliographic references as a final authority on patient care. Variations of these documents in practice may be warranted based on individual patient characteristics and unique clinical and non-clinical circumstances. Upon printing, this document will be valid for 11/28/2017 only. Please contact Taylor Healthcare regarding any associated forms.

Student Self-Learning Packet

HighPointe on Michigan and DeGraff SNF

Readings, Post Tests & Resident Abuse Review Verification Sheet

I acknowledge that I reviewed all the materials in the RN/LPN/C.N.A. Self-Learning Packet

Name: ___________________________________ Date: ________________

Print Name

Signature: ____

Agency: __________________________________

Please return to *ALL* the materials to the Nursing Supervisor after you've signed it. *Thank you!*

11/28/17 SMIC

Kaleida Health Long Term Care
HighPointe on Michigan

Student Attestation Form

Public Health Law Requires Facilities to Report:

1. Physical Abuse
2. All Mistreatment
3. Neglect that results in a negative outcome

Who Must Report Abuse?

- All caregivers are responsible to report immediately to their supervisor anything that appears to be abuse of any nature.
- Failure to report is a violation of the Public Health Law and may be punishable by a fine of up to $2,000 and further, the Licensing Board will be notified and disciplinary action may result.

I have reviewed, been given the opportunity to ask questions and understand the Resident Abuse, Neglect and Abuse Reporting Law and the Kaleida Health System's LTC Abuse Reporting Policy and Procedure:

Print Name: ____

Signature: ____

Date: _________________________________

School Name: ____