LTCCC Primer on Nursing Home Quality Standards: Part I

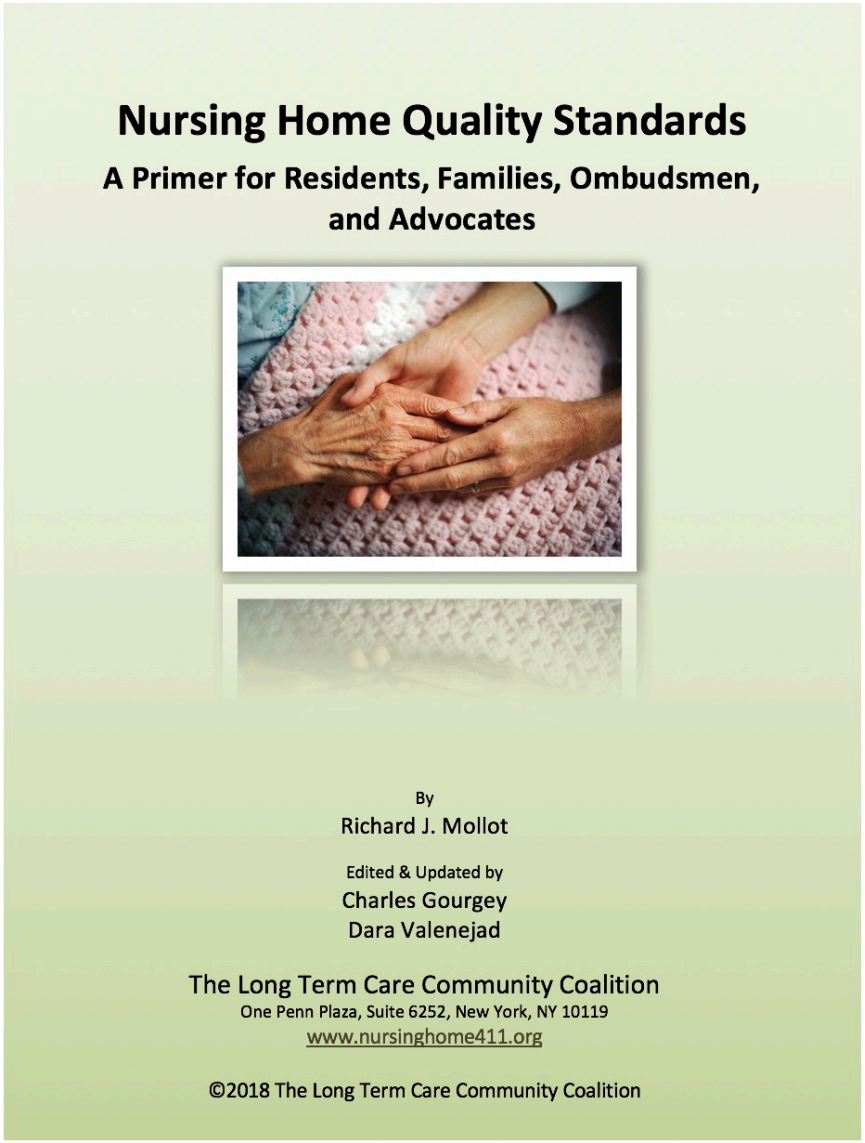
Presented by Richard Mollot
Long Term Care Community Coalition

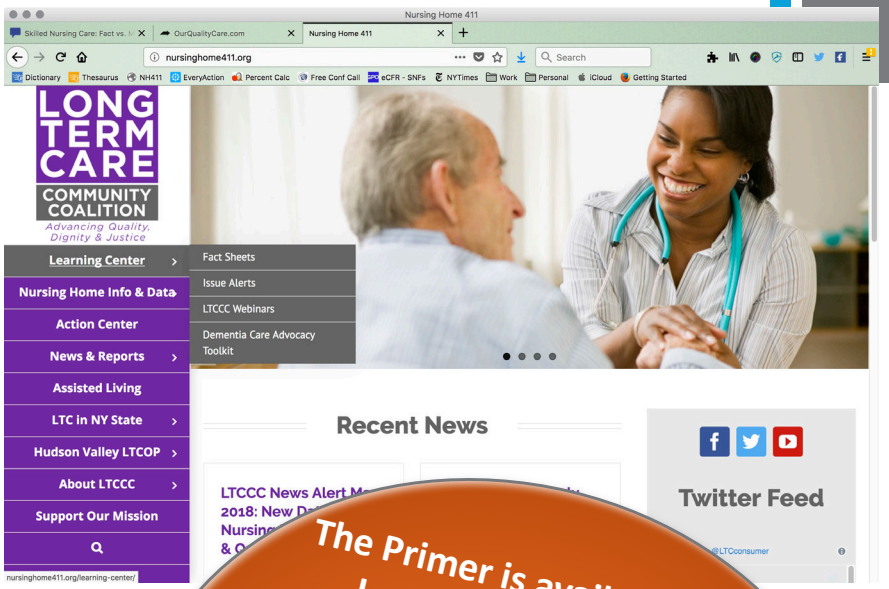
www.nursinghome411.org

What is the Long Term Care Community Coalition?

- **LTCCC**: Nonprofit organization dedicated to improving care & quality of life for the elderly & adult disabled in long term care (LTC).
- **Our focus**: People who live in nursing homes & assisted living.
- **What we do**:
  - Conduct policy analysis and systems advocacy in NY & nationally;
  - Provide information on staffing levels, quality measures, and enforcement actions for all licensed nursing homes;
  - Educate consumers and families, LTC ombudsmen and other stakeholders;
  - Home to the local LTC Ombudsman Program for the Hudson Valley, NY.
- **Richard Mollot**: Joined LTCCC in 2002. Executive director since 2005.
- **WWW.NURSINGHOME411.ORG**: All reports, educational materials and information on nursing home and assisted living quality are free to use and share on LTCCC's website.

What Will We Be Talking About TODAY?





The Primer is available in the Learning Center of our website, www.nursinghome411.org. The Learning Center also has Fact Sheets & Issue Alerts on many of the specific standards in the Primer. All resources are free to use, print and share.

What's in the Primer?

Table of Contents

Descriptive titles i.d. subject matter.

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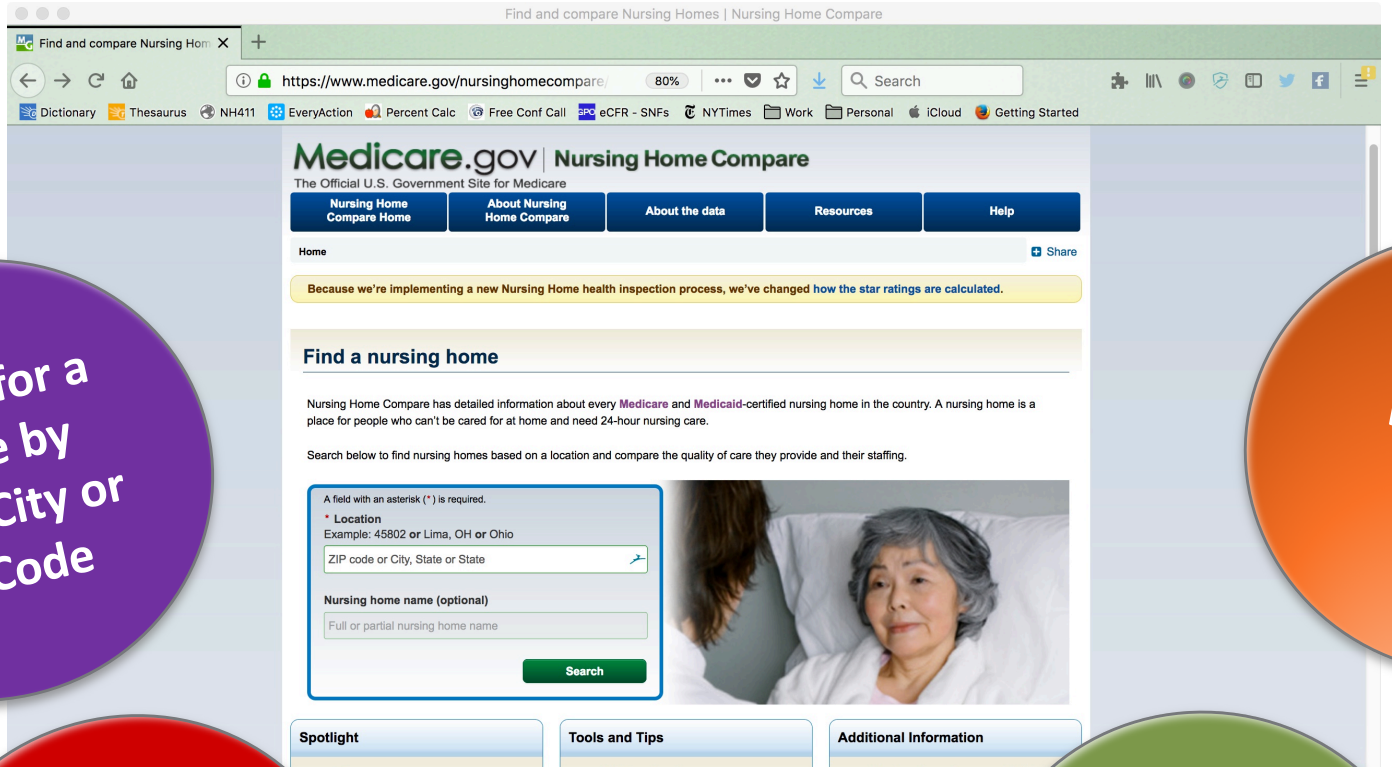
PDF file has hyperlinks: Click on the topic to go to the page.

Assessing Nursing Home Quality with Nursing Home Compare & Other Resources



Search for a Home by State, City or Zip Code

Five-Star Ratings

Inspection Results & Penalties

Ownership & Staffing Levels

Assessing Nursing Home Quality with NH Compare & Other Resources

- None of the data provided are perfect. However, NH Compare is, by far, the most comprehensive and reliable resource for finding out about a nursing home's quality and safety, and how it compares to other facilities in the community, state, and country on key criteria.

- As discussed in the Primer, NH Compare and the **data.medicare.gov** database can be used to find both basic and in-depth information on key criteria and outcomes for the last three years.

- In addition:
  - LTCCC's website, **www.nursinghome411.org**, provides a range of searchable data on levels of nursing home care staffing, antipsychotic drugging rates, enforcement actions, and more.
  - ProPublica's Nursing Home Inspect page, **projects.propublica.org/nursing-homes**, provides useful tools to search deficiencies and penalties.

www.medicare.gov/nursinghomecompare

Background: The Nursing Home System

- Virtually all nursing homes participate in Medicaid and/or Medicare.
- In order to participate in Medicaid/Medicare, a facility agrees to meet the standards provided for in the federal **Nursing Home Reform Law**.
- States may have ***additional*** protections, but no state can have less protections.
- **Federal protections are for all residents** in a facility, whether their care is paid for by Medicare, Medicaid or private pay.
- The federal agency, CMS, contracts with the state DOH to ensure that residents are protected and receive the services they need and deserve.

Background: The Nursing Home Reform Law

- The federal law requires that <u>every</u> nursing home resident is provided the care and quality of life services sufficient to attain and maintain her **highest practicable physical, emotional &social well-being**.
- The law emphasizes **individualized, patient-centered care**.
- Importantly, **the law lays out specific resident rights**, from good care and monitoring to a quality of life that maximizes choice, dignity &autonomy.
- The law passed in 1987. Regulatory standards came out in 1991 and were revised in 2016.

How can the Primer be used… and useful?

HOW TO USE THIS PRIMER

I. Important Notes on the Content

To make this primer as helpful as possible for the nonprofessional we have selected standards that we believe are most useful for resident-centered care and advocacy. This primer is not intended to cover all of the standards important to resident care, safety, and dignity. Rather, we have selected what we believe are the most essential points so that the reader can get an immediate grasp of the regulation's essence.

Also, please note that our summaries of many of the selected standards do not necessarily provide all of the relevant information about the standard. For example, we include the resident's right to choose a physician in the section on resident rights. However, we do not include the regulatory language relating to physician licensure and other requirements. All of the regulatory language is available at http://www.ecfr.gov.

II. Format of Descriptions of the Standards

Each standard's heading includes a descriptive title, the applicable section of the Federal code (CFR), and (when available) the corresponding F-tag (see note below). We provide a short discussion for each section, including: (1) excerpts from the code (in italics), (2) a brief narrative description, (3) excerpts from the CMS Interpretive Guidelines, and/or (4) illustrative examples.

The F-tags are important because Statements of Deficiencies (SoDs) use them to indicate each nursing home's problems. These SoDs are posted at http://www.medicare.gov/nursinghomecompare/search.html and http://projects.propublica.org/nursing-homes/. F-tags therefore can be used to find deficiencies that have been identified in the past three years for a given facility.

All excerpts from the Interpretive Guidelines are from the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

III. New Federal Regulations

The Centers for Medicare & Medicaid Services (CMS) issued revised federal nursing home regulations in October 2016, going into effect in stages between November 2016 and November 2019. New Interpretive Guidelines, which provide instructions for implementing the regulations, and the corresponding F-tags, went into effect in November 2017.

We will endeavor to provide any future changes to the information in this primer as it becomes available to the public. Please visit our website, www.nursinghome411.org, for updates in the future.

VISIT WWW.NURSINGHOME411.ORG FOR FACT SHEETS ON INDIVIDUAL STANDARDS, ISSUE BRIEFS AND OTHER RESOURCES.

In the rest of this program, and in our June 19 program, we will focus on some of the specific standards most relevant to resident care, quality of life, and dignity.

+ Standard #1: General Residents' Rights

Standard #2: Right to Be Fully Informed

Selected Standards Relevant to Quality Care[13]

1. General Residents' Rights [42 CFR 483.10, F-550][14]

(a) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

- *(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.*

(b) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

- *(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*
- *(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law.*
- *(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident.*
- *(7) In the case of a resident adjudged incompetent... (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.*

(d) The resident has the right to choose his or her attending physician.

2. Right to Be Fully Informed [42 CFR 483.10(c), F-552][15]

The resident has the right to be informed of, and participate in, his or her treatment, including:

- *(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.*
- *(2) The right to participate in the development and implementation of his or her person-centered plan of care, including:*

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[13] For the CMS guidance for all of the F-tags, see "State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities" (Hereinafter "CMS Guidance"). Available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

[14] Formerly F-151 - General Residents' Rights - CFR 483.10.

[15] Formerly F-154 - Right to be Fully Informed - 42 CFR 483.10(b)(3) and 483.10(d)(2).

Standard #2: Right to Be Fully Informed

- *(i) The right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.*
- *(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.*
- *(iv) The right to receive the services and/or items included in the plan of care.*

- *(3) The [care] planning process must:*
  - *(i) Facilitate the inclusion of the resident and/or resident representative.*
  - *(ii) Include an assessment of the resident's strengths and needs.*
  - *(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.*

A resident is fully informed when he or she receives information, in a manner he or she can understand, on (1) the benefits and reasonable risks of treatment, (2) potential changes to his or her medical condition, and (3) information about reasonably available alternatives.

Note: **Being appropriately informed, and in particular having the opportunity to provide informed consent, is increasingly considered a critical component of good and appropriate care**. For example, it has played an important part in efforts to improve dementia care and reduce antipsychotic drugging. Facility policies should include processes for providing informed consent, and residents' records should reflect implementation of these policies.

3. Right to Refuse: Formulate Advance Directives [42 CFR 483.10(c)(6), F-578][16]

The resident has the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental a research, and to formulate an advance directive.

Importantly, just like citizens who do not reside in a facility, **nursing home residents have the right to refuse treatment even if doing so is detrimental** (or perceived as detrimental by their caregivers).

Standard #4: Right to Choose Personal Physician

4. Right to Choose a Personal Attending Physician [42 CFR 483.10(d), F-555][17]

The resident has the right to choose his or her attending physician.

Residents have free choice in choosing their physician, but there are certain qualifications. The CMS Interpretive Guidelines state:

> The right to choose a personal physician does not mean that a resident is required to do so. It also does not mean that the physician the resident chose is obligated to provide service to the resident. If a resident or his or her representative declines to designate a personal physician or if a physician of the resident's choosing fails to fulfill their responsibilities, as specified in §483.30, F710, Physician Services, or elsewhere as

[16] Formerly F-155 - Right to Refuse: Formulate Advance Directives - CFR 483.10(b)(4).
[17] Formerly F-163 - Right to Choose a Personal Attending Physician – CFR 483.10 (d)(1).

Before We Move On…

Fact Sheets

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

CONSUMER FACTSHEET: INFORMED CONSENT

The right to informed consent is an important one for residents and families to know about (it is hard to exercise informed consent if you don't know you have a right to it!). It is also one of the most important standards related to dementia care and the widespread problem of inappropriate antipsychotic drugging.

Please note: (1) Text in italics is directly from the federal regulations. (2) Numbers in brackets refer to the federal regulations (42 CFR 483.xx) and F-tag (designation used by surveyors when a facility is cited). (3) These standards are applicable to all residents in licensed nursing homes in the United States, whether they are short-term or long-term, private pay, Medicaid, Medicare or have another type of insurance. (4) Where the resident lacks capacity to make decisions and/or has assigned decision-making to someone else, that person takes the place of the resident in exercising these rights.

WHAT IS INFORMED CONSENT?

"Informed consent is an ethical concept—that all patients should understand and agree to the potential consequences of their care—that has become codified in the law and in daily practice at every medical institution." [From A Practical Guide to Informed Consent.]

THE LAW

I. Right to be Informed of & Participate in Treatment Plan [42 CFR 483.10(c) F-552]

The resident has the right to be informed of, and participate in, his or her treatment, including:

- *The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.*
- *The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.*
- *The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.*

II. Right to Participate in Development & Implementation of Care Plan [42 CFR 483.10(c) F-553]

- *The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.*
- *The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.*
- *The right to be informed, in advance, of changes to the plan of care.*
- *The right to receive the services and/or items included in the plan of care.*
- *The right to see the care plan, including the right to sign after significant changes to the plan of care.*

III. Facility Must Inform Resident of the Right to Participate & Support the Resident in This Right [42 CFR 483.10(c)]

The planning process must—

- *Facilitate the inclusion of the resident and/or resident representative.*
- *Include an assessment of the resident's strengths and needs.*
- *Incorporate the resident's personal and cultural preferences in developing goals of care.*

CHECKLIST FOR RESIDENTS, FAMILIES & OMBUDSMEN

The physician (not a delegated representative) should disclose and discuss:

- ✓ The diagnosis, if known
- ✓ The nature and purpose of a proposed treatment or procedure
- ✓ The risks and benefits of proposed treatment or procedures
- ✓ Alternatives (regardless of costs or extent covered by insurance)
- ✓ The risks and benefits of alternatives
- ✓ The risks and benefits of not receiving treatments or undergoing procedures

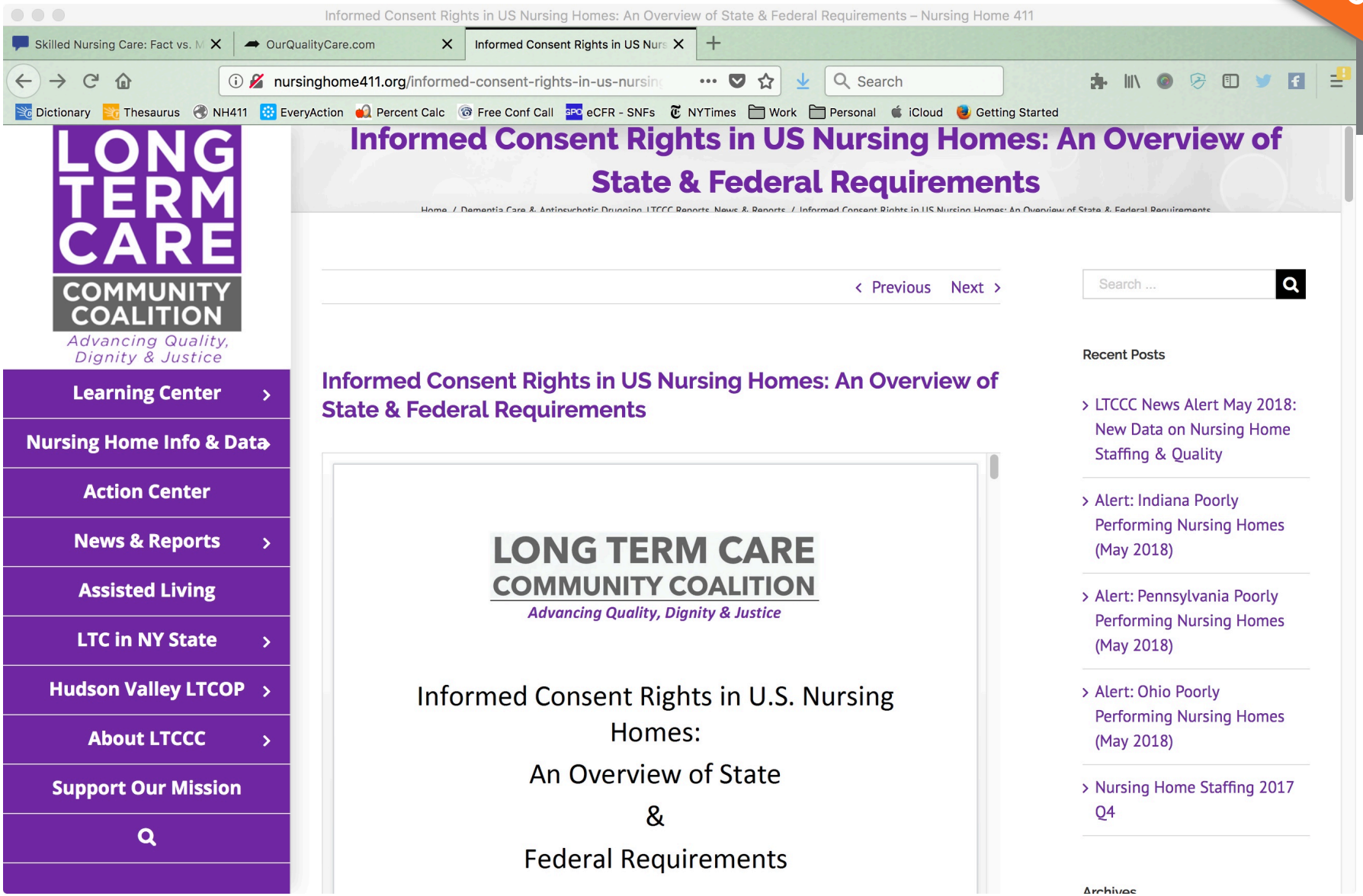
RESOURCES

- WWW.NURSINGHOME411.ORG. LTCCC's website includes materials on the relevant standards for nursing home care, a listing of antipsychotic drug names and other resources.
- WWW.THECONSUMERVOICE.ORG. The Consumer Voice has numerous materials and resources for residents, family members and LTC Ombudsmen.
- A PRACTICAL GUIDE TO INFORMED CONSENT. Temple Health has a very useful resource from which the above checklist and definition of informed consent are taken. It is available at http://www.templehealth.org/ICTOOLKIT/html/ictoolkitpage1.html.

…Connecting to Other Info & Resources.

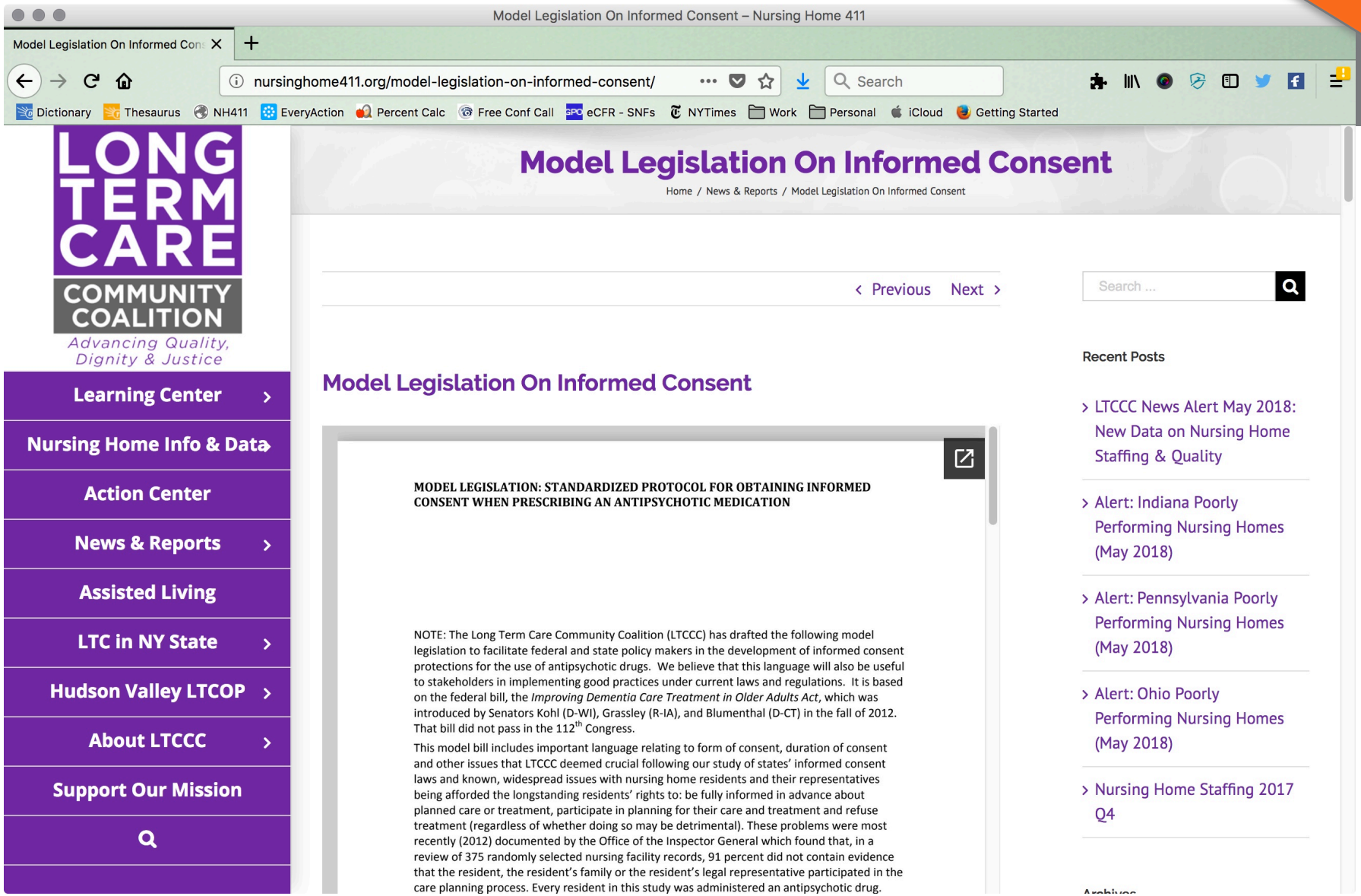
+ Connecting to Other Info & Resources

Reports



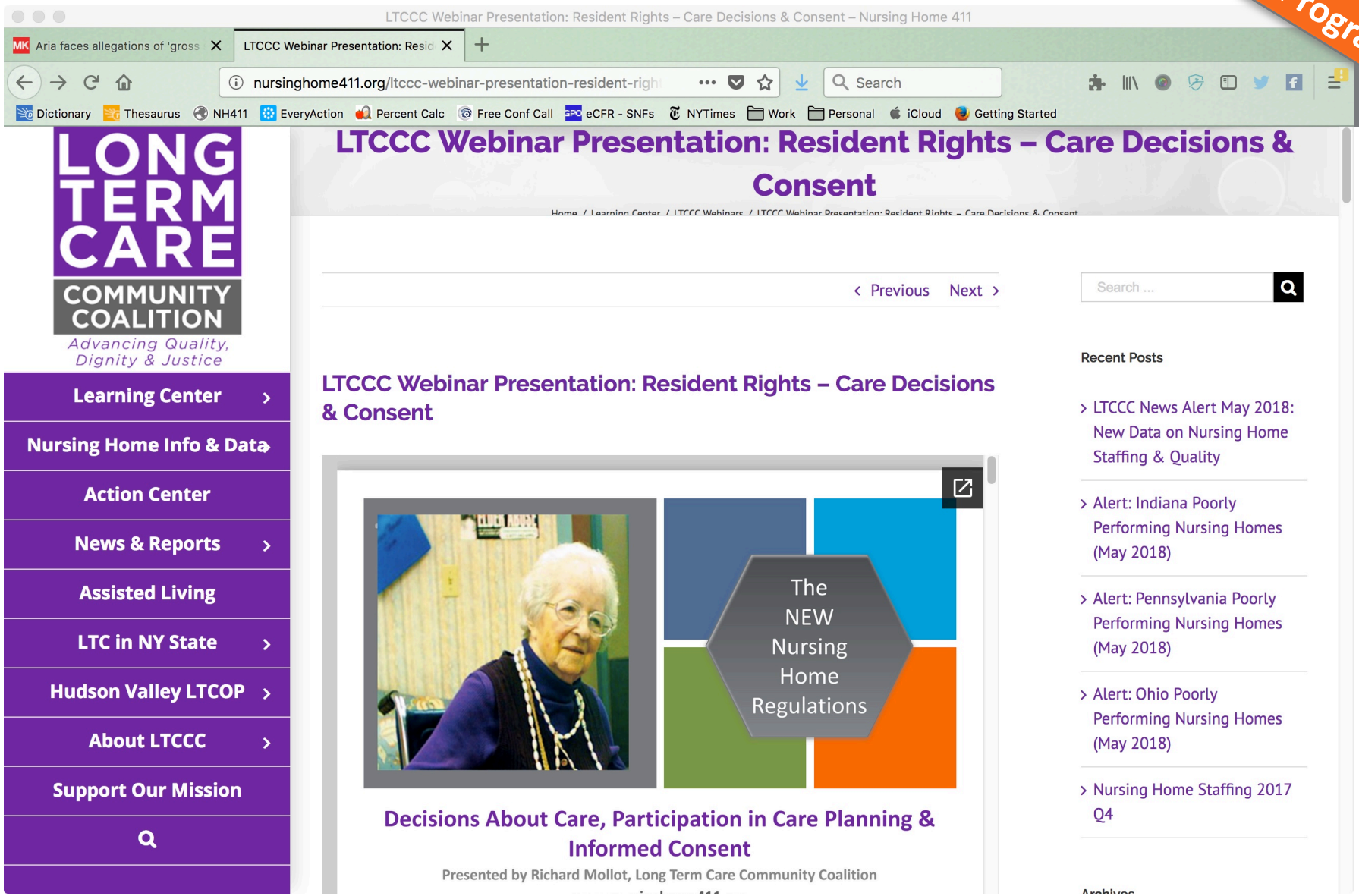
Connecting to Other Info & Resources

Legislation



+ Connecting to Other Info & Resources

Educational Programs



Standard #9: Freedom from Abuse & Neglect

health and safety of others. The facility must be able to demonstrate that the resident or, if applicable, resident representative, received information regarding the risks of refusal of treatment, and that staff conducted the appropriate assessment to determine if care plan revisions would allow the facility to meet the resident needs or protect the health and safety of others....

For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Additionally, conversion from a private pay rate to payment at the Medicaid rate does not constitute non-payment.

8. Right to be Free from Chemical Restraints – [42 CFR 483.10(e), F-605][21]

The resident has a right to be treated with respect and dignity, including (1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

A facility may be in violation of F-605 if an antipsychotic or other drug is administered and not required to treat medical symptoms. While in practice this is usually done to make it easier for caregivers to manage behaviors associated with dementia, it is important to note that the prohibition exists whether or not the antipsychotic is given for convenience or disciplinary purposes.[22] Conversely, even if the antipsychotic is required to treat a particular medical symptom, pursuant to F-605, the drug should not be administered for convenience or disciplinary purposes. F-605 is deliberately broad in this sense. Facilities sometimes rely on antipsychotic drugs to treat residents deemed difficult or uncooperative. For example, if a resident is behaving in a manner that the facility finds difficult to treat, a staff member could claim that the resident is exhibiting a "behavioral problem" and administer an antipsychotic drug to sedate the resident. This treatment may be easier for the staff member but is not necessarily therapeutic for the resident; masking behavioral symptoms of dementia is not an appropriate substitute for care that responds to a resident's needs.[23]

9. Freedom from Abuse, Neglect, and Involuntary Seclusion [42 CFR 483.12, F-600,602,603][24]

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.

The Interpretive Guidelines state:

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[21] Formerly F-222 - Right to be Free from Chemical Restraints - 42 CFR 483.13(a).
[22] CMS, in its May 24, 2013, Survey & Certification memo, specifically noted that if a survey team "identifies a concern that an antipsychotic medication may potentially be administered for discipline, convenience and not being used to treat a medical symptom, the survey team should review F222 [F-605 in the new numbering]...."
[23] California Advocates for Nursing Home Reform, *No Surprises: Chemical Restraints Sedate and Subdue the Elderly with Dementia* (January 3, 2012). Available at: http://www.canhr.org/stop-drugging/archives/839.
[24] Formerly F-223 - Free From Abuse/Involuntary Seclusion - CFR 483.13(b).

Standard #10: Freedom from 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 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.

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.

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.

Sexual abuse is non-consensual sexual contact of any type with a resident, [including] unwanted intimate touching of any kind [and] taking sexually explicit photographs and/or audio/video recordings of a resident 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.

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.

[Emphases added.]

10. Allegations of Mistreatment, Neglect or Abuse [42 CFR 483.12(c), F-609,610][25]

In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

- *(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately.*

[25] Formerly F-225 - Investigate and Report Allegations of Mistreatment, Neglect or Abuse- CFR 483.13(c).

Standard #10: Allegations of Abuse & Neglect

- *(2) Have evidence that all alleged violations are thoroughly investigated.*
- *(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.*
- *(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.*

The Interpretive Guidelines state:

> The facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.
>
> **"Immediately"** means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.
>
> "**Injuries of unknown source**" - An injury should be classified as an "injury of unknown source" when **both** of the following conditions are met:
>
> • The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; **and**
>
> • The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

As detailed in the CFR and Guidelines, nursing homes have specific standards with which they must comply to (1) ensure that residents are safe and free from abuse and neglect, and (2) investigate and report any instances or suspicion of abuse, neglect, or mistreatment**. In addition to these obligations, the 2010 federal Affordable Care Act established important requirements for the reporting of suspicion of a crime against a nursing home resident.**[26]

11. Facility Promotes/Enhances Quality of Life [42 CFR 483.24, F-675][27]

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and

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[26] For more information, see LTCCC's synopsis of the Affordable Care Act requirements at http://www.ltccc.org/documents/ReportingtoLawEnforcementofCrimesOccurringinLTCFacilitiesOct2012.pdf or the CMS Letter to State Survey Agency Directors, *Reporting Reasonable Suspicion of a Crime in a Long-Term Care (LTC) Facility: Section 1150B of the Social Security Act* (June 17, 2011), available at https://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_30.pdf.

[27] Formerly F-240 - Facility Promotes/Enhances Quality of Life - 42 CFR 483.15.

Requirements for Reporting Abuse, Neglect & Suspicion of a Crime Against a Resident

Summary

Regulation	42 CFR 483.12(b)(5) [And §1150B of the Act]	42 CFR 483.12(c)
F-tag	**F608**	**F609**
What	Any reasonable suspicion of a crime against a resident	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigations of alleged violations
Who is required to report?	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	State Survey Agency (SA) and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	The facility administrator and to other officials in accordance with State law, including to the SA and the adult protective services where state law provides for jurisdiction in long-term care facilities
When	Serious bodily injury- Immediately but not later than 2 hours after forming the suspicion. No serious bodily injury- not later than 24 hours. [Note: "Reporting requirements under this regulation are based on real (clock) time, not business hours"]	All alleged violations-Immediately but not later than (1) 2 hours- if the alleged violation involves abuse or results in serious bodily injury or (2) 24 hours- if the alleged violation does not involve abuse and does not result in serious bodily injury.

+ Connecting to Other Info & Resources

Fact Sheets

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

FACT SHEET: REQUIREMENTS FOR NURSING HOMES TO PROTECT RESIDENTS FROM ABUSE, NEGLECT & EXPLOITATION

Following are several standards and guidelines that we have identified as important when it comes to protecting residents from abuse, neglect and exploitation. The descriptions are taken directly from the federal regulations and guidelines (as indicated by text in italics). The excerpts are formatted into bulleted lists to make it easier to identify the points that we believe are most relevant. For more detailed information, see the webinar program & other resources on our website, www.nursinghome411.org.

[Notes: (1) The brackets below provide the citation to the federal regulation. (42 CFR 483.xx) and the F-tag used when a facility is cited for failing to meet the requirement. (2) All emphases added.]

I. Freedom From Abuse, Neglect & Exploitation [42 CFR 483.30(A) F-710]

*The **resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation**…. 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.*

II. Key Elements Of Noncompliance With This Standard

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.

III. Key Definitions

- **Abuse**: 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**: *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**: *non-consensual sexual contact of any type with a resident.*
- **Willful**: *means the individual must have acted deliberately, **not** that the individual must have intended to inflict injury or harm.*

IV. Federal Guidelines - Facility Characteristics Associated With Increased Risk of Abuse.

Identified facility characteristics, 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.*

V. Reporting Requirements for Abuse, Neglect & Suspicion of a Crime Against a Nursing Home Resident

There are both state and federal requirements for reporting abuse or neglect. Nevertheless, far too much resident abuse, neglect, theft of personal property, etc… goes unreported. To help address this problem, **the Affordable Care Act established important requirements for reporting any reasonable suspicion of a crime against a nursing home resident**.

Requirements for reporting all alleged abuse, neglect, exploitation or mistreatment:

- **Duty**: Must report *all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property*.
- **For Whom?**: The nursing home.
- **When?** *All alleged violations-Immediately but not later than (1) 2 hours- if the alleged violation involves abuse or results in serious bodily injury (2) 24 hours- if the alleged violation does not involve abuse and does not result in serious bodily injury*.
- **To Whom?**: *The facility administrator and to other officials in accordance with State law, including to the SA* [survey agency, i.e., Department of Health] *and the adult protective services where state law provides for jurisdiction in long-term care facilities.*

Requirements for reporting suspicion of a crime against a nursing home resident include:

- **Duty**: Must report any "reasonable suspicion" that a crime has been committed against a resident of the facility.
- **For Whom?**: Any and all of a nursing home's employees, owners, operators, managers, agents and contract workers.
- **When?** Immediately! Must be within 2-hours if the act or incident suspected to be a crime resulted in physical injury to a resident; otherwise, within 24-hours.
- **To Whom?**: Local law enforcement and the state survey agency (Dept. of Health).
- **Penalty**: Failure to report carries a fine of up to $221,048; if the failure results in increased harm to the original victim, or harm to another resident, the fine can be up to $331,752.

RESOURCES

WWW.NURSINGHOME411.ORG. LTCCC's website includes materials on the relevant standards for nursing home care and a variety of resources on specific issues, such as dementia care, resident assessment and care planning, dignity and quality of life.

Thank You For Joining Us Today!

Email **info@ltccc.org** or call **212-385-0355** if you would like to…

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Next Program: June 19 at 1pm

Topic: LTCCC Primer on Nursing Home Quality Standards: Part II

You can also…

- Join us on **Facebook** at www.facebook.com/ltccc
- Follow us on **Twitter** at www.twitter.com/LTCconsumer
- Visit us on the **Web** at www.nursinghome411.org.

For LTC Ombudsmen in NY State

If you would like us to let your supervisor know that you attended this training program, please take the quick survey at:

https://www.surveymonkey.com/r/ltccc-ltcop1

For Family Members in NY State

connect with the Alliance of NY Family Councils at **www.anyfc.org** (or email info@anyfc.org).


Questions?
Comments?