CHAPTER 6. ABUSE, NEGLECT, MISTREATMENT AND MISAPPROPRIATION OF RESIDENT PROPERTY

This chapter presents the State and federal requirements for reporting and investigating complaints alleging abuse incidents that involve residents of nursing homes, hospital long term care units and county medical care facilities. The Bureau has responsibility for investigating specific requirements pertaining to facility reporting of alleged abuse, neglect, mistreatment and misappropriation of resident property. These incidents may involve staff members, residents/patients, family members or any other persons.

Bureau policies that implement these requirements are included with statutory requirements and the definition of terms for State and federal requirements. The Bureau also has responsibility for investigating complaints against hospitals, hospices and other health facilities identified in MCL 333.20106 that allege non-compliance with the Public Health Code or federal Conditions of Participation for Medicare.

Nursing homes may adapt these processes for the internal investigation of complaints as required by Nursing Home Rule 325.20113(2) and PA. 11 of 2002, MCL 333.21723. They also may adapt them for the internal investigation of incidents of abuse, neglect or misappropriation as detailed in Chapter 5 of this manual.

6.1. STATE REQUIREMENTS FOR REPORTING ABUSE

State legislation regarding the filing of health facility complaints is found in Section 333.21771 of the Public Health Code shown below:

(1) A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat or harmfully neglect a patient.

(2) A nursing home employee who becomes aware of an act prohibited by this Section immediately shall report the matter to the nursing home administrator or nursing director. A nursing home administrator or nursing director who becomes aware of an act prohibited by this Section immediately shall report the matter by telephone to MDCH.

(3) Any person may report a violation of this section to the Department.

(4) A physician or other licensed health care personnel of a hospital or other health care facility to which a patient is transferred who becomes aware of an act prohibited by this Section shall report the act to the Department.

(5) The Department shall make an investigation upon receipt of a report made under this Section. The Department may require the person making the report to submit a written report or to supply additional information, or both.

(6) A licensee or nursing home administrator shall not evict, harass, dismiss, or retaliate against a patient, a patient's representative, or an employee who makes a report under this Section.

6.2. FEDERAL REQUIREMENTS FOR RESIDENT RIGHTS

Title 42, Section 483 of the *Code of Federal Regulations* (CFR) contains requirements for homes participating in Medicare and /or Medicaid.

42 CFR 483.10(f). *Grievances* A resident has the right to:

(1) Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

42.CFR 483.13(b) *Abuse.* The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

42.CFR 483.13(c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

(1) The facility must –

(i) Not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion 42 CFR 483.13(b), (c)(1)(i);

(ii) Not employ individuals who have been –

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property 42 CFR 483.13(c)(ii); and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities 42 CFR 483.13(c)(iii).

42.CFR 483.13(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

42.CFR 483.13(c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

42.CFR 483.13(c)(4) 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 five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

6.3. DEFINITIONS

There are a variety of similar, but not identical, terms used in state laws and federal regulations related to abuse, neglect, and misappropriation. This section discusses these terms and sets forth definitions that meet the intent of these multiple legal bases.

MCL 333.21771(1) states, "A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a patient." The key terms here are abuse, mistreat, and harmfully neglect. Also of interest are the adjectives mentally and emotionally used in regard to abuse.

42 CFR 483.13(c)(2) states, "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property...". The key terms here are mistreatment, neglect, abuse and misappropriation of resident property.

Following are consolidated definitions of these terms that are used by the Bureau for purposes of this manual.

A. Abuse

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The source of this definition is 42 CFR 488.301. The Public Health Code does not define the terms used in MCL 333.21771(1), so the federal definition is adopted for both state and federal purposes.

It is noted that abuse involves a willful, purposive and assertive action as opposed to a negligent action, accidental action, or lack of action. Abuse includes verbal, physical, sexual or mental abuse, corporal punishment and involuntary seclusion, as further defined below. There is a presumption that all instances of abuse of residents, even those in a coma, cause some degree of physical harm, or pain or mental anguish.

1. Physical Abuse

Physical abuse includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

In general, there is a presumption that physical abuse has occurred whenever there has been some type of impermissible or unjustifiable physical contact with a resident that has resulted in injury or harm to the resident.

A resident has been physically abused if all of the following conditions are satisfied:

a. Physical Contact Made

An individual makes or causes physical contact with the resident in question, either through direct bodily contact or through the use of some object,

b. Intentional or Careless Contact

The individual in question brings about this physical contact with the resident either intentionally or through carelessness,

c. Results of Physical Contact

The physical contact in question results, or is likely to result, in death, physical injury, or pain to the resident in question, and

d. Not Reasonably Justified

The physical contact in question cannot reasonably be justified under any of the exceptions set forth in paragraph below on permissible physical contact.

Examples of types of physical contact that may constitute physical abuse include, but are not limited to the following:

- Striking the resident by using a part of the body, such as hitting, slapping, beating, punching, kicking, pushing, shoving or spitting.
- Striking the resident through the use of an object (i.e., towel, rolled newspaper, shoe).
- Pulling or tugging on any part of the resident's body.
- Twisting any part of the resident's body.
- Squeezing or pinching any part of the resident's body.
- Digging into any part of the resident's body with fingers or nails.
- Burning the resident or resident with objects such as matches or cigarettes.
- Prodding, poking or sticking the resident with objects such as needles, pins, pencils, pens, eating utensils, or electrical devices.

2. Permissible Physical Contact

There are three types of situations in which physical contact that results, or is likely to result, in harm to a resident does not constitute physical abuse. They are:

a. Prescribed Form of Treatment or Therapy Physical Contact

When the physical contact in question occurs in the course of carrying out a prescribed form of treatment or therapy to which the resident has consented and both the type of contact involved and the amount of force used are reasonable and necessary in order to carry out that prescribed form of treatment or therapy; or

b. Physical Contact During Care, Comfort or Assistance

When the physical contact in question occurs in the course of providing care, comfort or assistance to which the resident has consented and both the type of contact and the amount of force used are absolutely necessary in order to provide care, comfort or assistance to that resident; or

c. Resident's Behavior In An Emergency

When the physical contact in question occurs in the course of attempting to restrain a resident's behavior in an emergency and both the type of contact involved and the amount of force used are reasonably necessary in order to prevent that resident from injuring himself/herself, injuring another person or damaging property.

3. Mental or Emotional Abuse

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

Verbal abuse is a primary means of mental or emotional abuse. It involves the use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. Please note that although verbal abuse is not specifically mentioned in MCL 333.21771(1), the terms mentally and emotionally are intended to include verbal abuse as a type of abuse.

There is no fixed rule on when an interaction between an individual and a resident is serious enough to warrant a finding of mental or emotional abuse. Even minimal psychological harm may be enough; the answer depends on the circumstances of the individual case.

However, the following factual situations provide a reasonable basis for concluding that mental or emotional abuse has occurred:

- The interaction coerces or intimidates the resident into surrendering his or her money or personal belongings.
- The interaction subjects the resident to scorn, ridicule or humiliation.
- The interaction produces a noticeable level of fear, anxiety, agitation, withdrawal or other emotional distress in the resident that is not otherwise explainable.
- The interaction involves a threat of physical harm, punishment, or deprivation.

Examples of Mental or Emotional Abuse are:

- Facility policy, without just cause, prohibits residents from smoking.
- An employee taunts or teases a resident or says things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
- A combative resident threatens to beat up another resident.
- Involuntary seclusion – i.e., the separation of a resident from other residents or from his or her room against the resident's will, or the will of the resident's legal representative. Temporary monitored separation from other residents will not be considered involuntary seclusion and may be permitted if reasonably used as a therapeutic intervention to reduce agitation as determined by professional staff and consistent with the resident's plan of care.

4. Involuntary Seclusion

Involuntary seclusion is a type of mental or emotional abuse that involves separation of a resident from other residents or from his or her room against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents is not considered involuntary seclusion and is 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.

5. Sexual Abuse

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

a. Examples of Sexual Abuse

- An employee sexually molests a resident. (For example, non-consensual touching of private body parts or forcing the resident to commit a sexual act.)

- A resident forcefully requires another resident to participate in a sexual act.

b. Possible Sexual Abuse
A resident returns from an at-home leave and reports being sexually molested.

6. Restraints
The use of physical and/or chemical restraints are limited to circumstances in which the resident has medical symptoms that warrant the use of restraints. Examples of when restraints should **not** be used are:

a. Restrict Freedom of Movement or Normal Access to One's Body.

b. Discipline or Convenience.
"Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents.
"Convenience" is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the residents' best interest.

B. Neglect
Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The source of this definition is 42 CFR 488.301. The Public Health Code does not define the term harmfully neglect used in MCL 333.21771(1). By definition, neglect is harmful, so the federal definition is adopted for both state and federal purposes.

Please note that by definition a particular event is either abuse or neglect, not both.

Basically, "neglect" involves the failure of a staff person to carry out his/her duties in regard to a resident. In theory, <u>any</u> failure to provide required services of <u>any</u> kind for <u>any</u> reason could be considered neglect. However, citations for neglect are normally issued only in cases where there is significant actual harm resulting from a failure to act in the presence of the knowledge of what should be done and the capability to provide the required services. Such cases may include a failure to follow a standard of practice. Even if neglect is not cited, citations are issued against the facility for the specific care issues involved.

There is a presumption that neglect has occurred whenever a facility or individual fails to provide a treatment or service to a resident which is necessary for a resident's health or safety, and the failure to provide that

treatment or service results in a deterioration of the resident's physical, mental or emotional condition.

A resident has been neglected whenever **all** of the following conditions are satisfied.

- The facility fails to provide or arrange for medical, dental, nursing, dietary, physical therapy, pharmacy, habilitation, psychological, speech, audiological or other treatments or services to the resident in question; **and**
- The facility's failure to provide these treatments or services is either intentional or the result of carelessness; **and**
- The failure to provide these treatments or services, results in a deterioration of the resident's physical, mental or emotional condition.

1. Examples of Neglect

The following actions or omissions constitute neglect whenever they result in a noticeable deterioration of the resident's physical, mental or emotional condition:

- Failure to carry out a physician's order for treatment, therapy, diagnostic testing, distribution of medications, etc.
- Failure to carry out nursing, treatment or individual resident care plans.
- Failure to notify a resident's attending physician and other responsible persons in the event of an incident involving that resident.
- Failure to notify a resident's attending physician and other responsible persons in the event of a significant change in that resident's physical, mental or emotional condition.
- Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals.
- Failure to adequately supervise the whereabouts and/or activities of a resident.
- Failure to take precautionary measures that have been ordered and which are reasonably necessary to protect the health or safety of a resident.
- Refusal or failure to provide any service to the resident for the purpose of punishing, disciplining or retaliation.
- Allowing the physical environment to deteriorate to the point that residents or residents are subject to hazardous situations such as electrical, water or structural hazards.
- Leaving a resident lying in feces or urine soaked linens for an extended period of time.

- Leaving a resident restrained in other than an immediate emergency, without a physician's order, solely for an employee's own convenience.

2. Neglect Exceptions

- No resident can be considered neglected for the sole reason that he or she relies on or is being furnished treatment in accordance with the tenets and teachings of a well-recognized church or denomination by a duly-accredited practitioner thereof.
- No resident should be considered neglected because they have knowingly refused a treatment or service.

C. Misappropriation

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. The source of this definition is 42 CFR 488.301. The Public Health Code does not mention misappropriation, so this definition applies for federal purposes only. It is noted that the term exploitation used in some laws or regulations is synonymous with misappropriation. In criminal law, misappropriation might be considered theft, embezzlement, fraud or a variety of other offenses.

Examples of misappropriation are:

- The facility combines money from resident trust funds with facility funds for facility use.
- A business office employee uses money from residents trust funds for purposes not authorized by the residents.
- A representative payee receives a Social Security check and does not use the funds for the benefit of the Social Security beneficiary.
- A resident steals jewelry from another resident.
- A court appointed guardian or conservator uses the resident's money for personal gain rather than spending the money for the resident's benefit.
- The daughter/son of a resident sells off the resident's assets without the resident's knowledge.
- Theft by facility staff of resident's personal items/money.

D. Mistreatment

"Mistreat" is used in MCL 333.21771(1) and "mistreatment" in 42 CFR 483.13(c)(2), but neither defines these terms. The American Collegiate Dictionary indicates in a discussion of the synonyms of "abuse", "misuse", "mistreat", "ill-treat", and "maltreat" that all of these verbs mean to treat a person or thing wrongfully or harmfully. It states that "mistreat" may imply

negligence or lack of knowledge on the offender's part, but more often refers to harm inflicted deliberately.

E. 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.

6.4. BUREAU POLICIES REGARDING STATE AND FEDERAL REPORTING REQUIREMENTS

The intent of both the Michigan and federal requirements is to identify and take immediate actions to prevent any further abuse, neglect, and misappropriation

A. "Immediate" Reporting

State and federal laws require "immediate" reporting by the facility. "Immediate" means as soon as possible, but not more than 24 hours after the discovery of the incident. Telephone and fax numbers are provided for reporting after 5:00 p.m. and on weekends and holidays.

MCL 333.21771 of the Public Health Code requires immediate reporting when the facility becomes aware of a prohibited act; physical, mental, or emotional abuse, mistreatment or harmful neglect of a patient by licensee, nursing home administrator, or employee.

Federal law requires an immediate report to the administrator and the State Survey Agency (BHS) of alleged violations involving mistreatment, neglect, abuse, incidents of injuries of unknown source or misappropriation of resident property. (The facility must also report the investigation findings to the Administrator and to the State Survey Agency (BHS) within five (State) working days of the incident investigated, regardless of the outcome of the investigation.)

B. Facility Responsibility to Investigate and Prevent Further Abuse

The federal regulation requires the facility to thoroughly investigate alleged abuse, to prevent further abuse while the investigation is in progress, and to report the results of the investigation to the State in accordance with State law within five (State) working days.

In contrast, Section 333.21771 lacks a specific requirement for the facility to do its own investigation and prevent further abuse. The Bureau believes that the higher federal requirements for a facility to immediately do its own investigation, prevent further abuse and report its investigation

within five days prevail. Chapter 6, Section 6.4 of this manual adds a requirement that certain events be reported to MDCH within 24 hours of discovery of all alleged/possible violations involving mistreatment, neglect, abuse, incidents of injuries of unknown source or misappropriation of resident property, regardless of whether the facility investigation is completed.

C. Employee vs. Non-employee Abuse, Neglect, or Misappropriation

CMS Tag F223 gives residents the right to be free of abuse by any person. In contrast, MCL 333.21771 is limited to abuse by staff members. Abuse by non-staff members such as other residents and visitors can be equally harmful. The State Adult Protective Services Act prohibits abuse regardless of the setting and the classification of the abuser. Section 6.4 of this chapter includes the requirements for the reporting and investigation of abuse in a facility by non-staff members consistent with the Adult Protective Services Act.

D. Facility Culpability

The state has an interest in protecting residents and residents from abuse, neglect, or misappropriation no matter who is responsible for the harm. Therefore, all reports of suspected abuse, neglect, or misappropriation involving residents are investigated. The Bureau decides whether or not the facility is culpable and will be cited appropriately.

E. Involvement of Facility Employees or Agents

For purposes of state law, a facility is responsible for its employees and agents regardless of any prior notice or apprehension of a potential problem. A citation will be issued under federal law if a facility does not comply with any criteria of State Operations Manual, Appendix P, Task 5G on Abuse Prohibition.

F. Involvement of Non-Employees

A facility is responsible for protecting a resident from non-employees such as other residents, family members, and general visitors whenever it had or should have reasonably had, an apprehension or warning of the potential problem. In such cases, the facility will be considered culpable and cited.

If the facility could not reasonably have known of the potential problem, the facility is not cited. However, the matter is referred to the Department of Human Services, Adult Protective Services Unit, or state or local criminal authorities if appropriate.

Examples of this would include:

- A son/daughter slaps his/her mother or father while visiting them at the facility.

- A resident picks a fight with another resident and knocks him down.
- A resident's spouse threatens to prevent them from having any visitors in retaliation for something they did or said.
- A visitor in the facility uses demeaning language to ridicule a resident.
- A resident returns to the facility with bruises after an at-home leave of absence.