- Develop and implement written policies and procedures related to posting conspicuous signage of employee rights related to retaliation against the employee for reporting a suspected crime; and prohibiting and preventing retaliation.

F609

(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.

(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.

(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(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, 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, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(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.

INTENT

The intent is for the facility to develop and implement policies and procedures that:

- Provide annual notification to each covered individual of their obligation to comply with the reporting requirements under section 1150B(b) of the Act;
- Ensure reporting reasonable suspicion of crimes against a resident or individual receiving care from the facility within prescribed timeframes to the appropriate entities, consistent with Section 1150B of the Act; and
- Ensure that all covered individuals, i.e., the owner, operator, employee, manager, agent or contractor, report reasonable suspicion of crimes, as required by Section 1150B of the Act.

The facility should provide oversight and monitoring to ensure that implement the required policies and procedures, per 42 CFR §483.12(b).

In addition, 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.

DEFINITIONS

"**Abuse**," is defined at §483.5 as "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."

"Alleged violation" is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

"Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility (see section 1150B(a)(3) of the Act).

"Crime": Section 1150B(b)(1) of the Act provides that a "crime" is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

"**Exploitation**," as defined at §483.5, means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when **all** of the following criteria are met:

- The source of the injury was not observed by any person; **and**
- 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.

"Law enforcement," as defined in section 2011(13) of the Act, is the full range of potential responders to elder abuse, neglect, and exploitation including: police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.

"**Misappropriation of resident property**," as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"Mistreatment," as defined at §483.5, is "inappropriate treatment or exploitation of a resident." "**Neglect**," as defined at §483.5, means "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."

"Serious bodily injury" is defined in section 2011(19) of the Act and means an injury involving extreme physical pain, substantial risk of death, protracted loss or impairment of the function of a bodily member, organ, or mental faculty, or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation (see section 2011(19)(A) of the Act). Serious bodily injury is considered to have occurred when an injury results from criminal sexual abuse (see section 2011(19)(B) of the Act).

"Criminal sexual abuse": In the case of "criminal sexual abuse" which is defined in section 2011(19)(B) of the Act, serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

"**Sexual abuse**," is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

"**Willful**," is defined at §483.5 in the definition of "abuse," and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

GUIDANCE REPORTING

It is the responsibility of the facility to ensure that all staff are aware of reporting requirements and to support an environment in which covered individuals report a reasonable suspicion of a crime, and staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Protection of residents can be compromised or impeded if individuals are fearful of reporting, especially if the alleged abuse has been carried out by a staff member [See §483.12(b)(5)(i)]. During investigations, some staff have stated that he/she was aware, or had knowledge, that the incident had occurred, but did not report because he/she did not think it met the definition of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property or a reasonable suspicion of a crime. Anecdotal reports have indicated that failure to report an alleged violation may be due to, but not limited to, the following:

- An individual's allegation is not believed due to a history of reporting false allegations;
- Staff fear of retaliation, or fear losing his/her job;
- Sympathy for co-workers, for example, not wanting to cause trouble for the co-worker;
- Communication, cultural, or language issues; or
- Residents/resident representatives may fear retaliation.

NOTE: Once an individual suspects that a crime has been committed, facility staff should exercise caution when handling materials that may be used for evidence or for a criminal investigation. Facilities should reference applicable State and local laws regarding preserving evidence. It has been reported that some investigations were impeded due to washing linens or clothing, destroying documentation, bathing or cleaning the resident before the resident has been examined, or failure to transfer a resident to the emergency room for examination including obtaining a rape kit, if appropriate.

The following table describes the different reporting requirements that are addressed under 42 CFR 483.12:

	42 CFR 483.12(b)(5) and Section 1150B of the Act	**42 CFR 483.12(c)**
What is to be reported	Any reasonable suspicion of a crime against a resident or an individual receiving care from the facility	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, which means the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	State Survey Agency (SA) and one or more law	The facility administrator and to other officials in accordance with State law,

	42 CFR 483.12(b)(5) and Section 1150B of the Act	42 CFR 483.12(c)
	enforcement entities for the political subdivision in which the facility is located (i.e., the full range of potential responders to elder abuse, neglect, and exploitation including police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	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*	All alleged violations- 1) Immediately but not later than 2 hours*- if the alleged violation involves abuse <u>or</u> results in serious bodily injury 2) Not later than 24 hours*- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; <u>and</u> does not result in serious bodily injury Results of all investigations of alleged violations- within 5 working days of the incident

* - Reporting requirements under this regulation are based on real (clock) time, not business hours

ENSURING THE REPORTING OF A REASONABLE SUSPICION OF A CRIME

A facility's policies and procedures for reporting under 42 CFR 483.12(b)(5) should specify the following components, which include, but are not limited to:

- Identification of who in the facility is considered a covered individual;
- Identification of crimes that must be reported;

  NOTE: Each State and local jurisdiction may vary in what is considered to be a crime and may have different definitions for each type of crime. Facilities should consult with local law enforcement to determine what is considered a crime.

- Identification of what constitutes "serious bodily injury;"
- The timeframe for which the reports must be made; and

- Which entities must be contacted, for example, the State Survey Agency and local law enforcement.

There are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to be reasonable suspicion of a crime. In these cases, the facility is obligated to report to the administrator, to the state survey agency, and to other officials in accordance with State law (see F609). Regardless, covered individuals still have the obligation to report the reasonable suspicion of a crime to the State Survey Agency and local law enforcement.

Some facilities may have policies and procedures where the administrator could coordinate timely reporting to the State Survey Agency and law enforcement on behalf of covered individuals who choose to the report to the administrator. Risks to the covered individual for reporting to the administrator could be mitigated if an individual has clear assurance that the administrator is reporting it and submitting a collective report would not cause delays in reporting according to specified timeframes. Reports should be documented and the administrator should keep a record of the documentation. It remains the responsibility of each covered individual to ensure that his/her individual reporting responsibility is fulfilled, so it is advisable for any multiple-person report to include identification of all individuals making the report. In addition, a facility cannot prohibit or circumscribe a covered individual from reporting directly to law enforcement even if it has a coordinated internal system.

Surveyors must review whether the facility has included in its policies and procedures examples of crimes that would be reported. Examples of situations that would likely be considered crimes in all subdivisions would include but are not limited to:

- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery;
- Drug diversion for personal use or gain;
- Identity theft; and
- Fraud and forgery.

There are political subdivisions that have other examples for which instances of elder mistreatment are considered to be crimes. Because all reasonable suspicions of crimes must be reported, regardless of whether it is perpetrated by facility staff, residents, or visitors, it would be especially beneficial for the facility to work with local law enforcement in determining what would not be reported (e.g., all cases of resident to resident conflict may not rise to the level of abuse and may not be appropriate to report to local law enforcement).

Even in the presence of a policy and procedure, failure to report a reasonable suspicion of a crime may be indicative of failure to implement the facility's policies and procedures. Surveyors should investigate further and document the failure to develop and/or implement policies and

procedures for reporting suspected crimes (e.g., how the facility may not have provided notification to its employees, how covered individuals are fearful of reporting or do not want to get others in trouble, etc.). Facilities must ensure the reporting of a reasonable suspicion of a crime by implementing proper policies and procedures addressing the following actions, which should include, but are not limited to:

- Orienting new and temporary/agency/contractor staff to the reporting requirements;
- Assuring that covered individuals are annually notified of their responsibilities in a language that they understand;
- Identifying barriers to reporting such as fear of retaliation or causing trouble for someone, and implementing interventions to remove barriers and promote a culture of transparency and reporting;
- Identifying which cases of abuse, neglect, and exploitation may rise to the level of a reasonable suspicion of crime and recognizing the physical and psychosocial indicators of abuse/neglect/exploitation;
- Working with law enforcement annually to determine which crimes are reported;
- Assuring that covered individuals can identify what is reportable as a reasonable suspicion of a crime, with competency testing or knowledge checks;
- Providing in-service training when covered individuals indicate that they do not understand their reporting responsibilities; and
- Providing periodic drills across all levels of staff across all shifts to assure that covered individuals understand the reporting requirements.

Annual Notification of Reporting Obligations to Covered Individuals

The facility must develop and implement written procedures that include, but are not limited to, notifying covered individuals annually of their obligations to report reasonable suspicion of crimes in the facility [See §483.12(b)(5)(i)]. Policies and procedures should include, but are not limited to, the following:

- Identification of who are the covered individuals in the facility;
- How covered individuals are notified of the reporting requirements. Notification must include the following:

    - Each covered individual's independent obligation to report the suspicion of a crime against a resident or individual receiving care and services from the facility directly to local law enforcement and the State Survey Agency;

    - The timeframe requirements for reporting reasonable suspicion of crimes:
        - If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual must report the suspicion immediately, but not later than 2 hours after forming the suspicion;
        - If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion.

- Penalties associated with failure to report:
    - If a covered individual fails to report within mandated timeframes, the covered individual will be subject to a civil money penalty of not more than $200,000, as adjusted annually under 45 CFR part 102; and the covered individual may be excluded from participation in any Federal health care program (as defined in section 1128B(f) of the Act).
    - If a covered individual fails to report within mandated timeframes and the violation exacerbates the harm to the victim of the crime or results in harm to another individual, the covered individual will be subject to a civil money penalty of not more than $300,000, as adjusted annually under 45 CFR part 102; and the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f) of the Act).
- The mechanism for documenting that all covered individuals have been notified annually of their reporting obligations. Documentation may include a copy of a notice or letter sent to covered individuals with confirmation that it was received or a completed training/orientation attendance sheet documenting the individual completed training on reporting obligations.

REPORTING ALLEGED VIOLATIONS

An alleged violation can be observed or reported by staff, resident, relative, visitor, another health care provider, or others. For example, a receiving hospital may report to the facility suspicious bruising of the resident near the inner thighs and groin area, which were identified during a medical exam in the emergency department. An individual (e.g., a resident, visitor, facility staff) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as "abuse," "neglect," "mistreatment," or "exploitation" in order to trigger the Federal requirements at §483.12(c). Rather, if facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered to be reportable and require action under §483.12(c). For example, if a resident is abused but does not allege abuse, the resident's failure or inability to provide information about the occurrence is immaterial when the abuse may be substantiated by other supporting evidence. Another example is when a nurse aide witnesses an act of abuse but fails to report the alleged violation; the failure to report does not support a conclusion that the abuse did not occur and the facility would not meet the reporting requirements.

All alleged violations, whether oral or in writing, must be reported 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 and adult protective services where State law provides for jurisdiction in long-term care facilities). Conformance with this provision requires that each State Agency has a means to collect reports, even during off-duty hours (e.g., answering machine, voice mail, fax, electronic transmission, etc.). The facility must have documentation of the report, including what was reported and the date and time the report was

made to the SA. The facility must submit reports that are accurate, to the best of its knowledge at the time of submission of the report. It is important that facilities not make reports that are misleading, such as reports that deliberately omit facts, or reports that are designed to make the incident appear less serious than it was, or reports that misrepresent the facility's response. Deliberate misrepresentations or omissions could result in a deficiency at F609 or may give rise to other deficiencies.

Initial Report- For alleged violations of abuse or if there is resulting serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made. For alleged violations of neglect, exploitation, misappropriation of resident property, or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours. The facility must provide in its report sufficient information to describe the alleged violation and indicate how residents are being protected [see §483.12(c)(3)]. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report, so that State agencies can initiate action necessary to oversee the protection of nursing home residents. Please see Exhibit 358 for a sample form for initial reporting, with examples of information.

Follow-up Investigation Report- Within 5 working days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report, so that State agencies can initiate action necessary to oversee the protection of nursing home residents [see §483.12(c)(4)]. The facility should include any updates to information provided in the initial report. Please see Exhibit 359 for a sample form for investigation report, with examples of information.

In the absence of a shorter State time frame requirement, all alleged violations involving abuse or resulting in serious bodily injury are reported immediately, but not later than 2 hours after the allegation is made. If the alleged allegation involves neglect, misappropriation of resident property, or exploitation and does not result in serious bodily injury, the facility must report not later than 24 hours after the allegation is made. The facility is not prohibited from fulfilling its reporting obligations earlier than the timeframes provided in the regulations, so that immediate actions can be taken to protect the resident(s).

If an alleged violation has been identified and reported to the administrator/designee, the facility must report it and provide protection for the identified resident(s) prior to conducting the investigation of the alleged violation. In some situations, the facility may initially evaluate an occurrence to determine whether it meets the definition of an "alleged violation." For example, upon discovery of an injury, the facility must take steps to evaluate whether the injury meets the definition of an "injury of unknown source." Similarly, if a resident states that his or her belongings are stolen, the facility may make an initial determination whether the item has been misplaced in the resident's room, in the laundry, or elsewhere before reporting misappropriation of property. However, if the alleged violation meets the definition of abuse, neglect, exploitation or mistreatment, the facility should not make an initial determination whether the allegation is credible before reporting the allegation.

NOTE: At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action, in accordance with §483.12(c)(4).

The phrase **"in accordance with State law"** modifies the word "officials" only. State law may stipulate that alleged violations and the results of the investigations be reported to additional State officials beyond those specified in Federal regulations. This phrase does not modify what **types** of alleged violations must be reported or the timeframes in which the reports are to be made. States may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, exploitation, and misappropriation of resident property) to be reported, nor can the State establish longer time frames for reporting than mandated in the regulations at §§483.12(c)(1) and (4). No State can override the obligation of the nursing home to fulfill the requirements under §483.12(c), as long as the Medicare/Medicaid certification is in place.

Some States may have different reporting requirements that could go beyond the Federal requirements or are more specific than the Federal requirements. For example, some States require that all falls be reported to the SA. The SA should continue to manage and investigate these cases under its state licensure authority. If the State determines that these occurrences do meet the definition of abuse, neglect, mistreatment, or injuries of unknown source, as outlined in this guidance, the SA must assess whether the nursing home has met the requirements for reporting and investigating these cases in accordance with 42 C.F.R. §483.12(c).

If the surveyor discovers a reasonable suspicion of a crime committed against a resident of or an individual receiving services from the facility and it has not been reported by a covered individual, the surveyor reminds the facility of the covered individuals' obligation to report suspected crimes pursuant to section 1150B of the Act within the required timeframes. "Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility as defined in section 1150B(a)(3) of the Act. If a covered individual reports the suspected crime to local law enforcement, the surveyor must verify that the report was made (e.g., obtain time/date of report, name of person who received report, case number, etc.). If the covered individual refuses to report, or the surveyor cannot verify that a report was done, the surveyor must consult with his/her supervisor immediately, and the State Agency must report the potential criminal incident to law enforcement immediately. (See F609)

IDENTIFICATION OF ALLEGED VIOLATIONS

The following addresses facility responsibilities for reporting allegations/occurrences involving staff-to-resident abuse; resident-to-resident altercations; injuries of unknown source; misappropriation of resident property/exploitation; and mistreatment. A report of an alleged violation does not automatically indicate that a citation at F600, F602, or F603 is warranted; the survey team must conduct a thorough investigation of the allegation. If the collected evidence supports that abuse, neglect, or misappropriation of resident property/exploitation has occurred, it is appropriate for the survey team to cite the current or past noncompliance at the appropriate tag (e.g., F600-Free from Abuse and Neglect).

Section I. Staff to Resident Abuse

All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes [see § 483.12(c)].
This includes, but is not limited to:

- All allegations/occurrences of physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion perpetrated by staff (See F600 and F603 for examples of types of abuse);
- Staff taking or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging; and
- All reports from residents of abuse perpetrated by staff; allegations must not be dismissed on the basis of a resident's cognitive impairment(s).

Section II. Resident to Resident Altercations

Resident-to-resident altercations that must be reported in accordance with the regulations include <u>any willful action that results in physical injury, mental anguish, or pain</u>, as defined at §483.5. The tables below includes examples of resident to resident altercations and whether they are required to be reported.

NOTE: This is not an exhaustive list of all reportable types of resident to resident altercations. There may be other incidents that are also reportable.

Examples of Mental/Verbal Conflict

Required to Report	**Not Required to Report (Unless it rises to the level of what's described in the first column)**
• Intimidation • Bullying- Aggressive behavior in which someone intentionally* and repeatedly causes another resident mental anguish or discomfort** (adapted from the American Psychological Association [2] • Communication that is motivated by an actual or perceived characteristic, such as race, color, religion, sex, disability, or sexual orientation that results in mental anguish or social withdrawal** • Threats of violence • Inappropriate sexual comments that are used in a deliberately* threatening manner	• Non-targeted outbursts • Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations • Arguments or disagreements, which do not include any behavior or communication identified in the "Required to Report" column

Required to Report	Not Required to Report (Unless it rises to the level of what's described in the first column)
• Inappropriate sexual comments that offend, humiliate, or demean a resident**; • Taking and/or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging	

NOTE:

* Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

** There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.

Examples of Sexual Contact

NOTE: See also guidance at F600 related to Sexual Abuse and Capacity and Consent.

Required to Report	Not Required to Report (Unless it rises to the level of what's described in the first column)
• Unwanted touching of the breasts or perineal area • A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues • Sexual activities where one resident indicates that the activity is unwanted through verbal or non-verbal cues • Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown • Sexual assault or battery (ex. rape, sodomy, coerced nudity) • Instances where the alleged victim is transferred to a hospital for examination and/or treatment of injuries resulting from possible sexual abuse	• Consensual sexual contact between residents who have the capacity to consent to sexual activity • Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or non-verbal cues • Sexual activity between residents in a relationship, married couples or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal cues.

Required to Report	Not Required to Report (Unless it rises to the level of what's described in the first column)
• Forced observation of masturbation, or pornography • Forced, coerced or extorted sexual activity • Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident	

Examples of Physical Altercations

Resident-to-resident physical altercations that must be reported include, <u>any willful action that results in physical injury, mental anguish, or pain</u>. Examples include, but are not limited to, the following:

WILLFUL ACTION*

Willful actions include, but are not limited to, the following:

- Hitting
- Slapping
- Punching
- Choking
- Pinching
- Biting
- Kicking
- Throwing objects
- Grabbing
- Shoving

***The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm**

That results in

PHYSICAL INJURY

A physical injury resulting from the willful action including, but not limited to, the following:

- Death
- Injury requiring medical attention beyond first aid (such as a cut requiring suturing or an injury requiring transfer to a hospital for examination and/or treatment)
- Fracture(s), subdural hematoma, concussion
- Bruises
- Facial injury(ies), such as broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks

MENTAL ANGUISH*

Psychosocial outcomes resulting from the willful action including, but not limited to, the following:

- Fear of a person or place or of being left alone or of being in the dark, disturbed sleep, nightmares
- Changes in behavior, including aggressive or disruptive behavior toward a specific person
- Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts

* There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.

PAIN

Pain resulting from the willful action including, but not limited to, the following:

- Complaints of pain related to the altercation
- Onset of pain evidenced by nonverbal indicators, such as
  - Groaning, crying, screaming
  - Grimacing, clenching of the jaw
  - Resistance to being touched
  - Rubbing/guarding body part

NOTE:

* Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.

The general examples of physical altercations below illustrate possible cases that would likely **NOT** need to be reported, as long as it is not a willful action that results in physical injury, mental anguish, or pain. Every case is fact specific and all facts, circumstances and conditions involving the event/occurrence would need to be examined.

- A resident lightly taps another resident to stop an irritating behavior or get attention, with no resulting physical injury, mental anguish, or pain.
- A resident who is slow, impedes the pathway of another resident, such as in the dining room, the other resident nudges the resident out of the way to get to his/her table faster, but there is no harm to the victim.
- A resident who swats at another resident who is trying to take some food off his/her plate, and no physical injury, mental anguish, or pain has occurred.

NOTE: Even if a physical altercation is not required to be reported, the facility should take into consideration that physical altercations can increase the risk for abuse to occur to residents involved in the altercation, and possibly other residents in the facility. The facility must meet requirements related to appropriate assessment (see § 483.20 – Resident Assessment), care planning by the interdisciplinary team (see § 483.21-Comprehensive Person-Centered Care Planning), and provide care and services according to acceptable standards of practice [see §483.21(b)(3)(i)- Tag F658] to prevent harm as a result of resident to resident altercations, as well as the development and implementation of policies and procedures to prevent abuse of residents [see § 483.12(b)(1)- Tag F607)].

Through these actions, the facility can determine areas of needed improvement in care/service provision, staff training or staff deployment.

Section III. Reporting Suspicious Injuries of Unknown Source

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when <u>ALL</u> of the following criteria are met:

- **The source of the injury was not observed by any person; and**
- **The source of the injury could not be explained by the resident; and**
- **The injury is suspicious because of:**
  a. **The extent of the injury, or**
  b. **The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or**
  c. **The number of injuries observed at one particular point in time, or**
  d. **The incidence of injuries over time.**

Examples of Injuries of Unknown Source

Required to Report	Not Required to Report (Unless it rises to the level of what's described in the first column)
• Unobserved/Unexplained fractures, sprains or dislocations • Unobserved/Unexplained injuries that could have resulted from a burn, including blisters or scalds • Unobserved/Unexplained bite marks • Unobserved/Unexplained scratches and bruises found in suspicious locations such as the head, neck, upper chest or back • Unobserved/Unexplained swelling that is not linked to a medical condition • Unobserved/Unexplained lacerations with or without bleeding • Unobserved/Unexplained skin tears in sites found in suspicious locations (e.g., in sites other than the arms or legs) • Unobserved/Unexplained skin tears in patterns (e.g., bilateral, symmetrical skin tears on both arms) • Unobserved/Unexplained patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object • Unobserved/Unexplained bilateral bruising to arms, bilateral bruising of the inner thighs, "wrap around" bruises that encircle the legs, arms or torso, and multicolored bruises which would indicate that several injuries were acquired over time. • Unobserved/Unexplained facial injuries, including facial fractures, black eye(s), bruising, or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth • Unobserved/Unexplained bruising or other injuries in the genital area, inner thighs, or breasts • Unobserved/unexplained injury requiring transfer to a hospital for examination and/or treatment **NOTE: Any injury that is explained and appears to be a result of abuse must be reported.**	• Bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect • Injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect • Injuries that were witnessed by staff, where there is no indication of abuse or neglect **NOTE: Even if the injury is not one that requires a report, the facility should adequately assess and monitor the resident, notify the physician/resident representative as appropriate, and document the injury and investigation as a part of the resident's medical record.**

NOTE: If there is a reasonable suspicion of a crime having occurred related to the injury, covered individuals must report to the State Survey Agency and law enforcement under required timeframes (See Tag F609).

Section IV. Reportable Events Related to Potential Neglect

"Neglect," means "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." (See §483.5) In other words, neglect occurs when the facility is aware, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress. There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's position would be impacted by the incident.

Examples of events to be reported include, but are not limited to, the following:

1. Failure to meet payroll or pay supplier bills resulting in residents not receiving goods or services, such as

    - Insufficient staff (including the night shift and weekends) resulting in the lack of provision for resident's care needs (e.g., residents who need continuous skilled nursing care or supervision, residents with cognitive deficits requiring continuous supervision); or
    - Lack of essential supplies or equipment such as incontinence supplies, wound care supplies, or oxygen equipment or adaptive equipment according to the needs of the resident(s); or
    - Lack of sufficient amounts of food to meet the residents' nutritional needs.

2. Staff repeatedly ignoring residents' needs for assistance with activities of daily living, resulting in residents remaining in bed when they want to be up and repeatedly missing activities; or residents being left in fecal material or urine.
3. Failure to oversee the management of pain for a resident resulting in a resident not receiving required medications or treatments, leading to prolonged excruciating pain.
4. Failure to implement and monitor care planned interventions, resulting in repeated failures to provide necessary care and services to prevent the development a new avoidable pressure ulcer that develops into a Stage 3 or 4 pressure ulcer.

NOTE: Noncompliance at the Resident's Rights/Quality of Care/Quality of Life tag alone does not automatically indicate noncompliance at F600, or F609. The survey team would need additional evidence that identifies that the facility knew, or should have known, to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident's needs, but failed to take action, resulting in harm to the resident. For example, a survey team identifies that a facility had failed to perform a skin assessment for a resident,

resulting in failure to implement interventions to prevent the development of an avoidable Stage 2 pressure ulcer for a resident. Upon further investigation, the survey team finds that the facility identified the pressure ulcer and treated it with no further worsening. While the survey team would identify noncompliance at F686, the facility would not be cited at F600 and the facility would not be expected to report this as an alleged violation of neglect.

Section V. Reportable Allegations of Misappropriation of Resident Property and Exploitation

The facility must exercise reasonable care for the protection of the resident's property from loss or theft. See tag F584, 42 CFR §483.10(i)(1)(ii). The facility is expected to be responsive to a resident's concerns about lost items.

"Exploitation," as defined at §483.5, means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Misappropriation of resident property," as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

Examples of allegations of misappropriation of resident property and exploitation that must be reported include, but are not limited to:

- Theft of personal property, including but not limited to jewelry, computer, phone, and other valuable items such as eyeglasses and hearing aids;
- Unauthorized/coerced use by staff of resident's personal property;
- Theft of money from bank accounts;
- Unauthorized or coerced purchases on a resident's credit card;
- Unauthorized or coerced purchases from resident's funds;
- Staff who accept money from a resident for any reason including when staff have made the resident believe that staff was in a financial crisis or the resident believes that he/she is in a relationship with the staff person;
- A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion; and
- Missing prescription medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain.

Examples of allegations that would not be reported are:

- Theft of nominal items with little to no monetary or sentimental value;
- Lost items that are not listed under "must be reported."

Section VI. Reportable Allegations of Mistreatment

"Mistreatment," as defined at §483.5, is "inappropriate treatment or exploitation of a resident."

Allegations of mistreatment should be reported only if they meet the criteria for reporting alleged violations of abuse and/or exploitation, which are described under the Sections above.

Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602 and F603.

INVESTIGATIVE PROTOCOL
FOR POLICIES AND PROCEDURES RELATED TO REPORTING OF REASONABLE SUSPICION OF A CRIME

USE

Use this protocol during any survey, if, based on a complaint or an investigation of abuse, neglect, misappropriation of resident property, or exploitation, a covered individual did not report a reasonable suspicion of a crime. Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602, and F603, which gathers information about what information was or was not reported by covered individuals and whether retaliation may have occurred.
The protocol below investigates whether the facility developed and implemented policies and procedures related to:

- Ensuring the reporting reasonable suspicion of crimes, and
- Notifying covered individuals of their reporting responsibilities.

PROCEDURES

If the surveyor discovers a reasonable suspicion of a crime being committed against a resident of or an individual receiving services from the facility and it has not been reported by a covered individual, the surveyor reminds the facility of the covered individuals' obligation to report suspected crimes pursuant to section 1150B of the Act within the required timeframes.

"Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility as defined in section 1150B(a)(3) of the Act. If a covered individual reports the suspected crime to local law enforcement, the surveyor must verify that the report was made (e.g., obtain time/date of report, name of person who received report, case number, etc.). If the covered individual refuses to report, or the surveyor cannot verify that a report was done, the surveyor must consult with his/her supervisor immediately, and the State Agency must report the potential criminal incident to law enforcement immediately.

Facility Policies and Procedures

Obtain and review the facility's policies and procedures to determine whether the facility is:

- Notifying covered individuals of their reporting responsibilities, and
- Ensuring the reporting of reasonable suspicions of crimes.

Interview Staff

Interview staff who may have knowledge of the alleged incident to determine how did staff follow facility policies and procedures, such as:

- What is his/her responsibility in reporting a reasonable suspicion of a crime,
- What is the facility's policies and procedures for reporting,
- What actions were taken when there was a suspected crime,
- When he/she may have last received orientation, training, in-service, and/or notification regarding the reporting of suspected crimes, and
- Whether there are any barriers to reporting.

Additional interviews with other staff across all levels and different shifts may also be conducted.

Interview – Administrator
Interview the Administrator to determine how the Administrator oversees the implementation of policies and procedures for reporting of suspected crimes.

Review of In-service Training/Orientation Records
Obtain and review documentation of training to determine whether covered individuals were notified annually of their responsibility in a language that the individual would understand to report allegations of suspected crimes against residents and individuals receiving care from the facility.

Key Elements of Noncompliance
To cite deficient practice at F609, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:

- Develop policies and procedures related to ensuring the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases) and notifying covered individuals annually of their reporting obligations;

- Identify a situation as an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property;

- Report an alleged violation involving abuse or resulting in serious bodily injury immediately, but not later than two hours after the allegation is made, to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law;

- Report an alleged violation involving neglect, misappropriation of resident property, exploitation, or mistreatment, and does not result in serious bodily injury not later than 24

hours to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law; or

- Report the results of all investigations within 5 working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency.

If Tag F609 is cited for failure to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime, the survey team includes the following language at the beginning of the Deficient Practice Statement on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act…"

DEFICIENCY CATEGORIZATION - ENSURING REPORTING OF A REASONABLE SUSPICION OF A CRIME

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Psychosocial Outcome Severity Guide).

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

- The facility failed to implement policies and procedures for covered individuals to identify and report a suspected crime to local law enforcement and the SA, resulting in failure to protect a resident from further potential criminal activity by an alleged perpetrator. In addition, the facility had failed to report the alleged violation of abuse to the Administrator, as well as the State Survey Agency. A resident, with a cognitive impairment who was dependent on staff for care, reported to family members that she was "touched down there" and identified the alleged perpetrator. Family members reported this to the licensed staff person on duty; however, the staff told the family that the resident was confused. Staff did not report the family's allegation to anyone and failed to provide protection for the resident allowing ongoing access to the resident by the alleged perpetrator. The resident had emotional changes including crying and agitation and cowered with fear whenever the alleged perpetrator approached the resident. The resident subsequently developed a sexually transmitted disease (STD). Based on interviews with various staff members, these covered individuals were not aware of their reporting responsibilities for a suspected crime, even though they had participated in abuse prevention training and had received their annual notification of their reporting obligations. Each staff member assumed that this did not need to be reported because the resident was confused; therefore, the facility had failed to ensure reporting.

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

- The facility failed to implement policies and procedures for covered individuals to report to local law enforcement, the suspicion of a crime related to drug diversion. A resident was prescribed opioid pain medication to manage severe pain following recent surgery for a fractured hip. A resident had requested that staff review his pain medication as it was not effective over the weekend. The resident informed staff that he was unable to attend weekend daytime activities due to discomfort and lack of sleep from having pain at night. The resident stated that he received a different colored pill during the weekend, but it did not seem to work like the medication that was given during the weekdays. The facility's investigation revealed that the same staff nurse worked on each of the weekend night shifts when the resident was identified to have unrelieved pain. This staff nurse had access to the controlled medications for residents on that unit. During interview with the nurse aide who worked on the same shift as the nurse, the nurse aide stated that she saw the nurse coming out of the resident's room with the medication cup, and the nurse had told her that the resident was sleeping and she would give the medication later. The nurse aide reported that she then saw the nurse take the medication herself. She stated that she was afraid to report what she had seen since she did not want to jump into any conclusions or cause any trouble for the nurse. Interviews with other staff revealed they were not aware of facility policies or of their obligations to report a suspected crime including possible drug diversion.

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

The facility failed to provide annual notification to staff on their obligations to report suspected crimes and to post signage of employee rights related to retaliation against the employee for reporting a suspected crime. During the investigation, the surveyors did not see any signage related to employee rights related to retaliation. Based on interviews with five staff members, they had not received their annual notification from the facility regarding their obligations to report suspected crimes to law enforcement and to the State Survey Agency, without fear of retaliation. However, the staff members were knowledgeable about their obligations. Additionally, two other staff members who were recently hired within the last 30 days, were not knowledgeable of their reporting obligations or rights to report a suspected crime without retaliation.

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

- The failure of the facility to meet the requirements under this Federal requirement is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement

---

1 American Psychiatric Association. (2022). Schizophrenia Spectrum and Other Psychotic Disorders. Diagnostic and statistical manual of mental disorders (5th ed., text rev.)