SPOT IT… STOP IT… REPORT IT…

Recognizing and Preventing Abuse & Neglect in Missouri's SNFs & ALFs

INNOVATE, NETWORK AND SUCCEED WITH MANHA
2025 ANNUAL CONVENTION
LODGE OF THE FOUR SEASONS
JUNE 8-11, 2025

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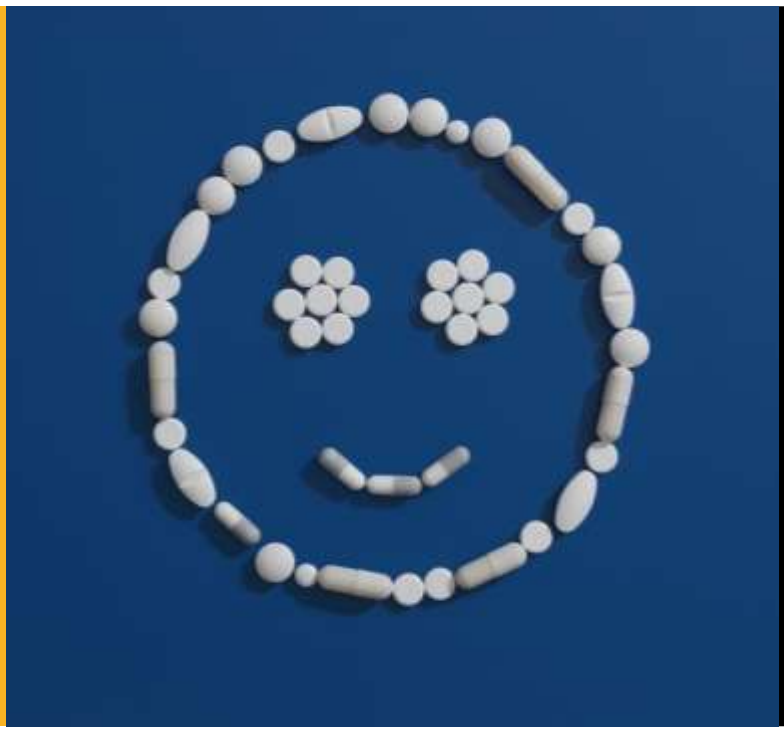

LAUGHTER IS THE BEST MEDICINE…

DO YOU KNOW WHY RUNNING A CARE CENTER IS A LOT LIKE CONDUCTING A SYMPHONY ???

2

IF JUST ONE PERSON PLAYS OUT OF TUNE, EVERYBODY HEARS ABOUT IT……..

USUALLY DURING SURVEY WEEK

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WHAT DID THE RESIDENT SAY TO THE MAINTENANCE MAN THAT FIXED THEIR CALL LIGHT ????

YOU LIGHT UP MY LIFE !!!!

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F 600

AND ALL THAT GOES ALONG WITH IT

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REGULATIONS

F 600	42 CFR 483.12
"RESIDENT HAS THE RIGHT TO BE FREE FROM ABUSE, NEGLECT, MISSAPPROPRIATION OF RESIDENT PROPERTY AND EXPLOITATION"	THIS APPLIES TO ALL STAFF, VOLUNTEERS, VISITOR AND CONTRACTORS

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DEFINITIONS

ABUSE: WILLFUL INFLICTION OF INJURY, UNREASONABLE CONFINEMENT, INTIMIDATION, OR PUNISHMENT

NEGLECT: FAILURE TO PROVIDE GOODS AND SERVICE NECESSARY TO AVOID HARM

EXPLOITATION: TAKING ADVANTAGE OF A RESIDENT FOR PERSONAL GAIN, MISUSE OF FUNDS OR RESOURCES,

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ABUSE BEYOND SLAP, SMACK, HIT, PUSH

SOCIAL MEDIA .....A STAFF MEMBER SECRETLY RECORDS A RESIDENT DURING CARE AND POST IT ON SOCIAL MEDIA AS A JOKE...

ROOM ASSIGNMENT....ASSIGNING A DISRUPTIVE ROOM MATE TO A VUNERABLE RESIDENT TO RETALIATE AGAINST A COMPLAINT.

LANGUAGE BARRIERS....KNOWINGLY ADMITTING A RESIDENT WHO SPEAKS ONLY SPANISH & IS IGNORED OR MISINFORMED ABOUT CARE BECAUSE STAFF CAN NOT ARRANGE AN INTERPRETER OR OTHER SOLUTION TO LANGUAGE BARRIER.

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VERBAL ABUSE

ANY USE OF ORAL, WRITTEN OR GESTURED LANGUAGE THAT WILLFULLY INCLUDES DISPARAGING AND DEROGATORY TERMS.

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VERBAL OR SEXUAL ABUSE

- THREATS MADE TO THE RESIDENT
- YELLING AT A RESIDENT. ..I TOLD YOU TO STOP PUSHING YOUR CALL LIGHT
- YOU ACT LIKE A BABY ….GROW UP AND STOP COMPLAINING
- IF YOU DON'T BEHAVE, I WON'T TAKE YOU OUT TO SMOKE
- IF YOU DON'T BEHAVE YOU CAN'T GO TO ACTIVITIES
- LET'S GO POTTY LIKE A "BIG GIRL"
- MABLE HAS WET HER CLOTHES AGAIN…… STANDING AT THE NURSES STATION
- BELITTLING OR MAKING FUN OF A RESIDENT
- SAYING THINGS TO FRIGHTEN THE RESIDENT,….YOU WILL NEVER SEE YOUR FAMILY AGAIN.
- **NON-CONSENSUAL CONTACT…..** WHETHER IT BE EMPLOYEE TO RESIDENT , MALE RESIDENT TO MALE RESIDENT, FEMALE TO FEMALE, FEMALE TO MALE OR MALE TO FEMALE

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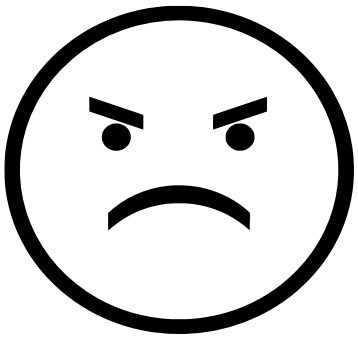
NEGLECT

FAILURE TO PROVIDE GOODS OR SERVICES NECESSARY TO AVOID HARM, PAIN, MENTAL ANGUISH, & EMOTIONAL DISTRESS……

- FAILURE TO ADMINISTER MEDICATIONS, (PAIN, THYROID, MOBILITY)
- MEDICATION ERRORS,
- DEPRIVATION OF PERSONAL BELONGINGS…..A RESIDENT'S CALL LIGHT IS MOVED OUT OF REACH
- THEIR EYEGLASSES ARE TAKEN FOR SAFE KEEPING….. BUT NEVER RETURNED,
- PHONES HIDDEN BECAUSE THEY CALL STATE OR 911
- PREVENTABLE FALLS….. FROM BROKEN CALL LIGHT SYTEM, BROKEN WHEELCHAIRS, BROKEN OR LOOSE SIDE RAILS



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NEGLECT

PSYCHOLOGICAL …..RESIDENT REPORTS MISSING MEDICATION DOSES AND STAFF CONSISTENTLY INSIST THEY'RE " JUST CONFUSED " WHEN MED COUNTS SHOW INCONSISTENCIES

PASSIVE –AGGRESSIVE……STAFF MEMBER DISLIKES A RESIDENT SO PURPOSEFULLY BRINGS MEALS LAST OR COLD MEALS OR DELAYS ANSWERING CALL LIGHTS, …..WHILE ALL ALONG TECHNICALLY FOLLOWING THE RULES ????

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- **MOST COMMON….**
- DEHYDRATION
- PRESSURE ULCERS
- POOR HYGIENE
- INFECTIONS OR CHRONIC CONDITIONS
- SOILED BEDDING OR CLOTHING

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EXPLOITATION

- TAKING ADVANTAGE OF A RESIDENT FOR PERSONAL GAIN THROUGH THE USE OF MANIPULATION, INTIMIDATION, THREATS OR COERCION……

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EXPLOITATION

- THEFT OF CASH…..
- THEFT OF JEWELERY
- FORGING SIGNATURES…. FOR EXAMPLE, CREDIT CARDS
- UNAUTHORIZED USE OF RESIDENT FUNDS…..RUNNING AN ERRAND FOR A RESIDENT TO WAL-MART AND MAKING A PERSONAL UNAUTHORIZED PURCHASE
- COERCION….RESIDENT FEELS SORRY FOR AN EMPLOYEE BECAUSE THEY DO NOT HAVE THE FUNDS TO BUY THEIR CHILDREN CHRISTMAS & GIVES THEM CASH ….
- GUARDIAN, DPOA, FAMILY MEMBER SELLS RESIDENTS' PROPERTY AND DOES NOT USE THE PROCEEDS FOR RESIDENT CARE
- A RESIDENT BEING PRESSURED INTO CHANGING THEIR LEGAL DOCUMENTS , SUCH AS A WILL, POA, BENEFICIARY.

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PREVENTION IS THE KEY

- STAFF EDUCATION AND TRAINING
- POLICY & PROCEDURES IN PLACE
- THOROUGH HIRING AND SCREENING PROCESS
- CREATING A CULTURE OF RESPECT AND DIGNITY
- RESIDENT AND FAMILY EDUCATION
- MONITORING AND ACCOUNTABILITY

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F 606
EMPLOYMENT

- FACILITIES MUST NOT EMPLOYEE INDIVIDUALS WHO HAVE BEEN FOUND GUILTY OF ABUSE, NEGLECT, EXPLOITATION, MISTREATMENT OR MISAPPROPRIATION OF PROPERTY.
- HAVE A FINDING ENTERED INTO THE STATE NURSE AIDE REGISTRY CONCERNING ABUSE, NEGLECT, EXPLOITATION, MISTREATMENT, MISAPPROPRIATION OF THEIR PROPERTY.
- HAVE DISCIPLINARY ACTION IN EFFECT AGAINST HIS OR HER PROFESSIONAL LICENSE BY A STATE LICENSURE BODY …..

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WHO IS COVERED

- LICENSED AND UNLICENSED STAFF
- CONTRACT EMPLOYEES
- AGENCY STAFF
- VOLUNTEERS
- CONSULTANTS AND TEMPORARY STAFF

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SCREENING REQUIREMENTS

THE NURSE AIDE REGISTRY MUST BE CHECKED FOR EVERY EMPLOYEE , REGARDLESS OF THE DEPARTMENT THEY ARE WORKING IN	CONDUCT BACKGROUND CHECKS	EDL CHECK
FAMILY CARE REGISTRY	MAINTAIN DOCUMENTATION OF ALL SCREENINGS	**ANNUAL TRAINING** ON ABUSE FOR ALL EMPLOYEES & UPON HIRE

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INVESTIGATION

SUGGESTED ITEMS TO OBTAIN WHEN DOING AN INVESTIGATION…..

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#1. FACILITY NAME
_____

DATE OF REPORT_____

INVESTIGATOR NAME & TITLE_____

INCIDENT DATE AND TIME_____

LOCATION OF INCIDENT_____

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INVESTIGATING

#2 RESIDENT INFORMATION:

NAME _____

ROOM NUMBER_____

DATE OF BIRTH_____

FAMILY/RESPONSIBLE PARTY/ OR LEGAL GUARDIAN_____

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INVESTIGATING

#3 TYPE OF ALLEGED ABUSE
…CHECK ALL THAT APPLY

__PHYSICAL
__EMOTIONAL OR PSYCHOLOGICAL
__SEXUAL
__NEGLECT
__FINANCIAL EXPLOITATION
__OTHER_____
_____
_____
_____
_____

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INVESTIGATING

#4 DESCRIPTION OF ALLEGED ABUSE:

DOCUMENT IN DETAIL….

- WHO REPORTED THE INCIDENT
- WHAT WAS ACTUALLY OBSERVED BY THEIR OWN EYES
- WHAT WAS HEARD
- NAME ALL RESIDENTS & OR STAFF INVOLVED IN THE INCIDENT
- SUGGEST GETTING WRITTEN STATEMENTS FROM EACH EMPLOYEE ON SHIFT AT THE TIME ON THAT UNIT/HALL …THE SOONER THE BETTER !!

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INVESTIGATING

#5 RESIDENT CONDITION:

INJURIES OBSERVED ….DESCRIBE IN DETAIL AND NOTE IF PHOTOGRAPHS ARE TAKEN …PLEASE CONSULT YOUR FACILITIES P&P, MANAGEMNT , CORPORATE , ETC….PRIOR TO PHOTOS

DOCUMENT RESIDENT STATEMENTS OR ANY BEHAVIOR NOTED PRIOR TO AND FOLLOWING THE INCIDENT

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INVESTIGATING

- **#6 WITNESSES**

OBTAIN THE FOLLOWING INFORMATION FOR ALL WITNESSES, WHETHER THEY ARE STAFF, OTHER RESIDENTS, VOLUNTEERS, VISITORS, CONTRACTORS, …

*NAME_____

*TITLE_____

*RELATIONSHIP _____

*CONTACT INFORMATION_____

*STATEMENT OR SUMMARY OF WHAT THEY SAW/HEARD….ALWAYS BEST IN WRITING IF WILLING._____

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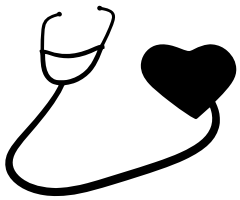
INVESTIGATING

#7 ALLEGED PERPETRATOR:



NAME:_____

TITLE /RELATIONSHIP TO RESIDENT_____

CURRENT STATUS IN FACILITY_____

DEPARTMENT WORKING IF EMPLOYEE_____

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INVESTIGATING

- **#8 IMMEDIATE ACTION TAKEN:**

RESIDENT SAFETY ENSURED……RELOCATION, MEDICAL CARE

NOTIFICATIONS MADE……..ADMINISTRATOR, DON,

IF STAFF INVOLVED…MUST BE SUSPENDED PENDING INVESTIGATION EVEN IF YOU FEEL IT IS UNSUBSTANTIATED!!!

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INVESTIGATING

- **#9 INVESTIGATION SUMMARY**
- LIST OF INTERVIEWS CONDUCTED AND SUMMARY
- RECORDS REVIEWED , MEDICAL, INCIDENT REPORTS ETC..
- EVIDENCE COLLECTED, IF ANY
- SURVEILLANCE VIDEO RESULTS IF APPLICABLE
- PAYROLL RECORDS
- RESULTS OF INVESTIGATION

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FORMS

#10 CORRECTIVE ACTIONS TAKEN

_____

_____

_____

_____

#11 FOLLOW UP / P& P REVIEWED, CHANGES MADE…

EDUCATION OR TRAINING OF STAFF

MONITORING IMPLEMENTED

REVISIONS TO DINING ROOM SEATING

REVISIONS TO SMOKING TIMES

ETC…….

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INVESTIGATING

NOTIFICATIONS!!!

ADM OR DON

#12 REPORTING:

ADMINISTRATOR NOTIFIED_____DATE & TIME_____

DON NOTIFIED_____DATE &TIME_____

REPORTED TO ABUSE HOTLINE_____DATE & TIME_____

REPORTED TO LAW ENFORCEMENT, IF APPLICABLE, DATE_____ TIME_____

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SELF REPORTING

ALL ALLEGATIONS OF ABUSE WITH SERIOUS BODILY INJURY ARE REQUIRED TO BE REPORTED IMMEDIATELY, BUT NO LATER THAN 2 HOURS.

ALL OTHER ALLEGATIONS WITH NO SERIOUS BODILY INJURY MUST BE MADE WITHIN 24 HOURS.

WITHIN 5 WORKING DAYS FACILITIES ARE REQUIRED TO SUBMIT A FOLLOW UP INVESTIGATION REPORT TO SLCR REGIONAL OFFICE.

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DHSS FOLLOW UP INVESTIGATION REPORT

https://health.mo.gov/seniors/nursinghomes/pdf/facility-rep-follow-up-report.pdf

Follow-up Investigation Report

**Please fax completed form to your regional office.

Within five (5) business days of the incident, a certified facility must provide in or report sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.

1. Identifying Information

2. Additional/Updated Information Related to the Reported Incident

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EXAMPLE #1

- BASED ON RECORD REVIEW, THE FACILITY FAILED TO PROTECT ONE CONFUSED AND VUNERABLE RESIDENT, RESIDENT #1 OUT OF FOUR SAMPLED. DURING MEDICATION ADMINISTRATION, WHEN FACILITY STAFF HELD THE RESIDENT'S HANDS AND FORCED HIS/HER MEDICATION IN HIS/HER MOUTH RESULTING IN THE RESIDENT SOBBING AND SCREAMING "THE STAFF WERE DEVILS." THE FACILITY CENSUS WAS 109
- ABUSE…..?? IT'S AN IMPORTANT MEDICINE
- ACTION NEEDED….
- DHSS RESULTS….

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EXAMPLE #2

ON 4/7 CNA A HIT RESIDENT #2 ON THE HAND WITH A GLASS, RESIDENT REPORTED THIS TO THE ADM IN FRONT OF A WITNESS, CNA CONTINUED TO WORK AND MEASURES WERE NOT TAKEN TO PROTECT OTHER RESIDENTS. ON 4/11 CNA CURSED AT AND SHOOK ROUGHLY, RESIDENT #1 . INTERVIEW WITH RESIDENT SAID CNA STATED," I DON'T HAVE TIME TO ********* MESS WITH YOU," RESIDENT STATES SHE/HE IS AFRAID.

ACTION NEEDED_____

DHSS RESULTS_____

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EXAMPLE #3

- CMT HIT RESIDENT #1 IN THE FACE WITH OPEN HAND. THE FACILITY ALLOWED THE ALLEGED PERPRETATOR TO STAY IN CONTACT WITH RESIDENT #1 WITHOUT SUPERVISION FOR AN ADDITIONAL 2.5 HOURS .
- ACTIONS NEEDED_____
- DHSS RESULTS_____

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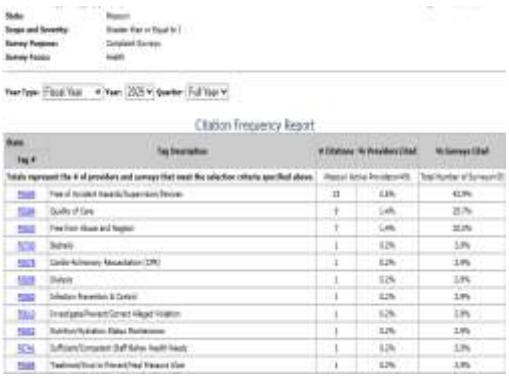
QCOR IJ CITATION FREQUENCY REPORT FY 2025

Citation Frequency Report



Citation Frequency Report

F604 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

§483.10(e) Treat with respect & dignity

§483.10(e)(1) Free from physical or chemical restraints imposed for purpose of discipline or convenience

§483.12 Free from abuse, neglect, misappropriation of resident property and exploitation. Freedom from corporal punishment, involuntary seclusion

F604 Intent

The intent of this requirement is for each resident to attain and maintain his/her highest practicable well-being in an environment that:

Prohibits the use of physical restraints for discipline or convenience;

Prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity; and

Limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints.

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Facility Practices That Meet the Definition of Physical Restraint

Placing	Placing	Tucking	Placing	Using	Applying	Holding	Placing	Using
Placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed;	Placing a resident on a concave mattress so that the resident cannot independently get out of bed;	Tucking in a sheet tightly so that the resident cannot get out of bed, or fastening fabric or clothing so that a resident's freedom of movement is restricted;	Placing a resident in a chair, such as a beanbag or recliner, that prevents a resident from rising independently;	Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising;	Applying leg or arm restraints, hand mitts, soft ties or vests that the resident cannot remove;	Holding down a resident in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care;	Placing a resident in an enclosed framed wheeled walker, in which the resident cannot open the front gate or if the device has been altered to prevent the resident from exiting the device; and	Using a position change alarm to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm.

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Reasons for Using Restraints for Convenience or Discipline

Staff state that a resident was placed in a restraint because staff are too busy to monitor the resident, and their workload includes too many residents to provide monitoring;

Staff believe that the resident does not exercise good judgment, including that he/she forgets about his/her physical limitations in standing, walking, or using the bathroom alone and will not wait for staff assistance;

Staff state that family have requested that the resident be restrained, as they are concerned about the resident falling especially during high activity times, such as during meals, when the staff are busy with other residents;

Staff have identified to management that there is not enough staff on a particular shift or during the weekend and staffing levels were not changed;

Staff state that new staff and/or temporary staff do not know the resident, how to approach, and/or how to address behavioral symptoms or care needs so they apply physical restraints;

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Reasons for Using Restraints for Convenience or Discipline

Lack of staff education regarding the alternatives to the use of restraints as a method for preventing falls and accidents;

Staff have negative feelings or a lack of respect towards the resident, and restrain the resident to teach him/her a lesson;

In response to a resident's wandering behavior, staff become frustrated and restrain a resident to a wheelchair; and

When a resident is confused and becomes combative when care is provided, and staff hold the resident's arms and legs down to complete the care

(NOTE: This example differs from an emergency situation where staff briefly hold a resident for the sole purpose of providing necessary immediate medical care ordered by a practitioner).

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Physical Risks and Psychosocial Impact Related to Use of Restraints

Physical restraints may increase the risk of one or more of the following:

- Decline in physical functioning including an increased dependence in activities of daily living (e.g., ability to walk), impaired muscle strength and balance, decline in range of motion, and risk for development of contractures;
- Respiratory complications;
- Skin breakdown around the area where the restraint was applied or skin integrity issues related to the use of the restraint (i.e., pressure ulcers/injuries);
- Urinary/bowel incontinence or constipation;
- Injury from attempts to free him/herself from the restraint; and
- Accidents such as falls, strangulation, or entrapment.

Psychosocial impact related to the use of physical restraints may include one or more of the following:

- Agitation, aggression, anxiety, or development of delirium;
- Social withdrawal, depression, or reduced social contact due to the loss of autonomy;
- Feelings of shame;
- Loss of dignity, self-respect, and identity;
- Dehumanization;
- Panic, feeling threatened or fearful; and
- Feelings of imprisonment or restriction of freedom of movement.

Example of Level 4 Noncompliance Immediate Jeopardy (SOM)

The facility *failed to identify* the resident's medical symptom that warranted the use of a restraint.

It was identified that a resident had repeated falls in his room usually after meals, when he attempted to transfer from his wheelchair to the bed.

The clinical record documented that the resident repeatedly requested to be assisted to lie down after eating. Staff recorded that the **belt restraint** was being applied to prevent falls as he had fallen several times when attempting to stand up from the wheelchair after meals and lie down.

Although the resident verbalized distress at being tied down in the wheelchair, staff stated they had informed the resident that they would put the resident in bed as soon as they finished taking care of the other residents in the dining room.

It was documented that after staff left the room, the resident had attempted to stand up with the lap belt in place in the wheelchair, and as a result, the wheelchair tipped over and he sustained a fracture of his hand and had hit his head, resulting in hospitalization and treatment for multiple head and face lacerations and a subdural hematoma.

Example of Level 4 Noncompliance Immediate Jeopardy (SOM)

The facility failed to identify bed rails as a physical restraint, *failed* to assess the resident for use of a bed rail, and failed to ensure that the bed rails did not pose a risk of injury from falls.

A moderately cognitively impaired resident was admitted to the facility who required *substantial/maximal* assistance with bed mobility and transfer, and was not ambulatory.

The staff recorded on admission that the resident was at *high risk* for falls and as a result, placed *full* bed rails on all open sides of the bed. No assessment was conducted related to the use of bed rails, or the use of restraints.

Documentation in the record revealed that the resident:

Crawled to the foot of her bed while the full bed rails were in a raised position	Attempted to stand and walk, and fell off the right side of the bed.	The resident was hospitalized for surgical repair of a femoral neck fracture.

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F605 Right To Be Free From Chemical Restraints

- **§483.10(e) Respect and Dignity**
- **§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation**
- **§483.12(a) The facility must—. . .**
- **§483.12(a)(2) Ensure that the resident is free from chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.**
- §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
  - (i) Anti-psychotic;
  - (ii) Anti-depressant;
  - (iii) Anti-anxiety; and
  - (iv) Hypnotic.
- §483.45(d) Unnecessary drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
  - (1) In excessive dose (including duplicate drug therapy); or
  - (2) For excessive duration; or
  - (3) Without adequate monitoring; or
  - (4) Without adequate indications for its use; or
  - (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
  - (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

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Intent

- *The intent of these requirements is to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.*
- *Also, residents must only remain on psychotropic medications when a gradual dose reduction and behavioral interventions have been attempted and/or deemed clinically contraindicated.*
- *Additionally, medication should only be used to treat resident's medical symptoms and not used for discipline or staff convenience, which would be deemed a chemical restraint.*

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Definition

*"**Chemical restraint**" refers to any drug used for discipline or that makes it more convenient (i.e., less effort) for staff to care for a resident, and not required to treat medical symptoms.*

This includes instances when a psychotropic medication may be approved to treat certain symptoms,

Nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety.

In these instances, a medication would be deemed not required to treat a resident's symptoms, because a safer alternative should be used.

For example, if a nonpharmacological intervention should be used or attempted and is not clinically contraindicated, but a medication is administered and has the effect consistent with the definition of convenience (defined below), the medication would be classified as a chemical restraint.

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Definitions

- ***Convenience*** *refers to the unnecessary administration of a medication that causes (intentionally or unintentionally) a change in a resident's behavior (e.g., sedation) such that the resident is subdued and/or requires less effort from staff. Therefore, if a medication causes symptoms consistent with sedation (e.g., excessive sleeping, drowsiness, withdrawal, decreased activity), it may take less effort to meet a resident's behavioral needs, which meets the definition of convenience.*

- ***Discipline*** *refers to any action, such as the administration of a medication, taken by facility staff for the purpose of punishing or penalizing residents. For example:*
- *A resident has been wandering into other resident's rooms and staff administer a medication to restrict the resident to their room.*
- *Staff become upset with a resident who resists receiving a bath and pinches staff. The staff did not assess the resident's needs or implement non-pharmacological interventions to address their resistance to bathing. Instead, staff administer medication to subdue the resident prior to providing the next bath.*

Medication Use

- *A medication used for staff convenience or to discipline and is not required to treat medical symptoms, may cause:*
  - *Sedation, such as sleeping during hours that he/she would not ordinarily sleep;*
  - *Withdrawal from activities and socializing;*
  - *Loss of autonomy and dignity;*
  - *Confusion, cognitive decline, and depression;*
  - *Weight loss, decline in skin integrity, or continence level; and/or*
  - *Decline in physical functioning including an increased dependence in activities of daily living.*

  These effects may result in convenience for the staff, as the resident may require staff to exert less effort than previously. Even if a medication was initially administered for a medical symptom, the continued administration of a medication in the absence of such symptom, that sedates a resident or otherwise makes it easier to care for them, would be deemed a chemical restraint.

Comprehensive Assessment and Behavioral (Nonpharmacological) Interventions/Approaches

- The indications for initiating, maintaining, or discontinuing medication(s), as well as the use of non-pharmacological approaches, in accordance with §483.45(e)(2), are determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment.
- The use of non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. The resident's medical record should include documentation of this evaluation and the rationale for chosen treatment options.

- Obtain a detailed social history, develop a picture of who the resident is, likes and dislikes
- Create a predictable, person-centered routine
- Ensure familiarity with consistent staffing, personal possessions
- Use simple language, explain actions
- Simplify tasks
- Distract and redirect
- Ensure a safe environment
- Orient (clocks, calendar where possible)
- Moderate lighting day and night
- Reduce excessive stimulation
- Tap into resident's interest: music, gardening, fishing, reading, etc.
- Use music, walking, activity, social interaction to address aggression, anxiety and/or depression

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Comprehensive Assessments & Evaluation

The facility should ensure that the resident's behaviors (expressions or indications of distress), which may have prompted the initiation or change in a psychotropic medication, are not:

- Upsetting to the resident or a safety concern to the resident or others;
- Due to a medical condition or problem (e.g., pain, fluid or electrolyte imbalance, infection, obstipation, medication side effect or poly-pharmacy) that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued;
- Due to environmental stressors alone (e.g., alteration in the resident's customary location or daily routine, unfamiliar care provider, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response), that can be addressed to improve the symptoms or maintain safety; and
- Due to psychological stressors alone (e.g., loneliness, taunting, abuse), anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g., the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses, unaddressed sensory deficits) that can be expected to improve or resolve as the situation is addressed.
- Additional information as well as examples of non-pharmacological interventions may be found in other guidance for regulations at (F741) §483.40, Behavioral Health Services and (F679) §483.24, Quality of Life (Activities)

Circumstances that warrant evaluation of a resident's underlying medical condition and medication(s) include:

- Admission or re-admission: Some residents may be admitted to the facility on psychotropic medications that were started in the hospital or the community without a clear, documented indication (i.e., history of schizophrenia without documentation to support the diagnosis per the DSM-5-TR) for why the medication was begun or should be continued. The prescribing practitioner and the IDT should subsequently determine if continuing the medication is justified by conducting a comprehensive medical and psychiatric evaluation;
- A new or worsening change in condition/status;
- An irregularity identified in the pharmacist's medication regimen review. See F756 for guidance related to the medication regimen review; and
- New medication order as an emergency measure – When a resident is experiencing an acute medical problem or psychiatric emergency and the acute phase has stabilized, the staff and prescriber should consider whether medications are still relevant.

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Example of Level 4 Noncompliance Immediate Jeopardy (SOM)

- *Failure to recognize* that use of an antipsychotic medication, originally prescribed for agitation, has caused significant *changes* in the resident's *quality of life*.
- The resident no longer participates in activities that they previously enjoyed, has difficulty concentrating and carrying on conversations, and spends most of the day isolated in their room, sleeping in a recliner or in bed.
- The antipsychotic medication was continued without an adequate clinical rationale and evidence of non-pharmacological approaches documented in the medical record, resulting in serious psychosocial harm.
- A PRN antipsychotic medication initiated more than 14 days ago, originally prescribed for acute delirium, continued to be administered daily without re-evaluation, and with no evidence of monitoring for adverse consequences.
- The *failures to monitor* for adverse consequences and *reevaluate* the appropriateness of giving the medication created a likelihood for serious harm from adverse consequences and a significant decline in functioning

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"Free From Physical/Chemical Restraints" IJ Citation

- Example: Facility failed to ensure residents were free from unnecessary physical restraints for 3/42 sampled residents along with implementing behavioral health interventions to prevent injury and excessive force and failed to investigate emergency events that led to an injury for resident #XYZ.
- Facility failed to ensure chemical restraints were not used unless medically necessary for 2/42sampled residents (Resident #ABC, #123). Failed to ensure all appropriate non-pharmacological interventions were attempted prior to administration of injections.
- Immediate jeopardy related to this failure was identified on 11/15/xx and was determined to first exist 07/11/xx when the facility failed to ensure resident #XYZ wasn't physically restrained while sustaining an injury. IJ identified on 11/15/xx and was determined to first exist on 11/13/xx for chemical restraints.
- Resident #XYZ Care Plan tab revealed per PASRR, history of behavioral changes requiring protective oversight in a secure setting. Current behaviors included yelling, screaming, attention seeking, suicide ideation, impulsiveness, visual and auditory hallucinations. Interventions include CALM de-escalation protocols, if needed and coping skills noted as music, TV and talking with peers, no pharmaceutical interventions, 1:1 intervention as needed. There was *no care plan related to physical restraints.*

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"Free From Physical/Chemical Restraints" IJ Citation

- Resident #XYZ became physically aggressive with nurse, grabbing and shoving, placed in 2-man hold.
- Physical aggressiveness continued with attempting to kick nurse, shoving nurse backwards….placed in a 5-man hold. Resident received an IM injection and was released from the 5-man hold
- Resident #XYZ received a left elbow dislocation.
- Review of the resident's POS indicated no orders or consents for physical restraints.
- Similar incident with resident #ABC: aggressive behavior, Code Green called, 5-man CALM hold with administration of injection
- Resident's care plan for management of behavior, dated 06/07/xx, revealed no reference to using a 5-man hold or psychotropic medication.

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"Free From Physical/Chemical Restraints" IJ Citation

- Resident #123 care plan indicated manifestations of behaviors related to mental illness including easily irritated by others, verbal/physical aggression, agitation and anxiety. Coping skills include talking about family member and soda. If behaviors and coping skills not effective, refer to CALM de-escalation protocols. Non-pharmacological interventions include encourage resident to watch TV, listen to music, 1:1 visits, talk with trusted person/staff, redirect resident. If staff observe a trigger, refer to resident's preferred coping skills and redirect behavior.
- Resident yelling about taking a shower, becoming physically aggressive with staff, placed in 2-man CALM hold. Physically and verbally aggressive, trying to get out of w/c. Placed in 5-man CALM hold, administered IM injection.
- Review of POS showed no orders or consents for physical restraints. There was nothing in orders to indicate alternative non-pharmacological methods of de-escalation.

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F607 Develop/Implement Abuse/Neglect , etc. Policies

- **§483.12(b) The facility must develop and implement written policies and procedures that:**
- **§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,**
- **§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and**
- **§483.12(b)(3) Include training as required at paragraph §483.95,**
- **§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.**
- **§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.**
- **§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.**
- **§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.**

F607 Intent

- This regulation was written to provide protections for the health, welfare and rights of each resident residing in the facility. In order to provide these protections, the facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, limited to, the following components:
- Screening [See §§483.12(a)(3) and 483.12(b)(1)];
- Training [See §483.12(b)(3)]; *
- Prevention [See §483.12(b)(1)];*
- Identification [See §483.12(b)(2)];
- Investigation [See §483.12(b)(2)];
- Protection [See §§483.12(b)(2) and 483.12(c)(3)]; and
- Reporting/response [See §§483.12(b)(2), 483.12(b)(4), 483.12(b)(5), 483.12(c)(1) and (4)].
- In order to ensure that the facility is doing all that is within its control to prevent such occurrences, these policies must be implemented (i.e., carried out), otherwise, the policies and procedures would not be effective.
- The facility is expected to provide *oversight and monitoring* to ensure that its staff, who are agents of the facility, implement these policies during the provision of care and services to each resident residing in the facility.
- A facility cannot disown the acts of its staff, since the facility relies on them to meet the Medicare and Medicaid requirements for participation by providing care in a safe environment.

F607 Training

The facility must have written policies and procedures that include training *new and existing nursing home staff* and *in-service training for nurse aides* in the following topics which include:

- Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation;
- Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property;
- Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property, such as physical or psychosocial indicators;
- Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal; and
- Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms, include, but are not limited to, the following:
  - Aggressive and/or catastrophic reactions of residents;
  - Wandering or elopement-type behaviors;
  - Resistance to care;
  - Outbursts or yelling out; and
  - Difficulty in adjusting to new routines or staff.

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F607 Prevention

The facility must have and implement written policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves (but is not limited to):

- Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship;
- Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes the implementation of policies that address the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any (see also F727 related to proficiency of nurse aides);
- Assuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents, which includes, but is not limited to, the provision of a facility assessment to determine what resources are necessary to care for its residents competently;

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F607 Prevention

- The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as:
- Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating
- Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects;
- Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;
- Taking, touching, or rummaging through other's property;
- Wandering into other's rooms/space;
- Residents with a history of self-injurious behaviors;
- Residents with communication disorders or who speak a different language; and
- Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.

- Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions;
- Providing residents and representatives, information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed. (See F585 for further information regarding grievances).

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F607 Prevention

- The facility may also develop and implement policies and procedures, which achieve the following:
- Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. This includes an analysis of and implementation of policies that address at a minimum:
  - *Features of the physical environment* that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur, such as secluded areas of the facility; and
  - The identification of who is *responsible for the supervision* of staff on all shifts and *how supervision will occur* in order to identify inappropriate staff behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, and directing residents who need assistance with the bathroom to urinate or defecate in their beds.
- Providing staff information on how and to whom they may report concerns, such as insufficient staffing or a shortage in supplies, without the fear of retribution; and providing feedback regarding the concerns that have been expressed.

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F607 KEY ELEMENTS OF NON-COMPLIANCE (SOM)

To cite deficient practice at F607, the surveyor's investigation will generally show that the facility has failed to do one or more of the following:

- Develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property and includes the screening of prospective employees and residents; or
- Develop and implement written policies and procedures for the investigation of allegations of abuse, neglect and exploitation of residents and misappropriation of resident property and includes the staff identification of abuse, neglect, exploitation, and misappropriation of resident property, protection of residents during investigations, and the reporting of allegations and investigative findings and taking corrective actions; or
- Develop and implement written policies and procedures that include training as required at §483.95; or
- Develop and implement written policies and procedures that establish coordination with the QAPI program required under §483.75; or
- 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.

F610 INVESTIGATE/PREVENT/CORRECT ALLEGED VIOLATION

- §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:
- §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.
- §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
- §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 facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment:

- Thoroughly investigate the alleged violation;
- Prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress; and
- Take appropriate corrective action, as a result of investigation findings.

NOTE: Refer to F609 for the requirement to report the findings of the investigation within 5 working days.

F610 Key Elements of Non-Compliance (SOM)

To cite deficient practice at F610, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:

- Initiate an investigation of an alleged violation of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source; or
- Complete a thorough investigation of the alleged violation; or
- Maintain documentation that an alleged violation was thoroughly investigated; or
- Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation of an alleged violation is in progress; or
- Take corrective action following an investigation of an alleged violation, if the allegation was verified.

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IJ Citation: F610 Failure to Investigate

- Based on interview and record review, the facility failed to thoroughly investigate reports of abuse for 2/7 sampled residents.

Incident with Resident #2:

- While providing care on xx/xx/24, CNA Y hit resident #2 on hand with mug. Resident #2 reported to Administrator. The allegation was not investigated and the CNA Y continued to work.
- On xx/xx/x24 resident #1 was shaken and thrown on the bed by CNA Y. The administrator did not investigate the allegations as per facility policy and procedure.
- During interview, the SSW said the administrator was sitting in his/her office when resident #2 came in. The resident reported the incident with the CNA directly to the administrator who then got up from his/her chair and walked out of the office.
- The SSW assumed the Adm was going to begin an investigation.
- The SSW failed to document the allegations and did not follow up.
- The facility policy directed staff to initiate an investigation.
- During interview, the administrator said he/she had never been informed of any incident with resident #2. He/she denied the resident informed him/her. The Adm said CNA Y was not removed from the schedule.
- The facility did not provide an investigation or facility reported incident for the source of resident #2's injury. Review of the resident's medical record showed no documentation of the source of the resident's injury or notes regarding abuse allegation.

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IJ Citation: F610 Failure to Investigate

Incident with Resident #1:

- Review of a written statement provided by the Adm showed CNA B witnessed CNA Y yell and then shake Resident #1 on xx/xx/24. CNA B heard yelling , looked in the resident's room and heard CNA Y yelling, cursing, shaking the resident's wheelchair with the resident in the chair, then shook the resident by the shoulders, lifted the resident up and threw him/her into the bed. CNA B reported to HR and an LPN. CNA B was instructed to write a statement which he/she completed.
- HR notified the DON of the physical abuse by phone.
- CNA Y when questioned, did not deny the allegation and was asked to leave.
- The DON returned to the building, started a resident questionnaire and instructed CNA B to write a statement. The DON was aware of the allegation of verbal and physical abuse and called and informed the Adm, which was protocol.
- During interview, the Adm denied being told of the allegation of physical abuse. He/she interviewed the resident who said there had been no physical abuse, so the investigation was concluded.
- The Adm did not further investigate or contact CNA B for clarification of his/her recently found statement.
- The Adm said it is the facility's policy and procedure to thoroughly investigate all allegations of abuse

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IJ Citation: F684 Quality of Care

Example #1:

- Based on interview and record review, the facility failed to follow acceptable standards of practice and their emergency first Aid policy when staff failed to call EMS when 1/8 sampled residents, began choking on food during a meal and required emergency treatment. The resident died.
- 5:24 pm The event began in the dining room with the resident choking on the evening meal.
- Staff attempted back thrusts. The resident was still breathing.
- 5:26 pm the resident was taken to his/her room, eyes open, mouth closed
- 5:28 pm nurse manager brought crash cart to room
- 5:30 pm DON brought vital sign machine to room
- 5:33 pm staff listened for heartbeat for 1" and no heartbeat detected
- 5:36 pm DON exited room, staff member brought in mechanical lift
- 5:42 pm all staff left resident's room

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IJ Citation: F684 Quality of Care

Example #2 continued:

Per multiple staff interviews:

- No one instructed the CNA to call EMS at any point
- CNA did not think any other staff called EMS
- A nurse suctioned the resident obtaining small pieces of meat but was unable to clear the airway
- Staff continued their attempts until the resident no longer had a heartbeat or respirations
- Staff did not call EMS while the resident was choking
- Per DON interview the protocol for a choking resident was to begin the Heimlich maneuver and call EMS
- Per Adm interview the facility policy was to call EMS in an emergent situation

IJ Citation: F684 Quality of Care

Example #2:

- Based on interview and record review, staff failed to implement a system to ensure facility staff communicated a reports on resident's condition to agency staff prior to their shifts and failed to direct agency staff where to find the binder containing instructions on resident's care needs. The facility to failed to ensure 1/2 resident's #18 care plan instructions for staff reflected the resident's assessed needs, including use of mechanical lift transfer.
- On xx/xx/24 an unknown nurse directed CNA C to transfer the resident from his/her bed without communication of the resident's need for a mechanical left transfer.
- CNA C utilized a gait belt, instead of Hoyer lift. The resident fell during the transfer and sustained fractures to ribs, legs and left ankle.
- The resident's physician said staff failed to notify him/her of the incident until later in the evening. EMS did not transfer the resident to the hospital until 10:08 pm (10 hours after incident) and reported the resident was hard to arouse.

IJ Citation: F684 Quality of Care

Example #2 continued:

- MDS identified resident with diagnoses of stroke, depression and repeated falls
- Review of care plan showed resident required extensive assistance of 1 staff for turning and repositioning, "at risk" for falls
- The care plan did not instruct the staff to utilize a Hoyer lift for transfers
- Throughout the day, evening, staff monitored the resident for ankle pain. At 8:56 pm the nurse received report the CNA on days shift had attempted to transfer the resident and heard a pop. The resident had been in severe pain in bilateral lower extremities. The areas were painful to touch, and right leg appeared swollen. He/she complained of pain to left leg but no bruising present in extremities. Resident's pain 10/10, physician notified with increased order for Tramadol and obtain 3-view x-ray right ankle to R/O fracture/dislocation. X-ray tech to come following day.
- Order received at 9:40 pm to send resident to hospital. Per EMS resident's BP 58/33 during transport
- X-rays revealed bilateral femur fractures (bones broken in multiple places due to significant trauma), fractures of distal left tibia and fibula (usually caused by hard fall or hard blow to the leg or sudden twist of the leg), fracture of left calcaneal , bruise on right thigh and rib fractures of left first rib, right third, fifth, sixth ribs

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IJ Citation: F684 Quality of Care

Example #2 continued:

- Review of binder containing care instructions for residents dated xx/xx/24 showed for resident #18: Transfer: The resident required extensive assist by 1 staff to move between surfaces. Upon return from hospital, use mechanical lift and 2 staff assist (updated xx/xx/24)

Staff interviews indicated:

- Agency staff were to view the binder at the nurse's station for information about the residents
- Agency staff are to receive verbal report from the charge nurse at the start of his/her shift about their assignments
- There was not a system in place to verify if agency staff viewed the binder or receive verbal report
- The nurse did not indicate to the CNA how the resident should be transferred, and the CNA did not ask anyone how the resident should be transferred
- The CNA did not receive report on the day of the incident

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IJ Citation: F684 Quality of Care

Example #3:

Based on interview and record review, the facility failed to follow physician orders for x-rays for 1/7 sampled residents who had fallen from his/her bed on x/x/24.

A physician order was received same day for stat x-ray left shoulder, left arm, left hip two views, right hip two views and chest x-ray

The x-ray order was not completed for nine days, during which the resident experience pain and refused care, which he/she had not done prior.

The resident was diagnosed with a right hip fracture

IJ Citation: F684 Quality of Care

Example #4:

- Based on interview and record review, the facility failed to provide care and treatment following a fall with injury for 1/9 sampled residents with a H/O stroke and receiving anticoagulant therapy.
- The resident complained of rib pain 9/10 to the right side. Staff described the resident as very tearful, in a lot of pain when repositioned and the physician was not notified.
- The following day the physician ordered the resident to the ER, non-emergent, due to an abnormal lab result. In the ER, the resident was noted to have a large right sided hemothorax with multiple displaced rib fractures and a right scapular fracture
- At the time of the fall, the on-call physician (not the resident's PCP) was notified the resident had slipped from the wheelchair and there was no injury, and the notification was facility procedure.
- The physician was not notified the resident was:
  - in pain after the fall
  - continued to have pain throughout the night
  - the use of anticoagulant medication
  - the resident's shortness of breath
  - that the fall was unwitnessed

Best Practices and Strategies for Success

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Best Practices & Strategies for Success

- **Comprehensive Staff Training**: Effective training is essential to abuse prevention. It should cover identification, prevention and reporting. Continuous training, updated regularly to reflect best practices and regulatory requirements is crucial to maintaining a knowledgeable vigilant workforce. Staff should be educated on handling high stress situations and practicing de-escalation techniques to prevent harm.
- **Clear Reporting Procedures**: Establish and communicate clear procedures for reporting abuse. Staff should know who to report to and how to documents incidents. Create a culture of accountability, where mandatory reporting is protected. Transparent and accessible reporting procedures ensure that issues are addressed promptly and appropriately.
- **Resident-Focused Care Plans**: Develop person-centered care plans that cater to each resident's specific needs. Training should emphasize recognizing and respecting resident rights and preferences. These personalized plans help prevent unintentional neglect or abuse by meeting each resident's unique needs and desires.
- **Regular Assessment and Audits**: Use tools like the CMS 20059 Abuse CEP (10/2022) and CMS 20077 Neglect CEP (10/2023) for self-assessment and auditing. Regularly review the facility's compliance with regulations and quality of care provided. Ongoing evaluations help identify and address potential issues, ensuring continuous improvement in resident care and safety.

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Best Practices & Strategies for Success

- **Implement Zero-Tolerance Policy**: Clearly communicate that any abuse or neglect is unacceptable and will result in immediate action, including potential dismissal and legal consequences. Publicize and enforce the policy consistently to demonstrate the facility's commitment to protecting residents.
- **Regular Interaction With Residents**: Encourage staff to engage in meaningful interactions with residents. This improves quality care and helps staff readily notice signs of distress or abuse.
- **Regular Review of Policies and Procedures**: Update policies and procedures to reflect best practices and regulatory requirements. Ensure policies are accessible and understood by all staff. Keeping policies current ensures the facility is always prepared to effectively address potential abuse issues.
- **Feedback Mechanism for Residents and Families**: Create channels for residents and families to provide feedback or vice concerns through meetings, suggestion boxes or surveys. Listening to residents and families can provide critical insight into the quality of care and potential issues, allowing for timely intervention and continuous improvement.

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CALM De-Escalation Techniques

C Communicate
Gather information, speak slowly.

A Assess
Look for basic needs, be aware of your team's plan.

L Listen
Validate feelings and pay attention to body language.

M Mediate
Respond with empathy and agree on a solution.

- https://namiswwa.org/calm-de-escalation-and-regulation-in-the-workplace/

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Resources

- www.cms.gov State Operations Manual, CMS Critical Element Pathways
- https://qcor.cms.gov/main.jsp
- https://namiswwa.org/calm-de-escalation-and-regulation-in-the-workplace

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