Behaviors – Before, During and After

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Poll Question:

Who do we have in the room today?

Poll Question:

What is the single most disruptive behavior in your building?

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  - American Psychiatric Association
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Objectives

- **Navigate** the rising acuity of the modern neurobehavioral resident population using a comprehensive biopsychosocial framework.
- **Master Immediate Response Protocols** to stabilize high-risk resident events (suicidality, elopement, and substance use) safely within a congregate setting.
- **Implement Proactive Interdisciplinary Strategies** to resolve community flashpoints, including resident-to-resident conflict, hoarding, and staff-splitting.
- **Describe** alternative interventions, gradual dose reductions (GDRs), and capacity assessments to satisfy the dual mandates of resident rights and regulatory compliance.

The Neurobehavioral Evolution

The industry is witnessing a seismic shift from **custodial care** to complex **Neurobehavioral management.** This transition is driven by:

→ **Rising Acuity**: Increase in residents with comorbid psychiatric conditions and mild cases treated in lower levels of care.

→ **Psych Role in Medical Outcomes**: Increased understanding of the role of BH in medical outcomes

→ **Regulatory Focus**: Increased scrutiny around BH needs and outcomes

The Biopsychosocial Standard

Biological

Understanding Biological basis for the illness. Evaluating for med side effects. Evaluating contribution of medical conditions.

Psychological

Assessing personality defense mechanisms, history of trauma, and personality factors

Social

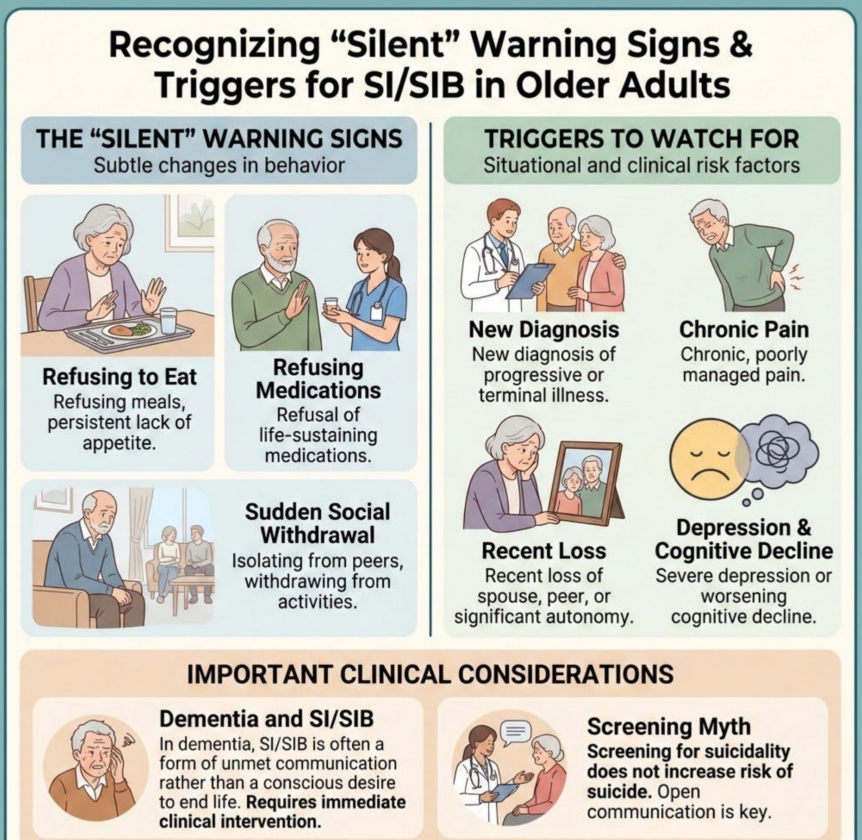
Mitigating isolation, environmental territoriality, and interpersonal facility dynamics.

High-Risk Safety Events: Prevention and Response

- Suicidality and Self-Injurious Behavior
- Elopement & Unsafe Wandering
- Substance Use in Facility
- Resident-to-Resident Mistreatment
- Resident w/Verbal Abuse and Discriminatory Language
- Sexual Disinhibition &
- Inappropriate Sexual Behaviors (ISB)
- Splitting Staff
- Refusal of Care
- Accusations of Overmedicating
- Hoarding & Environmental Hazards

Suicidality and Self-Injurious Behavior

Suicidal Ideation & Self Harm



SI: Immediate Safety & Mitigation

1. **Establish continuous monitoring**

   Immediate

   Initiate a 1:1 line-of-sight supervision immediately. The resident must not be left alone under any circumstances until psychiatric evaluation is completed.

1. **Secure the environment**

   Within Minutes

   Conduct a through sweep of the resident's room and bathroom. Safely remove potential means of self-harm, including sharps (razors, scissors), ligature points (cords, belts, long tubing), and medications or toxic chemicals.

1. **Notify leadership and providers**

   Concurrent

   Immediately notify the DON, attending, psychiatrist or emergency services if threat is imminent.

1. **Arrange psychiatric evaluation**

   Same day

   Coordinate an emergency psychiatric assessment, this may be in ER, via telemedicine

SI: Ongoing Management & Care Planning

For residents with a known history of suicidal ideation or non-suicidal self-injury, management focuses on prevention, vigilant monitoring and theraputic support.

1. Comprehensive Safety Planning

Do not rely on verbal "no-harm contracts," which are clinically ineffective. Instead, collaborate with the resident (if cognitively capable) to build a Behavioral Safety Plan.

- **Identify Triggers**: Document specific signs that precede distress (e.g., anniversary of a spouse's death, worsening pain, social isolation).
- **Coping Strategies**: List activities that calm the resident (e.g., listening to music, spending time in communal areas, breathing exercises).
- **Key Contacts**: Clearly list who the resident should notify when they feel overwhelmed (e.g., a specific favorite nurse, social worker, or family member).

2. Controlled Medication Management

- **Lethal Dose Mitigation**: Ensure all medications—especially sedatives, analgesics, and antidepressants—are strictly controlled. Residents with a history of suicidal intent should never keep medications at the bedside.
- **Mouth Checks**: When administering pills, perform discreet mouth checks to ensure the resident isn't "cheeking" medications to hoard them for an overdose.

3. Environmental & Shift Communication

- The "**Warm Handoff**": Suicidal ideation risks often spike during shift changes when routine vigilance dips. Ensure the resident's psychological status is a core feature of every shift report.
- **Environmental Audits**: Regularly review the physical environment of the facility to minimize hidden spaces or easily accessible hazards.

SI: Saff Support

Managing self-injurious behavior is emotionally taxing for frontline caregivers. Facilities must provide:

- **Post-Incident Debriefs:** Opportunities for staff to process the emotional impact of a suicide attempt or severe self-harm incident.
- **Continuous Training:** Regular education on identifying the subtle signs of late-life depression, which often presents as somatic complaints (unexplained physical pain) or severe refusal to eat/drink rather than overt statements of wanting to die.

Elopement & Unsafe Wandering

Wandering vs Elopement

Wandering is aimless or purposeful locomotion within a safe, monitored environment. It is a common symptom of dementia, affecting roughly **60% of individuals** with the disease.

Elopement occurs when a cognitively impaired resident successfully leaves the safe boundaries of the facility unnoticed, exposing themselves to immediate, unsupervised danger.

Why does wandering & elopement happen in dementia?

Goal-Directed Disorientation: The resident believes they have a vital task to complete—such as "picking up the kids from school" or "going to work"—and dynamically seeks an exit.

Environmental Overstimulation: Loud noises, crowded hallways, or shift changes overwhelm the resident, triggering a "flight" response to find a quiet space.

Transfer Trauma: Newly admitted residents are at the absolute highest risk. Their lack of familiarity with the layout causes them to actively search for home.

Elopement: the facility paradox

Elopement: Immediate Protocol

1. **Sound the alert and lock down**

   Minutes 1-2

   Announce the facility's specific elopement code over the PA system. Immediately assign staff to secure all facility exists and check the immediate outdoor perimeter (parking lots, courtyards).

1. **Execute a rapid internal search**

   Minutes 2-10

   Search the facility systematically, starting from the last known location. Check high-risk or easily overlooked spots: utility closets, stairwells, empty resident rooms, bathrooms, and laundry areas.

1. **Review Elopement Binder**

   Minute 10

   Retrieve the resident's emergency file. This must contain a current photograph, a physical description, a list of likely destinations (e.g., a former home address or favorite park), and their behavioral history.

1. **Notify authorities and family**

   Minute 15

   If the resident is not found within 15 minutes, notify local law enforcement to initiate an alert and follow up immediately with resident's family and notify administration

Elopement: Ongoing Management for High-Risk Residents

1. Technology & Environmental Barriers

Rather than locking people away, modern facilities use subtle, dignified tech safeguards to track and redirect residents.

- **Electronic Monitoring Systems**: High-risk residents should be fitted with an electronic tracking device
- **Visual Camouflage**: Painting exit doors or door frames the same color as the surrounding walls—or placing large murals of bookshelves or landscapes over them
- **Keypad Exits**: Ensure all perimeter doors require code access for entry and exit, with alarms

2. Behavioral Root-Cause Mapping

Wandering is rarely random. Staff should track wandering patterns for a week to identify the root cause using the "Three Ws":

- **When**: Does it happen at a specific time? (e.g., "Sundowning," where confusion spikes as daylight fades).
- **Where**: Are they heading to a specific exit because it looks like a bus stop or a workplace?
- **Why**: Are they searching for a deceased spouse, trying to "go to work," or simply looking for a bathroom because they are lost?

Once the trigger is known, staff can create a personalized diversion plan—such as giving a resident who used to be an administrative assistant a stack of papers to sort when they start wandering anxiously.

3. Safe Wandering Alternatives

Trying to force a mobile dementia resident to sit still will often trigger agitation or catastrophic reactions.

- **Continuous Walking Paths**: Design circular indoor or enclosed outdoor pathways that have no dead ends, allowing residents to walk safely until they are tired.
- **Structured Life Stations**: Place interactive areas along walking paths (e.g., a fake nursery station with baby dolls, a workbench with plastic tools, or a folding station with towels) to capture their attention and give their wandering a safe purpose.

Substance Use in Facility

Substance Use: The Reality

- Between 2006 and 2020, the number of older adults living with an SUD more than doubled, jumping from 2.8 million to 7.1 million.

- **The Substances:** Alcohol remains the most abused substance, but **cannabis use and prescription drug misuse** (specifically opioids and benzodiazepines) are skyrocketing.

- **Legal & Admission Realities:** Under the Americans with Disabilities Act (ADA), nursing homes generally cannot refuse admission to someone purely because they have an OUD (Opioid Use Disorder) or are on recovery medications. Facilities must be prepared to care for them.

Substance Use: the Action Plan

- Implement **universal screening.**
    - **CAGE-AID:** A quick, 4-question screening tool adapted to look at both alcohol and drug use. (next slide)
    - Watch for **Medication Behaviors**: Train nurses to flag frequent renewals of PRN benzodiazepines/opiates or intense fixation on narcotic/benzo schedules.
- **Secure Access to MAT** (Medication-Assisted Treatment)
    - MAT is the gold standard for opioid and alcohol recovery
    - Ensure psych is managing Buprenorphine (suboxone), naltrexone, acamprosate
- **Update Safety & Visitation Policies**
    - **Supervised Visitations**: If family members or specific visitors are known to supply drugs, the facility has the right to enforce supervised visits.
    - **Property Inspections**: Establish clear, legally compliant consent policies for voluntary property/room inspections if use is suspected.

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cutoff for the CAGE is two positive answers, however, the Consensus Panel recommends that the primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders. A number of other screening tools are available.

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984

Resident-to-Resident Mistreatment

What is Resident-to-Resident Mistreatment (RRM)

- The Definition: **Resident-to-Resident Mistreatment (RRM)** covers negative physical, sexual, or verbal interactions between long-term care residents that would be considered unwelcome and harmful in any other setting.
- The Shocking Metric: Roughly **1 in 6 nursing home residents** experience some form of aggression or physical/verbal conflict from another resident every single month.
- The Total Share: Resident-on-resident assaults actually account for **22% of all documented abuse cases** in nursing homes.
- Most cases are never reported

RRM: Core Triggers & Risk Factors

Dementia & Cognitive Decline

- Severe cognitive impairment is the number one driver.
- Boundary confusion (e.g., wandering into other residents' rooms, taking property).

Environmental Flashpoints

- High-density, chaotic spaces trigger violence.
- Excessive noise, poor lighting, or extreme temperatures.

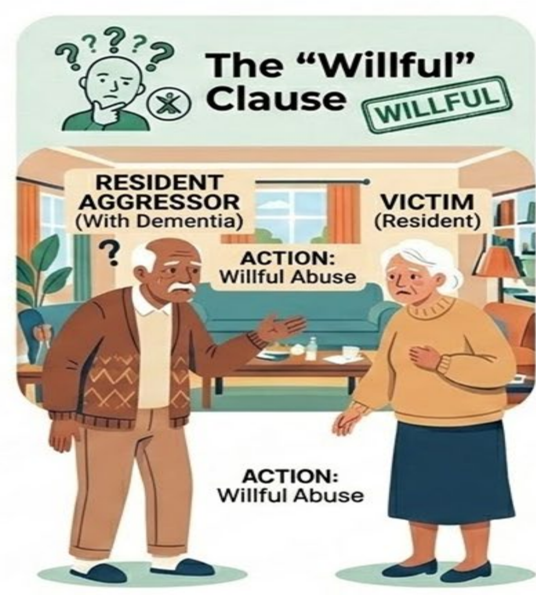
Unmet Physical Needs

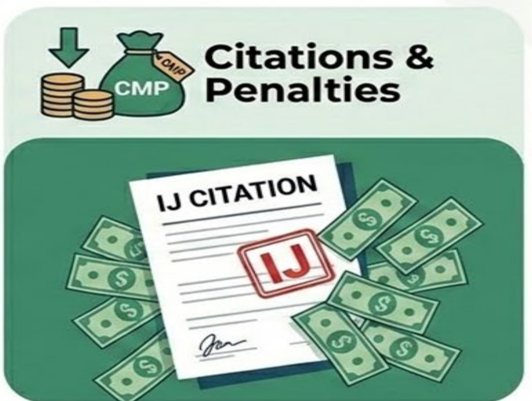
- Aggression as non-verbal communication.
- Unexpressed pain, hunger, boredom, or the need to use the restroom.

RRM: Regulatory & Financial Stakes

F600: Active protection required

- from **ALL** forms of abuse, by **ANYONE.**
- **F689:** Blames facility for lack of adequate staff supervision leading to incidents.





Resident-to-Pesident

- Resident-to-Resident violence is a primary driver of IJ Citations.
- Citations can cost tens of thousands of dollars **PER DAY.**

Resident-to-Resident Mistreatment (RRM)

Mandatory CMS Reporting

Minutes 1–30

- Separate residents immediately for physical safety.
- Check **BOTH** residents for injuries.
- Permanent room/living area separation if necessary.

Hours 1–24

- Investigate root cause (e.g., TV fight, wandering into room).
- Peak shift-change chaos analysis.

Day 1

- Update care plans for both residents (e.g., separate seating, continuous activity).
- Provide script for staff response.

Within 2 to 24 Hours

- File formal report with State Survey Agency.
- Serious injury within 2 hours; no serious injury within 24 hours.

RRM: Systemic Solutions for the facility

- **Consistent Staff Assignments**: Assigning the exact same CNAs and nurses to the same wings allows them to spot subtle behavioral shifts (like increased pacing or muttering) *before* an explosion occurs.
- **De-escalation Training**: Frontline staff must be explicitly trained in validation therapy and redirection techniques rather than relying on defensive physical restraints or chemical sedation, both of which are highly restricted.
- **Fix Understaffing**: Most RRM occurs when common areas are left unmonitored because staff are buried in clinical care or charting. Adequate floor presence is the ultimate defense.

Resident w/Verbal Abuse and Discriminatory Language

Resident's Verbal Abuse: Legal Catch-22

- Under Title VII, employees have a right to a workplace free from a "hostile work environment."
- Facilities must protect staff from persistent verbal abuse and offensive language, even from residents.

- Under CMS (Center for Medicare & Medicaid Services), **residents have a right to receive care without discrimination.**
- A resident **cannot be summarily evicted, physically restrained, or chemically sedated** simply for offensive language.

Verbally Abusive Resident: Unmasking the Behavior

The Cognitively Impaired Resident

- The Cause: Damage to the frontal lobe (common in Alzheimer's and vascular dementia) strips away social filters and executive functioning. A resident may revert to language from their youth, yell slurs, or make inappropriate comments due to disorientation, fear, or a complete inability to regulate impulses.
- The Response: Treat this as a behavioral symptom of a disease, not a disciplinary infraction.

The Cognitively Intact Resident

- The Cause: The resident is fully aware of their actions and is intentionally using slurs or abusive language to assert dominance, express bigotry, or harass staff.
- The Response: Treat this as a violation of the facility's community residency agreement and a behavioral disruption.

Verbally Abusive Resident: Playbook for Cognitively Impaired Residents

- **Implement Validation and Redirection**: Train staff never to argue, lecture, or shame a resident with dementia about why their language is offensive (they cannot process it). Instead, use validation therapy to figure out the underlying trigger (e.g., "I see you're angry, let's walk over here and see what's wrong") and redirect their attention.
- **Rotate Care Assignments Legally**: Administrators must protect targeted staff. If a resident is directing racial slurs at a specific employee, the administrator should reassign that employee away from the resident *for the employee's well-being*. Crucial Legal Caveat: This must be done to support the employee, never as a punishment or demotion, and the resident *cannot* dictate staff assignments based on race.
- **Audit the Care Plan**: Convene the interdisciplinary team (IDT). Look for root causes: Does the behavior happen only during showers? Is it a reaction to pain? Adjust the care plan to include behavioral interventions, non-pharmacological soothing techniques, or a psychiatric review.

Verbally Abusive Resident: Playbook for Cognitively Intact Residents

If a resident has full capacity and is choosing to use discriminatory, abusive language, administrators must take a firm, documented approach.

- **The Resident Care Conference:** Call an immediate meeting with the resident and their designated family member/power of attorney.
- **Establish Clear Boundaries**: Explicitly inform the resident that while the facility is their home, it is also a place of business. Explain that federal law prohibits the facility from forcing employees to work in a hostile environment, and that abusive or discriminatory language will not be tolerated.
- **The Behavioral Contract**: Issue a formal behavioral agreement outlining the expected conduct and the consequences of continuing the behavior.
- **Involuntary Discharge (The Last Resort)**: If the resident's abusive behavior continually disrupts the facility or endangers the emotional and psychological welfare of staff/other residents, the administrator can initiate the formal, state-regulated process for involuntary discharge under the clause: *"The safety/health of individuals in the facility is endangered."*

Verbally Abusive Resident:
Protecting and Retaining Your Staff

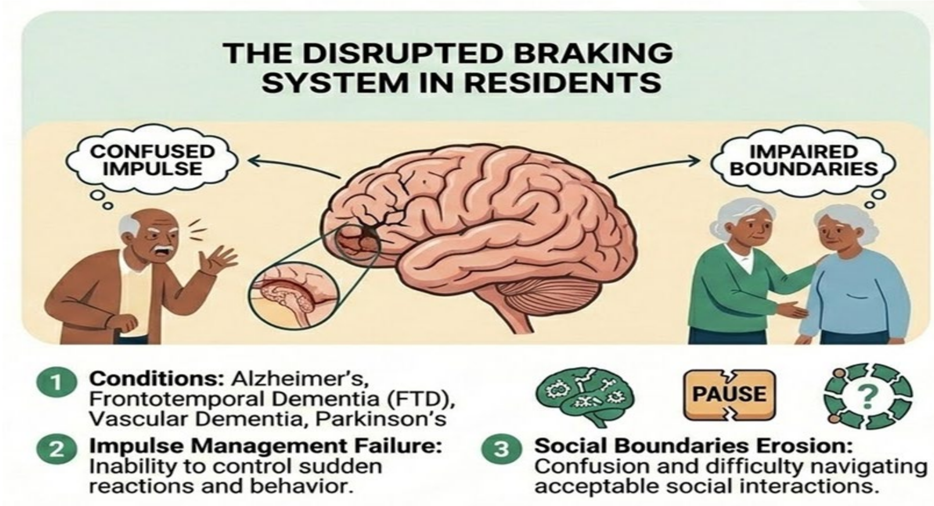
A failure to support staff in these moments is a primary driver of nursing home turnover. Owners must build a culture of safety.

- **The "Right to Step Away" Policy:** Establish a clear protocol allowing an employee to safely step away from a non-emergency care situation if a resident begins using abusive or discriminatory slurs, provided another staff member can ensure resident safety.
- **Mandatory Debriefing & Mental Health Support**: When an employee is subjected to a barrage of discriminatory language, managers must debrief with them, validate their experience, and offer counseling resources (like an Employee Assistance Program).
- **Consistent Zero-Tolerance Stance**: Leadership must explicitly voice their support for staff. When employees see that administrators take their dignity seriously, it reduces burnout, mitigates legal liability, and builds trust across the entire building.

Sexual Disinhibition & Inappropriate Sexual Behaviors (ISB)

Inappropriate Sexual Behaviors: The Clinical Reality

- Administrators must ensure their clinical team understands that ISB in long-term care is rarely driven by a sudden surge in libido. Instead, it is typically a symptom of neurodegenerative diseases.
- **Frontal Lobe Damage**: Conditions like Alzheimer's disease, frontotemporal dementia (FTD), vascular dementia, or Parkinson's disease often damage the orbitofrontal cortex. This is the brain's "braking system" that controls impulse management and social boundaries.



Inappropriate Sexual Behaviors: Administrative and Operations Strategy

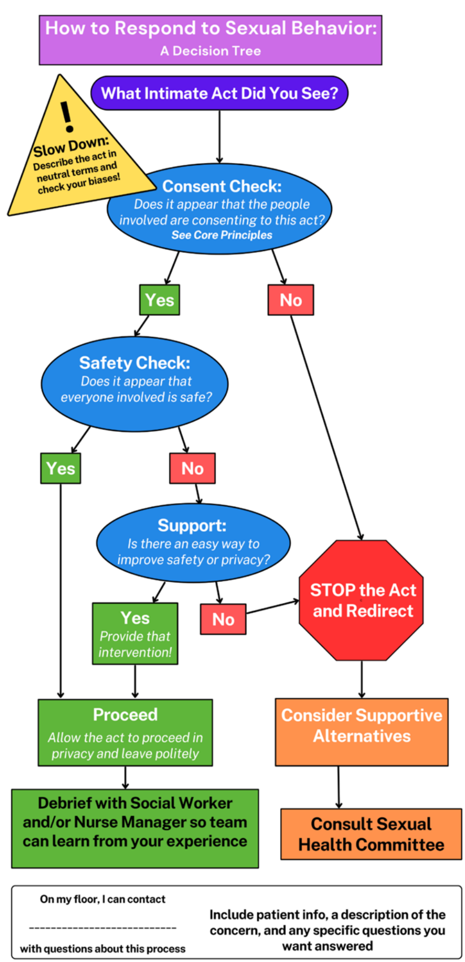
1. **Ensure Immediate Safety and Separation:**
   If an aggressive or non-consensual act occurs between residents or toward staff, immediately separate the individuals. Escort the resident to a quiet, low-stimulus environment using calm, non-judgmental redirection.

2. **Conduct a Detailed Behavioral Assessment:**
   Document the exact behavior using objective tracking tools (like the Cohen-Mansfield Agitation Inventory). Identify the antecedent (what happened right before), the behavior itself, and the consequences. Rule out immediate clinical culprits like UTIs, pain, or drug interactions.

3. **Modify Environment and Care Plans:**
   Adjust the resident's care plan. Introduce non-pharmacological interventions first: adapt clothing (e.g., adaptive jumpsuits with back closures if public stripping is frequent), increase structured activities to reduce boredom-induced behaviors, or alter staff assignments to protect vulnerable caregivers.

4. **Report and Document Compliance:**
   Ensure compliance with state regulations and federal guidelines (such as CMS requirements under Appendix PP). Document everything thoroughly to prove the facility did not neglect resident safety or ignore a known pattern of behavior.

Inappropriate Sexual Behaviors: Assessing Consent Capacity



Inappropriate Sexual Behaviors: Non-Pharmacological & Pharmacological Interventions

Always exhaust environmental and behavioral changes before turning to chemical solutions.

- **Environmental Adjustments**: Increase visual supervision, provide weighted blankets for sensory grounding, or schedule high-energy activities during times when the resident typically exhibits behavioral changes (often during "sundowning" hours late in the day).
- **Medication Management**: If behaviors pose an imminent risk and behavioral interventions fail, consult with a geriatric psychiatrist.
    - *SSRIs* (like sertraline) are often favored first due to their side-effect profile, which can naturally lower libido while managing underlying anxiety or depression.
    - *Anti-androgens or hormonal therapies* are rare, high-threshold interventions reserved exclusively for severe, aggressive physical behaviors after thorough ethical and legal review.
    - *Antipsychotics* carry black-box warnings for elderly patients with dementia and should only be used as a last resort if the behavior poses a direct danger to themselves or others.

Splitting Staff

Anatomy of a Split: How it Manifests

A resident who splits creates a psychological divide within your building. They subconsciously manipulate the environment to intense fear of abandonment or loss of control.

Staff Splitting: staff protocols

When a resident actively splits staff, standard care planning will fail. Administrators must implement a structured, unified operational framework to neutralize the behavior.

1. Mandate a Unified Care Approach:
Establish a strict, unyielding policy of consistency. Every shift, every nurse, and every CNA must deliver care in the exact same manner, enforcing the same rules. If the care plan states bedtime is at 9:00 PM, the "good" staff cannot allow the resident to stay up until midnight "just this once."

2. Implement Mandatory Interdisciplinary Briefings:
Bring the "good" staff and "bad" staff into the same room with social services and nursing leadership. Forcing both sides to look at the clinical reality together strips away the resident's power to manipulate the narrative. Air out the contradictions in how the resident behaves with different shifts.

3. Enforce Strict Professional Boundaries:
Instruct staff that they are to remain neutral, polite, and matter-of-fact. They must refuse confidential "secrets" from the resident and politely decline any gifts or special favors. Staff should never validate complaints about their coworkers; they should redirect with: "If you have a complaint about nurse Sarah, I will help you log it with the supervisor, but I cannot discuss her with you."

4. Centralize Communication and Grievances:
Require all complaints from this resident to go through one designated point of contact—usually SSD or DON. Do not let the resident shop around for different floor supervisors until they find one who gives them the answer they want.

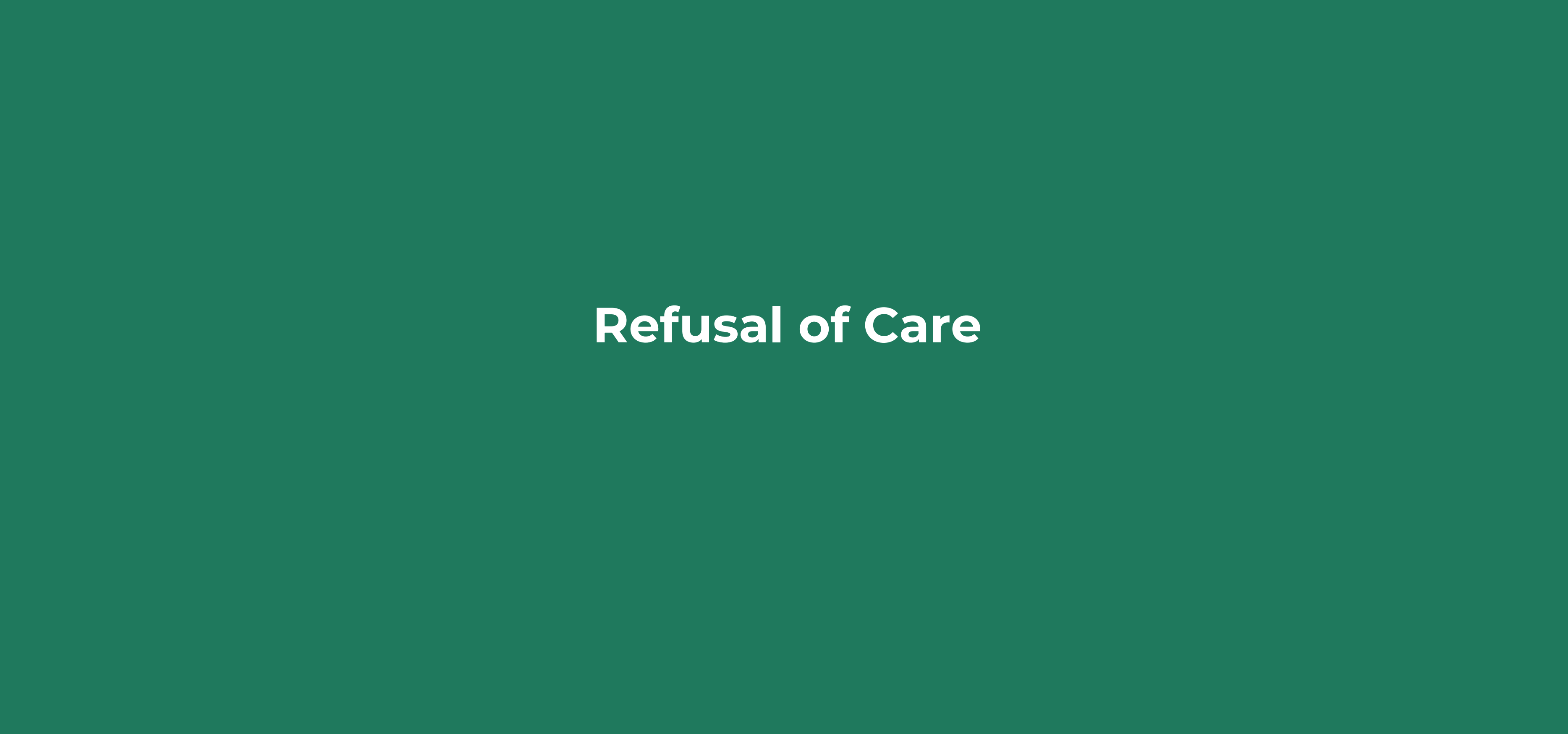
Protecting Staff Moral & Retaining Talent in a Split

The staff members labeled "bad" by the resident are at massive risk for burnout and sudden resignation. They are being subjected to emotional abuse, verbal hostility, and constant threats to their license via false allegations.

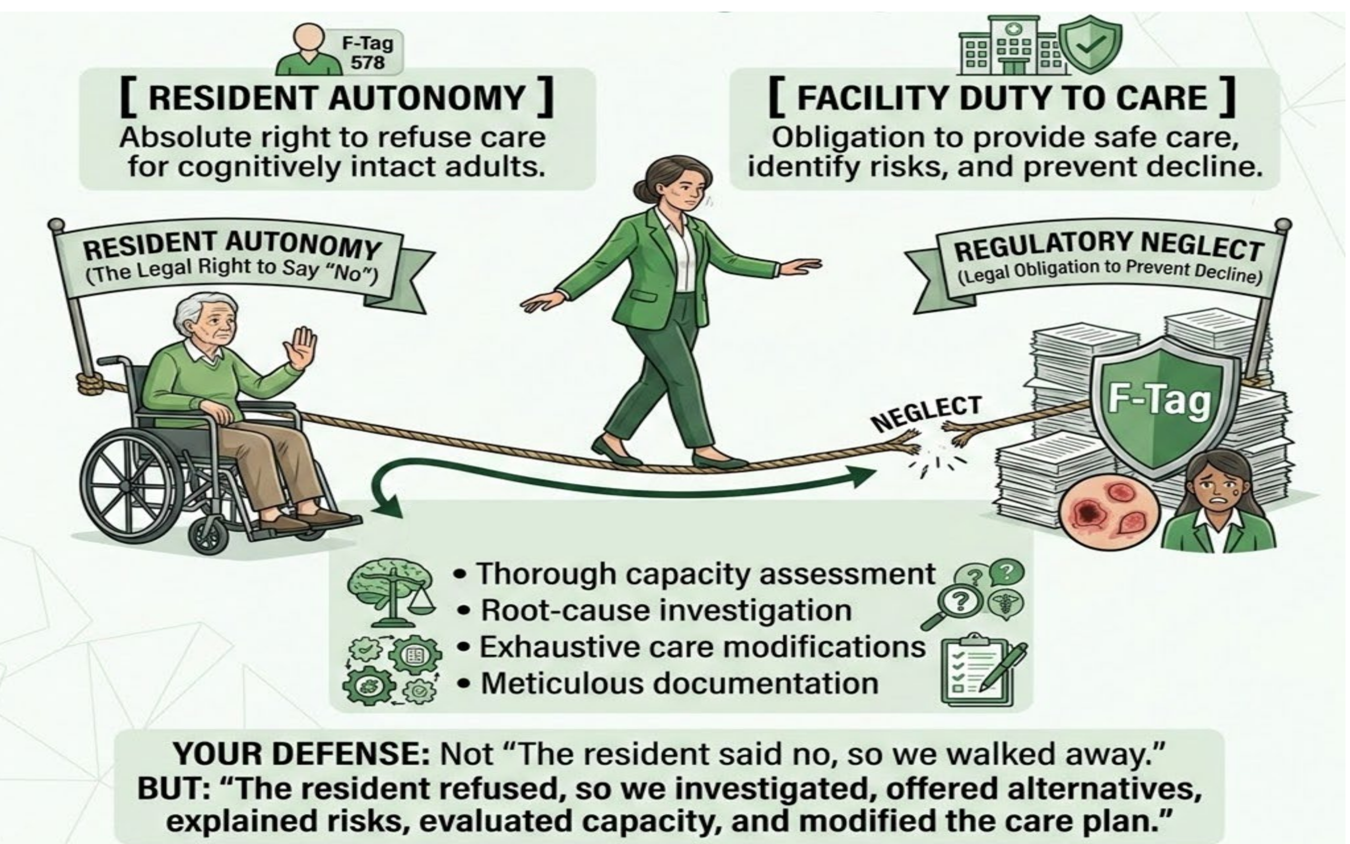
- **De-escalate the False Accusation Panic:** When a resident who splits files a grievance claiming an aide "abused" them by refusing to bring coffee, administrators must investigate, but should do so objectively without assuming immediate guilt. Look for patterns. If an employee has an unblemished 5-year record and suddenly faces wild allegations from a splitting resident, support your staffer.

- **Rotate Assignments Logically:** Do not leave a single CNA assigned to a devalued slot indefinitely. However, **never completely capitulate** by permanently removing all "bad" staff, as this teaches the resident that splitting successfully dictates facility staffing. Use balanced rotation schedules.

- **Provide Psychosocial Support:** Offer debriefing sessions. Ensure your frontline staff understand the clinical mechanism behind Borderline Personality Disorder or splitting traits so they realize *it is not personal*—it is a maladaptive coping mechanism.


Refusal of Care

Refusal of Care



Refusal of Care: Operational Protocol

1. **Investigate the Root Cause:** Immediate Action.
   Do not take the refusal at face value. Ask *why*. Is the resident refusing a shower because they are modest and want a caregiver of the same gender? Are they refusing therapy because they are in unmanaged pain? Is the food unappealing? Fix the underlying trigger first.

2. **Assess Cognitive Capacity:** Clinical Evaluation.
   Determine if the resident has the capacity to understand the consequences of their refusal. A resident with advanced dementia who refuses to let staff turn them in bed does not understand that they are creating a life-threatening bone-deep pressure injury. If capacity is lacking, immediately engage the power of attorney (POA) or healthcare proxy.

3. **Educate and Explain Risks:** Informed Consent.
   Clearly explain what will happen if the care is omitted. Use plain language: *"If we don't change this dressing, the infection could spread to your bloodstream and become life-threatening."* This conversation must be witnessed and documented.

4. **Offer Alternatives and Negotiate:** Care Planning.
   If they refuse a full shower, offer a bed bath. If they refuse morning therapy, offer an afternoon slot. If they refuse a solid meal, offer a nutritional shake. Meet the resident halfway to mitigate clinical risk.

5 **.Document the 'Chain of Autonomy':** Compliance.
   If the resident still refuses, meticulously chart the specific details. Include the exact care offered, the reasons given for refusal, the alternatives offered, the education provided on risks, the notification sent to the physician and family, and the resident's ongoing mental capacity status.

Accusations of Overmedicating

Accusations of Overmedicating From:

INTERNAL STAFF

Concerned colleagues reporting unusual sedation or lack of consent.

OUTSIDERS WITH REGULAR ACCESS

Ombudsman, Pharmacis-ts, Providers, Volunteers identifying patterns or specific cases.

OUTSIDERS WITH REGULAR ACCESS

Ombudsman, Self-reporting symptoms like confusion, drowsiness, or lack of control.

REGULATORY & LEGAL ENTITIES

State Surveyors, APS, Personal Injury Lawyers conducting inspections or filing claims.

FAMILY, POA, GUARDIANS

Family, POA, Guardians noting changes in personality, cognitive decline, or physical side effects.

Overmedicating: Regulatory Battlefield

- **The Definition of Overmedication:** In the eyes of CMS, a medication is unnecessary if it is given in an excessive dose, for an excessive duration, without adequate monitoring, or in the presence of adverse consequences that indicate the dose should be reduced or stopped.
- **F758 (Free from Unnecessary Psychotropic Meds/PRN Use)**: This is the primary citation for overmedication. It mandates that residents do not receive psychotropic drugs unless they are medically necessary to treat a specific, diagnosed, and documented condition.
- **Chemical Restraints**: If a psychotropic medication (such as an antipsychotic, antidepressant, or benzodiazepine) is used purely to manage a resident's behavior for staff convenience or as a form of discipline rather than medical treatment, it is legally classified as a chemical restraint.
- **Black Box Warning**: The FDA places a strict "Black Box Warning" on atypical antipsychotics, highlighting an increased risk of death when administered to elderly patients with dementia-related psychosis. Surveyors are hyper-aware of this off-label usage.
- **PRN Limits**: PRN orders for psychotropic drugs are highly restricted. PRN orders for antipsychotics are limited to 14 days and cannot be renewed

A Solution to Overmedicating:

Demonstrating appropriate use:

- **Gradual Dose Reductions (GDR)**: Unless clinically contraindicated by a physician, the facility must attempt a GDR (tapering the dose down) for any resident on psychotropic drugs twice a year to see if the resident can maintain stability on a lower dose. **Must be residents specific.**
- **Behavioral Tracking Logs**: You cannot just document that a resident was "agitated." Staff must document specific, measurable target behaviors (e.g., "striking out during morning care") and show that non-pharmacological interventions (like music therapy or redirection) were tried first and failed.
- **Informed Consent**: The resident or their legal representative must be given a clear explanation of the risks (including the Black Box warnings) and benefits before a psychotropic regimen begins. This voluntary consent must be signed and kept on file.
- **Pharmacy Reviews**: Your consultant pharmacist must conduct a monthly Medication Regimen Review (MRR) for every resident, specifically flagging polypharmacy (excessive numbers of medications) and potentially inappropriate medications (PIMs).

Immediate Action Plan When an Accusation Surfaces

Hoarding & Environmental Hazards

Hoarding: Regulatory Crosshairs

If a surveyor walks into a resident's room and finds stacked papers, blocking pathways, or hidden rotting food, you face immediate citations. Surveyors/CMS will look at the facility through several key regulatory lenses:

- **F550 (Resident Rights / Dignity):** Residents have the right to retain personal possessions. You cannot simply throw a resident's belongings away without a process, or you violate their dignity and rights.
- **F584 (Safe/Clean/Comfortable/Homelike Environment):** The facility must provide a safe, clean, and functional environment. Hoarding directly compromises this by creating unsanitary or structurally unsafe rooms.
- **F921 (Safe/Functional/Sanitary Inside Environment):** This tag focuses heavily on maintenance and physical plant safety.
- **F880 (Infection Control):** Hoarded food attracts pests (roaches, rodents) and breeds mold or bacteria. Hidden soiled brief materials or biological waste turn a room into a biohazard.

Hoarding: IDT Approach

Social Services

Identifies the root cause (e.g., hoarding disorder, early dementia, trauma-induced anxiety). Leads emotional negotiation with resident and family.

Nursing

Monitors resident for physical impacts (e.g., skin breakdown from poor hygiene, hidden wounds) and manages behavioral interventions.

Environmental Services (EVS)

Works with resident to establish regular, non-threatening cleaning routines. Checks for rotting food, pests, and mold.

Maintenance / Fire Safety

Regularly measures pathways for minimum width (32-36 inches) for wheelchair/walker clearance. Checks electrical safety.

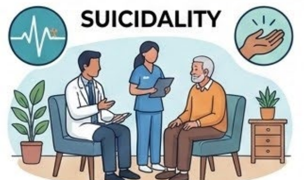
Psychiatry

Evaluate for a treatable hoarding disorder and provide supportive counseling.

Psychiatry Providers & Solutions to Difficult Behaviors

We are here for your team and ready to help!

SUICIDALITY



Evaluating risk, safety planning, and therapy.

ELOPEMENT

Managing exit-seeking, designing safe environmental engagement.

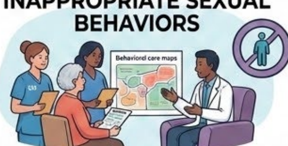
SUBSTANCE USE

Assessment, intervention, and referral.

VERBAL ABUSE

Staff training on de-escalation, managing difficult interactions.

INAPPROPRIATE SEXUAL BEHAVIORS



Behavioral care plans, setting boundaries, addressing root causes.

SPLITTING STAFF

Consistent communication strategies, preventing manipulation.

REFUSALS (e.g., CARE/MEDS)

Identifying underlying reasons, motivating engagement, respecting autonomy.

NECESSARY MEDS ONLY (DE-PRESCRIBING)

Medication reconciliation, eliminating polypharmacy, optimizing treatments.

HOARDING

Therapeutic interventions, environment modification, supportive counseling.

Lean on your psychiatry providers to help with difficult behaviors. We provide clinical expertise and team support!

THANK YOU!

Dr Jacob Fyda MD CMD

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