Title: Abuse, Neglect, and Exploitation of Patients/Residents	CARE BRAVELY
Department: Patient Care Services **Document Owner:** Shanae McLean **Approver(s):** Ernest Shock (VP CNO - LEVINDALE), Raymond Miller (PHYSICIAN)	**Effective Date:** 07/30/2019 **Expiration Date:** 07/30/2022 **Reference #:** 12154

Site(s):

☐ Sinai Hospital of Baltimore	☐ Practice Dynamics
☐ Northwest Hospital Center	☐ Baltimore Child Abuse Center
☐ Carroll Hospital Center	☐ BridgingLife
☒ Levindale Hebrew Geriatric Center and Hospital	☐ William E. Kahlert Regional Cancer Center
☐ Grace Medical Center	☐ LifeBridge Health & Fitness
	☐ Carroll Health Group

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

LEVINDALE
A LifeBridge Health Center

CARE BRAVELY

Policy and Procedure	Policy #: CARE - 114 Facility: Levindale Hebrew Geriatric Center and Hospital Department: Administration Effective Date: 10/94 Revised: 9/95, 3/97, 5/97, 9/97, 8/99, 11/00, 10/02, 3/03, 8/06, 12/08, 3/10, 9/10, 11/11, 3/13, 10/13, 3/18, 8/18, 7/19 Next Review Date: 7/22

TITLE: Abuse, Neglect & Exploitation of Residents/Patients

POLICY: The facility does not permit residents/patients to be subjected to abuse, neglect, corporal punishment, involuntary seclusion, or exploitation by anyone, including staff members, other residents/patients, consultants, volunteers, students, staff of other agencies, family members, legal guardian, friends and/or other individuals.

PURPOSE:

1. To provide guidelines for the identification, treatment, reporting, protection and referral of residents/patients [R/P] who are suspected of being abused either at home, another facility or at this facility.

2. To protect R/P from neglect, misappropriation of property, psychological, sexual, verbal, mental or physical abuse and involuntary seclusion from staff, other residents, family members, visitors, students, or volunteers.

3. To identify staff responsibilities regarding identifying, treating, reporting documenting and protecting the residents/patients from abuse, neglect, exploitation and self-neglect.

RESPONSIBILITY: All facility staff (direct and indirect care and auxillary functions), contractors, and volunteers.

FORMS:

Staff Member Incident Statement
Resident/Patient/Family/Staff Reporting Abuse Interview Questionnaire
Abuse Investigation Checklist
Contents of the Abuse Investigation File
Abuse Summary of Investigation

DEFINITIONS:

a. **Abuse:** Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

b. **Accident:** A chance event; Failure to prevent or report.

c. **Adult:** Person 18 years of age or older.

d. **Allegation:** An assertion yet to be proved.

e. **Assault:** Refers to the threat of violence.

f. **Battery:** Involves injury or other contact upon another person in a manner to cause bodily harm.

g. **Elder:** Over 65 years of age.

h. **Vulnerable Adult:** Any adult who lacks physical or mental capacity to provide for their own daily needs.

i. **Physical Assault:** The sustaining of any physical injury to an adult or vulnerable adult as a result of cruel or inhumane treatment or as a result of a malicious act by any person.

j. **Psychological/ Mental Abuse:** The infliction of emotional pain or distress, by harassment, by threats of punishment or deprivation, insults and/or humiliation which may be expressed verbally or non-verbally.

k. **Domestic Abuse:** Abuse that occurs in the home or family environment.

l. **Elder Abuse:** Abuse that occurs to a person over 65 years of age.

m. **Exploitation:** Any action that involves the misuse of an adult or vulnerable adult's fund, property or person.

n. **Neglect:** Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. This impaired quality of life includes withholding or inadequately providing food and hydration (without physician, resident or surrogate approval), clothing, medical care and good hygiene. May also include placing the individual in unsafe or unsupervised conditions.

o.. **Self-Neglect:** The inability of an adult or vulnerable adult to provide for his/her physical or mental health and well-being.

p. **Injuries of Unknown Source:** An injury that meets both of the following conditions: The source of the injury was not observed by any person **or** the source could not be explained by the resident; AND the injury is suspicious because of the extent of the injury or the location of the injury (e.g. injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time or the incidence of injuries over time.

q. **Rape:** Sexual intercourse without consent through the use of force or deception or if the victim is incapacitated.

r. **Sexual Molestation:** Any act that inflicts unwanted sexual advances or touches of an inappropriate nature on a person without their consent.

s. **Mistreatment:** The wrongful treatment of a resident either verbally or non-verbally.

t. **Involuntary Seclusion:** A R/P' separation from other R/P or from the R/P's room or confinement to his/her room (with or without roommate) against his/her will or the will of his/her legal representative. Involuntary Seclusion may occur if a call light is not within a R/P reach.

u. **Misappropriation** Deliberate misappropriation of a R/P's asset's or

of R/P Property: income. This includes spending the R/P's asset's or income against or without the R/P's consent or for the use and benefit of a person other than the R/P.

General Guidelines:

1. All residents/patients have a right to be free from physical, mental, sexual and verbal abuse, involuntary seclusion, neglect and exploitation.

2. A nonjudgmental approach should be maintained toward residents/patients and family members at all times. The family is kept informed of what is happening to the resident/patient. The right to privileged communication and confidentiality between physician and resident/patient is waived in suspected abuse or neglect cases. It is important to remind the physician that legally this information can be shared with the police departments and the Department of Social Services investigating the case. Medical Records Department should not release this information to parties other than the above without a court order.

3. All suspected or actual abuse cases are referred to the proper authorities in accordance with Maryland law. (COMAR 10.07.09.15 Resident's Bill of Rights; COMAR10.07.02.46(F) Comprehensive Care Facilities and Extended Care Facilities; 42C.F.R.§483.13 and Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act.).

4. All reports of abuse or suspected abuse are reported to Administration, Nursing, and Risk Management immediately and a thorough investigation is conducted. Immediately means as soon as possible but not to exceed 24 hours after discovery of the incident.

5. A case review is done with the Director of Nursing Long Term Care/Sub Acute, Director of Nursing Home Operations Administrator, VP/CNO, Unit Manager, Director of Performance Improvement/ Risk Management/Patient Safety/Quality, and Social Worker to identify if any system or procedural changes are necessary to prevent further occurrences. Other members of the staff may be invited to participate in the review. Recommendations for improvement are reported through the QAPI Program.

6. The facility provides annual training designed to assist employees and health care workers associated with the facility in identifying resident/patient abuse, neglect or illegal, unprofessional or unethical conduct by or in the facility. [Refer to CARE 114 A]

PROCEDURE:

A. Identification

1. At the time of admission, residents/patients are assessed for signs of abuse and/or neglect. Abuse may be in the form of sexual offense, physical violence, and/or psychological abuse.

    a. A complete physical examination and history of the resident/patient is obtained and documented by Medicine.

b. Nursing performs a complete assessment including assessment of the skin and diagrams every mark on the skin assessment form. The body is checked for marks that would indicate patterns of bumps, bruises, hematomas, chafing, excoriation, fractures, signs of malnutrition or dehydration. If indications of abuse or neglect are identified, a social worker is contacted immediately.
c. Social Work performs a complete initial psycho-social assessment with the input of all available medical and nursing information and a discussion with the family/caregiver/surrogate and Extended Care Facility (if applicable) of the vulnerable adult.

NOTE: If the resident/patient requests or it is deemed appropriate by a member of the health care team, the resident/patient should be separated from the accompanying caretaker.

2. To prevent resident-to-resident abuse in the Households, residents with a history of physical and/or verbal abuse of other persons are evaluated prior to admission to ensure this community can provide the services the resident needs and to protect other residents from harm.
    a. The resident, family members and others acquainted with the resident's behaviors are asked the following information:
        i. Behaviors the resident has exhibited that would be considered threatening to others.
        ii. What triggers those behaviors?
        iii. What interventions worked or did not work to extinguish the behavior?
    b. The household interdisciplinary team evaluates the above information along with the resident's medical and other information related to his/her physical and/or verbal abuse and develops a plan to create an environment that will support the resident and decrease the opportunity for resident-to-resident abuse.
    c. If the resident continues to exhibit behaviors that could harm other residents, the team meets with the resident, legal representative and/or designated family members to discuss the inability of the household to meet the resident's need and the need to move to another residence.

3. If at the time of admission the multidisciplinary team has reason to suspect that the abuse or neglect occurred in the community:

    a. The social worker makes a referral to the Adult Protective Services [APS] immediately and provides all required information.
    b. Following the referral to APS, the social worker acts as the liaison with APS, family and caregiver until such time as the adult or vulnerable adult is discharged from the facility.
    c. APS is notified if the resident/patient is discharged back to the community.

4. Ongoing daily observations for signs of abuse, neglect, and/or injuries of unknown origin are done by the interdisciplinary team.

5. In the non-verbal, cognitively impaired or dementia resident/patient it is important to observe behaviors that may be present or appear suddenly. These symptoms **may** indicate abuse and include but not limited to the following:
    a. crying

b. unexplained fears
c. unwillingness to talk
d. agitation
e. screaming
f. striking others
g. secretive behavior
h. changes in appetite

6. If an injury is noted as unknown an assessment is completed by a licensed nurse.
    a. An Injury of Unknown Source Algorithm is part of the incident report question query to confirm if the injury of unknown origin is considered abuse.
    b. Photographs of the injury should be taken at the time of discovery. Additional timeline of photographs may be taken at the direction of senior management or the risk manager.
    c. Team members report the presence of bruising, and/or skin tears on residents/patients on the nurse immediately. The nurse evaluates the possible causes for all injuries and determines if the injury could be the result of mistreatment or neglect.

7. If misappropriation of resident or patient property is discovered, it is reported to the Administrator immediately for investigation. If during the investigation there is evidence that the incident meets the definition of misappropriation of property, the OHCQ is notified. If a crime is thought to have been committed, local law enforcement is notified. Security is notified any time the local law enforcement is on the premises.
    a. In the event the incident relates to a missing item, permission is obtained from the resident/patient to search the resident's/patient's room. The resident/patient or responsible party should be present during the search.
    b. Public areas, laundry and other possible locations maybe searched for the missing item.
    c. If the incident relates to misappropriation of a resident's fund account, the Neighborhood Director requests reconciliation of accounts. If Financial Services employees cannot reconcile the account, an audit of the records by a qualified individual not responsible for the funds account maybe conducted.

8. If a resident/patient is found in a situation of involuntary seclusion, it is reported to Nursing Administration and a complete investigation is conducted.

B. Characteristics & Observable Behaviors

1. Physical Abuse

a. Threatening or using a weapon.
b. Throwing an object or substance at another or use of implements such as belts, hairbrushes, etc. on another.
c. Slapping, hitting, choking or strangling, beating, punching, or burning another.
d. Biting, kicking, pinching, scratching, twisting, wrenching or pulling of hair or another body part.
e. Holding someone down against his/her wishes.
f. Denying and interfering with the meeting of ones basic needs such as eating, sleeping or toileting.

g. Controlling behavior through corporal punishment/confinement.
h. Evidence of bruises, black eyes, lacerations, bone fractures, open wounds, burns, untreated injuries in various stages of healing.

2. Sexual Abuse

a. Sexual Harassment
b. Making demeaning remarks about a person's body or body parts.
c. Minimize a person's feelings about sex.
d. Inappropriate sexual touches.
e. Forcing a person to have sex (sexual coercion).
f. Sexual Assault.
g. Evidence of bruises around the breasts or genital area, unexplained genital infection or newly acquired sexually transmitted diseases, unexplained vaginal or anal bleeding.

3. Verbal Abuse

a. Calling Resident/Patient names.
b. Cursing at Resident/Patient.
c. Demeaning or making fun of Resident/Patient so that the Resident/Patient is embarrassed or humiliated.

4. Neglect

a. Malnourished, dehydration
b. Over/under medicated
c. Lack of heat and/or running water
d. Lack of medical care
e. Lack of personal hygiene and/or appropriate clothing
f. Evidence of advance stage pressure ulcer left untreated

5. Exploitation

a. Taking the social security/SSI check
b. Taking property and/or other resources
c. Borrowing money or property from the resident/patient
d. Incitement of the resident/patient by the offender to commit acts that are or may be detrimental to the resident/patient, however, may gratify the offender
e. Involving the resident/patient in any practice or scheme of conduct that may include sexual contact for the purposed of arousal or gratification of the offender

C. Treatment

1. In any case of obvious trauma to a resident/patient such as gross bleeding, lacerations, sexual abuse, etc. the staff refrains from any cleansing of wound of the resident/patient, changing bed linens and removal or disturbance of anything in the room/area. The area must be treated like a crime scene and all evidence preserved until the primary investigation is done unless this would be life threatening to the resident/ patient.

2. After the primary investigator (LTC = Nurse Manager; CH = Unit Manager or Nursing Supervisor) sees the resident/patient, the physician or designee examines him/her and orders treatment as appropriate to the resident/patient's needs including transfer or discharge to a hospital or other service.

3. If rape has occurred, a team member remains with the resident/patient to provide support and comfort. If an injury is noted, licensed personnel provide immediate first aid, being careful not to wash or clean the perineal area as this will destroy evidence. Resident/patient clothing is not changed and the location of the suspected rape is not cleaned until law enforcement has directed such action. The resident/ patient and family member must agree with the plan of care and treatment prior to escorting the resident/patient by ambulance to the nearest Rape Center for examination, treatment, and services. If the resident/patient or responsible party refuses to agree to the report and the situation is suspected to be high risk, it is reviewed with the Administrator /President and the Director of Social Worker.

D. Protection and Investigation

1. The resident/patient is made immediately safe and protected from harm. This may include but not limited to:
   - Moving the resident/patient to a different physical location
   - Changing caregiver assignments
   - Removing the alleged perpetrator from the facility pending investigation
   - Have someone stay with the resident/patient at all times, if appropriate to the situation.
   - In resident-to-resident/patient-to-patient altercations, separate the residents/patients involved. Resident-to-resident/patient-to-patient means when one R/P assaults with or without inflicting injury, intentionally or randomly, on another R/P, with or without provocation.

2. Any staff person who observes signs of possible or observed abuse, notifies the nurse immediately so an assessment can be performed. Refrain from "cleaning up" the areas as all evidence must be maintained until the primary investigation is done.

3. As the primary investigator, the Department Manager/Unit Manager, Nursing Supervisor, Director of Nursing/Director of Nursing Homes Operations/Administrator or designee conducts an investigation of the event. Use the Abuse Investigation Checklist to help coordinate the response. Investigation starts at the time of the event. Communicate the status of the investigation process to the appropriate nursing supervisor/manager on the subsequent shifts.

4. Written statements are obtained from the victim, all witnesses and/or from the person who identified the problem. The questions should address: What is the allegation? Who, what, when, where and how was the incident discovered? What actually occurred and when, where, how did it occur? Who or what possibility caused the event to occur? The resident's/patient's emotional and mental state are also assessed and documented. Responses need to be recorded in the person's own words, signed and dated.

a. The primary investigator records the incident as stated by the resident/patient.
b. The social worker may also interview the resident/patient, if appropriate, and write a statement.
c. Injuries which are suspected to have been caused by abuse and/or neglect should be photographed in order to provide adequate documentation of the injury.
d. Interviews of staff and gathering of information surrounding care of the victim includes a look back of at least 48-hours prior to the discovery of the incident. Staff statements are collected or interviewer can record the findings from the interview and the staff member signs the recorded statement to verify accuracy. Interviews of each individual are conducted in a room that provides privacy. It is permissible for the people conducting the interview to have a second person present to record the information obtained during the interview.

5. Visit the incident site. Sketch or photograph pertinent aspects of the site as needed. Collect physical evidence such as position of residents/patients, equipment in use and the settings, safety devices in use, type of bed, materials being used at the site, condition of the site related to lighting, odor, sanitation conditions, etc.

6. If the incident involves a resident's/patient's family member or visitor, the resident/patient is asked if he/she wish to continue receiving visits from that individual. If yes, the visits are supervised by a team member until the investigation is completed. If the resident/patient state he/she does not want further visits from the individual, the resident's/patient's right to deny visitation is followed. This information is communicated to the team members and security. If the incident meets the definition of a crime against a person, local law enforcement and adult protective services are notified.

7. If the alleged abuse involves an employee, the suspected or identified employee is removed from patient care, obtain the employee statement, do not leave the employee alone (including going to the bathroom) and suspended until the investigation is complete. Part of the investigational process includes review of the employee's file. Termination will occur as appropriate. If it involves contract staff, agency staff or anyone providing services to the resident/patient on behalf of the facility, they are removed from care responsibilities and reported to their supervisor.

    a. The social worker may interview other potential victims within 24-48 hours of the alleged incident.
    b. Resident/patient interview is conducted using the Resident/Patient/Family/Staff Reporting Abuse Interview Questionnaire.

E. Reporting/Response

1. All alleged violations involving abuse, neglect, mistreatment, injury of unknown source, and misappropriation of property are reported immediately through a chain of command.
    a. The unit manager or charge nurse/supervisor notifies the Director of Nursing/Director of Nursing Home Operations/Administrator, the attending Physician and appropriate family member immediately upon recognition.
    b. Director of Nursing/Director of Nursing Home Operations or designee notifies the Administrator/President, VP/CNO and Risk Manager. Other notifications may involve police, biomedical engineering and pharmacy (DEA).
    c. The Abuse Coordinator is the Administrator/President or designee.

d. In the chronic specialty hospital, the abuse may be reported to the local police department at the time of the occurrence if there is evidence of a crime. The responsible party reserves the right to request that the local police called. In LTC, alleged resident abuse, neglect, exploitation or mistreatment is reported to the Office of Health Care Quality [OHCQ] within two hours if the alleged events have resulted in serious bodily injury. If the alleged events did not result in abuse or serious bodily injury, the report is reported to OHCQ within twenty-four hours of discovery. In addition, one of the following may be notified:

i. Office of Aging - Ombudsman;
ii. Local Police Department – must be notified.
iii. State Licensing/Certification agency responsible for surveying/licensing the facility;
iv. Resident's Representative of Record;
v. Adult Protective Services should the patient/resident is being discharged to home
vi. Resident's Attending Physician;
vii. Facility Medical Director

The incident is thoroughly investigated and follow-up is submitted to the OHCQ within 5 days from discovery.

e. In LTC and CH, Security is notified each time local law enforcement is called to the premises.

2. If the alleged violation is by a staff member, appropriate corrective action is taken including:

a. Notification of Human Resources through appropriate disciplinary action. The employee is suspended pending investigation.
b. Notification of the State Professional Board(s) of Practice, appropriate to the discipline involved.

3. Any person who in good faith makes or participates in making a report about suspected abuse, neglect, self-neglect, or exploitation of a vulnerable adult is immune from any civil liability. The same is true for those who participate in the investigation of resultant judicial proceedings. (Section 14-309 of Annotated Code of Maryland).

4. If abuse is suspected in another health care facility, the Risk Manager or designee notifies the Administrator of that facility as well as the proper authorities according to Maryland law.

5. Resident/Patient/Responsible Party has a right to honest information. The Administrator informs them of the incident and what care is being rendered while an investigation is underway. Do not explain what you think happened or assumed happened. Plan for how the results of medical care and all outcomes will be disclosed.

F. Documentation

1. Documentation by the attending physician or designee and all other members of the multidisciplinary team involved is recorded in the medical record.

2. Documentation in the medical record includes:
    a. Process of identification, treatment, reporting and referral of the resident/ patient.
    b. Appropriate consent for the assessment and treatment of the results of the event.
    c. Any documentation of such material pertinent to the investigation that was collected, retained or safeguarded.
    d. Notification of proper authorities and referrals made to provide or arrange for evaluation of care for abuse victims.
    e. Notification and disclosures to the family/responsible party.

3. Record the incident on the 24-hour report.

4. Generate an incident report in VSuite at the time of notifying appropriate administrative personnel.
    a. With observed or suspected abuse.
    b. With resident-to-resident or patient-to-patient altercations, an incident report is completed on each individual resident/patient involved.

    NOTE: These documents are NOT part of the medical record.

5. A Summary of Investigation is completed by the Director or Risk Manager and filed with the investigative documents. All documentation on investigations of abuse is maintained in administration files.

G. Quality Improvement

1. The results of investigations are reported and discussed to the respective Quality and Patient Safety Committee (e.g. monthly during QAPI meeting).

2. Trends and patterns or root causes for the incident(s) are addressed for opportunities to improve practices through in-service education or changes in policies and procedures.

CROSS REFERENCES: Care 114A Abuse Prohibition

REFERENCES:

COMAR 10.07.09.15 Resident's Bill of Rights

COMAR10.07.02.46(F) Comprehensive Care Facilities and Extended Care Facilities; 2C.F.R.§483.13

Annotated Code of Maryland. Section 14-309

CMS/State Operations Manual.

Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC):

Section 1150B of the Social Security Act. Ref: S&C: 11-30-NH. REVISED 01.20.12

Survey Tags: F223; F224; F225; F226

_____ Date: _____
Deborah Graves
President & Chief Operating Officer

_____ Date: _____
Ross Maultash
Director of Nursing Home Operations/Administrator

_____ Date: _____
Shanae Williams McLean MBA, MSN, RN
Director of Nursing
Long Term Care/Subacute

_____ Date: _____
Dr. Raymond Miller, MD
Medical Director