

*Illinois Department on Aging*  
**Illinois Long-Term Care Ombudsman Program  
Supplemental Training Curriculum**

**Supplemental Module # 8  
It Takes a Community to Prevent Abuse and Neglect of  
Residents**

**TEACHING TIPS**

Pre Publication Edition I

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Developed by Margaret Niederer and Erin Strotheide

Field Editors:  
Statewide Regional Ombudsmen

Rod R. Blagojevich, Governor

Charles D. Johnson, Director

## **SUPPLEMENTAL MODULE # 8**

### **IT TAKES A COMMUNITY TO PREVENT ABUSE AND NEGLECT OF RESIDENTS**

### **TEACHING TIPS**

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions. This module incorporates individual reading, group discussion, questions on what is not clear and an evaluation of what was learned.

This module is designed to be adaptable to various teaching methods and settings: training/ in-services for ombudsmen or presentations to families or facility staff. This module can be divided into as many training sessions as needed and a variety of methods can be used, including a lecture method.

#### **You may need:**

- Copies of the exercises
- Overhead projector and screen

Sample master transparencies to use in reviewing some of the module content can be used. Sample transparencies to use in reviewing some of the module content can be used for group discussion are included. These may be converted into slides.

#### **Emphasis in this Module: Contact Supervisor to Assure that Program Handles All Suspected and Actual Abuse and Neglect Cases Consistently**

**The ombudsman program has not handled abuse and neglect issues in a consistent, aggressive manner to stop practices of those facilities that allow systemic abuse and neglect to continue. Since ombudsmen should have a zero tolerance of neglect and abuse, the requirement to contact the ombudsman program supervisor when there are abuse and neglect allegations is emphasized in this module. The supervisor may be the regional ombudsman or a paid ombudsman.**

**The Office of State Ombudsman needs to be assured that all cases of alleged or actual neglect and abuse are reported and handled properly, assuring confidentiality. For that reason, the trainer for this module should emphasize the requirement to report these types of complaints immediately to the supervisor and explain how the system will work for the particular regional program, i.e., who is in charge, who to contact when no one is in the office, etc.**

**The ombudsman in the field must have sufficient technical support to handle abuse and neglect issues, all of which are difficult. The mandate to protect residents requires that neglect and abuse issues need to be expertly handled, not only at the resident advocacy level, but the systemic advocacy level, to prevent a continuation of abuse and neglect.**

**Neither the state ombudsman nor the regional ombudsman, responsible for this program, can allow ongoing neglect in facilities, without bringing this to the attention of local and state officials, and if needed to the attention of the public. Local, State and Federal laws and required plans of correction must be enforced to stop ongoing neglect and abuse in poor performing facilities.**

**Laws are not self-effecting. The ombudsman program plays a key role in reporting to the proper authorities and commenting on this issue in a public manner.**

**No ombudsman should ignore any signs of neglect or abuse, nor should the ombudsman accept the facility's response of having resolved abuse and/or neglect issues without investigation, always keeping the supervisor aware of the issues until there is real change within the facility.**

### **Accountability**

After the discussion, ombudsman trainees will be asked to discuss as a group:

- 1) An incident or condition observed or suspected in a facility that might lead to neglect or abuse, including how you would verify this condition
- 2) How to proceed to resolve an issue or case, using a selected scenario.

### **Resources**

	<b>Page</b>
Abuse and Neglect Regulations/Guidelines from the <i>State Operations Manual</i>	6
State Regulations on Contacting Law Enforcement	Appendix A
Department on Aging Letter Regarding Privacy Rules	Appendix B
Department of Public Health Memorandum on Neglect	Appendix C

Appendices A, B and C are attached and need to be inserted in this document.

## ACCOUNTABILITY EXERCISE #1

**An incident or condition you have observed or suspected in a facility that might lead to neglect or abuse--include how you would verify, investigate and resolve this condition.**

## ACCOUNTABILITY EXERCISE #2

How would you proceed to resolve a systemic issue of neglect in a facility?

## STATE OPERATIONS MANUAL—ABUSE AND NEGLECT SECTIONS

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F223	<p>(b) <u>Abuse</u>. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p>	<p><u>Intent: 483.13(b)</u>                      Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.</p> <p><u>Guidelines: 483.13(b) and (c)</u>                      “Abuse” means the willful infliction of injure, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” (42 CFR 488.301)</p> <p>This 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. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.</p> <p>“Verbal abuse” is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</p> <p>“Sexual abuse” includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.</p> <p>“Physical abuse” includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.</p> <p>“Mental abuse” includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.</p> <p>Involuntary seclusion” is defined as separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident’s will, or the will of the resident’s legal representative. Emergency or short term monitored permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs.</p> <p>Investigation of possible involuntary seclusion, may involve one of two types of situations: that in which resident’s are living in an area of the facility that restricts their freedom of</p>

<p>F223 (Cont.)</p>		<p>movement throughout the facility, or that in which a resident is temporarily separated from other residents.</p> <ul style="list-style-type: none"> <li>• If the stated purpose of a unit which prevents residents from free movement throughout the facility is to provide Specialized care for residents who are cognitively impaired, then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident needs and preferences.</li> <li>• If a resident is receiving emergency short-term monitored separation due to temporary behavioral symptoms (such as brief catastrophic reactions or combative or aggressive behaviors which pose a threat to the resident, other residents, staff or others in the facility), this is not considered involuntary seclusion as long as this is the least restrictive approach for the minimum amount of time, and is being done according to resident needs and not for staff convenience.</li> </ul> <p>If a resident is being temporarily separated from other residents, i.e., for less than 24 hours, as an emergency short-term intervention, answer these questions:</p> <ol style="list-style-type: none"> <li>1. What are the symptoms that led to the consideration of the separation?</li> <li>2. Are these symptoms caused by failure to:       <ol style="list-style-type: none"> <li>a. Meet individual needs?</li> <li>b. Provide meaningful activities?</li> <li>c. Manipulate the resident's environment?</li> </ol> </li> <li>3. Can the cause(s) be removed?</li> <li>4. If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation?</li> <li>5. If these alternatives have been tried and found ineffective, does the facility use separation for the least amount of time?</li> <li>6. To what extent has the resident, surrogate or representative (if any) participated in care planning and made an informed choice about separation?</li> <li>7. Does the facility monitor and adjust care to reduce negative outcomes, while continually trying to find and use less restrictive alternatives?</li> </ol> <p>If, during the course of the survey, you identify the possibility of abuse according to the definitions above, investigate through interviews, observations, and record review. (For investigative options, refer to the Guidelines for Complaint Investigation which outlines the steps of investigations for various types of suspected abuse and misappropriation of</p>
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F223 (Cont.)		steps of investigations for various types of suspected abuse and misappropriation of property.) Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act. The nature of the abuse and where and when it occurred. Ensure that the facility addresses the incident immediately.
F224* F226**	<p><u>( c ) Staff treatment of residents</u></p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Use tag F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.</p> <p>Use tag F226 for deficiencies concerning the facilities development and implementation of policies and procedures.</p>	<p>Intent: 483.13( c ) F224 Each resident has the right to be free from mistreatment, neglect and misappropriation of property. This includes the facility’s identification of residents, whose personal histories render them at risk for abusing other residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.</p> <p>Intent: 483.13( c ) F226 The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for The prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.</p> <p>Guidelines: 483.13( c ) F224 “Neglect” means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (42 CFR 488.301)</p> <p>“Misappropriation of resident property” means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent. (42 CFR 488.301)</p> <p>Guidelines 483.13 ( c ) F226 The facility must develop and implement policies and procedures that include the seven components: screening, training, prevention, identification, investigation, protection and reporting/response. The items under each component listed below are examples of ways in which the facility could operationalize each component.</p> <p>I. Screening (483.13( c )( 1 )( ii )( A )&amp;( B ): Have procedures to:</p> <p>Screen potential employees for a history of abuse, neglect or mistreating residents as defined by the applicable requirements at 483.13 ( c )( 1 )( ii )( A )&amp;( B ). This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries.</p> <p>II. Training (42 CFR 483.74( e )): Have Procedures to:</p> <ul style="list-style-type: none"> <li>• Train employees, through orientation and on-going sessions on issues related to abuse prohibition practices such as:</li> </ul>

<p>F224* F226** (Cont.)</p>		<ul style="list-style-type: none"> <li>- Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents;</li> <li>- How staff should report their knowledge related to allegations without fear of reprisal;</li> <li>- How to recognize signs of burnout, frustration and stress that may lead to abuse; and</li> <li>- What constitutes abuse, neglect and misappropriation of resident property</li> </ul> <p>III. Prevention (483.13( b ) and 483.13( c )): Have procedures to:</p> <ul style="list-style-type: none"> <li>- <b>Provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution: and provide feedback regarding the concerns that have been expressed. (See 483.10(f) for further information regarding grievances.)</b></li> <li>- <b>Identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur.</b></li> </ul> <p><b>This includes an analysis of:</b></p> <ul style="list-style-type: none"> <li>- <b>Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility:</b></li> <li>- <b>The deployment of 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:</b></li> <li>- <b>The supervision of staff to identify inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in their beds; and</b></li> <li>- <b>The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff.</b></li> </ul> <p>IV. Identification (483.13 ( c )( 2 )): Have procedures to:</p> <ul style="list-style-type: none"> <li>- <b>Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.</b></li> </ul>
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<p>F224* F226** (Cont.)</p>		<p>investigation.</p> <p>V. Investigation (483.13( c )( 3 )); Have procedures to:</p> <ul style="list-style-type: none"> <li>• Investigate different types of incidents; and</li> <li>• Identify the staff member responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities. (See 483.13( c )( 2 ),( 3 ), and ( 4 ))</li> </ul> <p>VI. Protection (483.13( c )( 3 )): Have procedures to:</p> <ul style="list-style-type: none"> <li>• Protect residents from harm during an investigation</li> </ul> <p>VII. Reporting/Response (483.13( c )( 1 )( iii ), 483.13( c )( 2 ) and 483.13( c )( 4 )): Have procedures to:</p> <ul style="list-style-type: none"> <li>• Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation;</li> <li>• Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and</li> <li>• Analyze the occurrences to determine what changes are needed, if any, to policies and Procedures to prevent further occurrences.</li> </ul>
<p>Refer to F223</p>	<p>( 1 ) The facility must- ( I ) Not use verbal, mental, sexual or physical abuse corporal punishment, or involuntary seclusion;</p>	
<p>F225</p>	<p>( ii ) Not employ individuals who have been—  ( A ) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or  ( B ) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and</p>	<p><u>Intent: 483.13( c )( 1 )( ii )( iii )</u></p> <p>The facility must not hire a potential employee with a history of abuse, if that information is known to the facility. The facility must report knowledge of actions by a court of law against an employee that indicates the employee is unfit for duty. The facility must report alleged violations, conduct an investigation of all alleged violations, report the results to proper authorities, and take necessary corrective actions.</p> <p><u>Guidelines: 482.13( c )( 1 )( ii ) and ( iii )</u></p>

<p>F225 (Cont.)</p>	<p><b>( iii ) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aid or other facility staff to the State nurse aid registry or licensing authorities</b></p> <p>( 2 ) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and the other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>( 3 ) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>( 4 ) The result of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency). Within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	<p>Facilities must be thorough in their investigations of the past histories of individuals they are considering hiring. In addition to inquiry of the State nurse aide registry or licensing authorities, the facility should check information from previous and/or current employers and make reasonable efforts to uncover information about any past criminal prosecutions.</p> <p>“Found guilty...by a court of law” applies to situations where the defendant pleads guilty, is found guilty, or pleads no to contendere.</p> <p>“Finding” is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents, or misappropriation of their property.</p> <p>A certified nurse aide found guilty of neglect, abuse, or mistreating residents or misappropriation of property by a court of law, must have her/his name entered into the nurse aide registry. A licensed staff member found guilty of the above must be reported to their licensing board. Further, if a facility determines that actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), then the facility must report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authorities (if a licensed staff member) Such a determination by the facility is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment.</p> <p>A State must not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.</p> <p>The facility’s reporting requirements under 483.13( c )( 2 ) and ( 4 ) include reporting both alleged violations and the results of investigations to the State survey agency.</p>
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## **Appendix A: State Regulations on Contacting Law Enforcement**

**Appendix B: Department on Aging Letter Regarding Privacy Rules**

## **Appendix C: Department of Public Health Memorandum on Neglect**