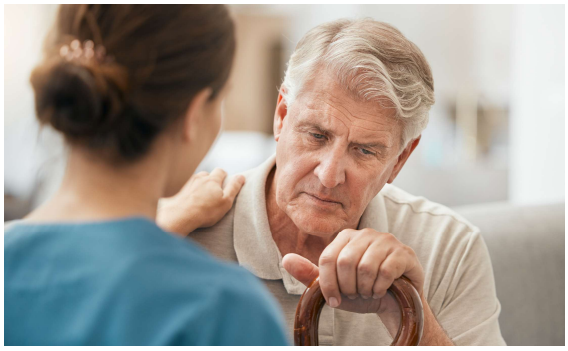
Managing Allegations of Abuse, Neglect and Exploitation

Cyndi Siders
MSN, RN, CPHRM, CPPS, DFASHRM
Executive Consultant
Siders HealthCare Consulting, LLC



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The Presenter has No Conflicts of Interest to Disclose.

Contracted Provider of Services

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Today

- Claim Trends
- Definitions
- North Dakota Regulations
- Federal Regulations
- Examples of Cited Abuse
- Reporting Requirements
- Risk Management Strategies
- Scenarios

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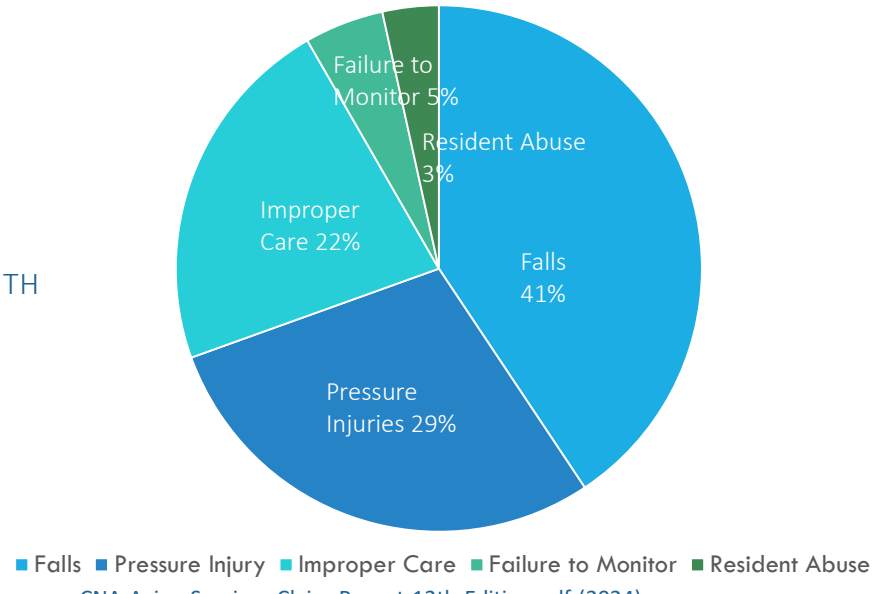
CNA AGING SERVICES CLAIMS REPORT – 12TH EDITION

Most Frequent Claim Trends – Skilled Nursing



CNA-Aging-Services-Claim-Report-12th-Edition.pdf (2024)

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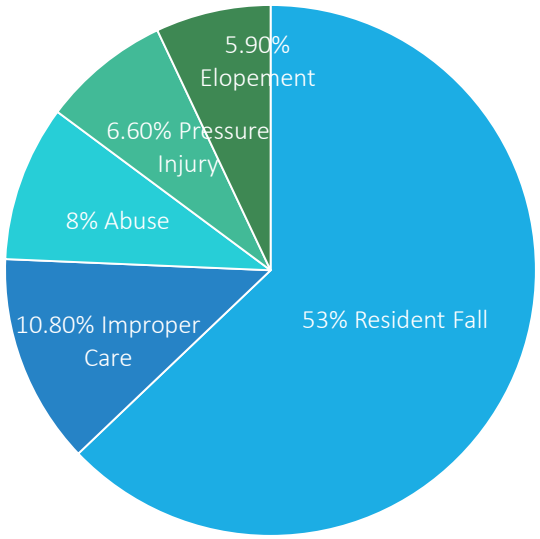
CNA AGING SERVICES CLAIMS REPORT – 12TH EDITION

Most Frequent Claim Trends – Assisted Living



CNA-Aging-Services-Claim-Report-12th-Edition.pdf (2024)

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AVERAGE TOP INCURRED COST - CNA AGING SERVICES CLAIMS REPORT – 12TH EDITION

Assisted Living		Skilled Nursing	
Abuse	$396,263	Abuse	$375,338
Elopement	$344,184	Failure to Monitor	$285,472
Pressure Injury	$330,196	Pressure Injury	$261,678
Resident Fall	$267,455	Improper Care	$245,272
Improper Care	$248,348	Resident Fall	$228,034

CNA Aging Services Claims Report – 12th Edition – CNA-Aging-Services-Claim-Report-12th-Edition.pdf (2024)

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"Per court documents, the director of the facility told police that she received a call from the alleged victim's adult son, who said he saw his mother engaged in a sexual act with an employee. The son reportedly saw the act via a live camera that was placed within the alleged victim's room." The resident, 78-years-old, has Alzheimer's and Dementia.

Source - [February 5, 2025] State records reveal more allegations against Scottsdale care facility sex assault suspect | Crime Files | FOX 10 Phoenix

"The owner and an employee of an assisted living facility in California were arrested after an 88-year-old resident with dementia wandered from the complex while the worker slept and later died, state officials said."

Source - [February 7, 2025] Officials: Assisted living worker slept while dementia patient wandered away, died – 104.5 WOKV

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IN THE NEWS

"A 21-year-old assisted living employee was arrested Thursday after forging checks from a resident's account"
"The 76-year-old woman discovered $1,800 worth of unauthorized transactions during a meeting with her financial advisor."

Source - [September 6, 2024] www.1011now.com
Lincoln assisted living employee arrested for check forgery and elder abuse

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In the News
XXX nursing home to pay $12 million settlement over abuse and fraud claims

- A Syracuse nursing home will pay $12 million in a settlement with New York state over claims of abuse and Medicaid fraud.
- Sepsis – wound infection
- Falls
- Medications not administered
- Dehydration

Source - Van Duyn nursing home to pay $12 million settlement over abuse and fraud claims | WRVO Public Media

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Jury selection begins in elder abuse case

September 03, 2025
Minot Daily News

- The couple was charged in March after a "cybertip from the National Center for Missing and Exploited Children allegedly discovered images and videos on the couple's cell phones of numerous individuals in a hospital or nursing home setting."

Source - Jury selection begins in elder abuse case | News, Sports, Jobs - Minot Daily News

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North Dakota Mandatory Reporters

Source - Reporting Abuse and Neglect of a Vulnerable Adult | Health and Human Services North Dakota

Who Must Report - Mandated Reporters

In North Dakota, these professionals and individuals are required to report abuse, neglect, and exploitation of vulnerable adults.

Qualified individuals *(means any agent, investment adviser representative, or person who serves in a supervisory, compliance, or legal capacity for a broker-dealer or investment adviser)*

- Clergy *(NOTE: not required if knowledge is gained as a spiritual advisor)*
- Addiction counselor
- Caregiver
- Chiropractor
- Congregate care personnel
- Coroner
- Counselor
- Dental hygienist
- Dentist
- Emergency medical personnel
- Family therapist
- Firefighter
- Hospital personnel
- Law enforcement officer
- Marriage therapist
- Medical examiner
- Mental health professional
- Nurse
- Nursing home personnel
- Occupational therapist
- Optometrist
- Pharmacist
- Physical therapist
- Physician
- Podiatrist
- Social worker
- Other professionals

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When to Report

A mandated reporter must report if in an official or professional capacity, he or she:

- has knowledge that a vulnerable adult has been subjected to abuse or neglect; or
- observes a vulnerable adult being subjected to conditions or circumstances that reasonably would result in abuse or neglect.
- **Important:** A mandated reporter **is required to report as soon as possible.**

What to Include in the Report

To the extent reasonably possible:

- Name, age, and residence address of the alleged vulnerable adult.
- Name and residence address of the caregiver (if any).
- Nature and extent of the alleged abuse or neglect or the conditions and circumstances that would reasonably be expected to result in abuse or neglect.
- Any evidence of previous abuse or neglect.
- Any other information that, in the reporter's opinion, may be helpful in establishing the cause of the alleged abuse or neglect and the identity of the individual responsible for the alleged abuse or neglect.

Penalty

- Any person required to report who willfully fails to do so is guilty of an infraction and subject to a fine up to $1,000.

Source - Reporting Abuse and Neglect of a Vulnerable Adult | Health and Human Services North Dakota

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Definitions – Federal Regulations §483.5 Definitions Guidance §483.12

Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 229; Issued: 04-25-25)

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Definitions – Federal Regulations §483.5 Definitions Guidance §483.12

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.

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Definitions – Federal Regulations §483.5 Definitions Guidance §483.12

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.

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Definitions – Federal Regulations §483.5 Definitions Guidance §483.12

Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.

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Definitions – Abuse Federal Regulations §483.5 Definitions Guidance §483.12

It includes **verbal abuse, sexual abuse, physical abuse, and mental abuse** including abuse facilitated or enabled through the use of technology.

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Abuse

- Force-feeding
- Scolding, ignoring, ridiculing, or cursing a resident
- Rough handling during caregiving or moving a resident
- Non-consensual sexual contact of any type
- Taking, using, and/or sharing photographs or recordings of residents that would demean or humiliate them.

The National Consumer Voice for Long-Term Care. abuse-fact-sheet.pdf (ltcombudsman.org)

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Federal Regulations §483.5 Definitions Guidance §483.12

- Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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Patient Rights/Neglect/ Professional Conduct

- Elderly Patient Admitted To The Hospital With A Gastrointestinal (GI) bleed.
- The Initial Nursing Assessment on Admission Classified the Patient As A "Low Fall Risk"
- The Patient Met Many Of The Facility's "High-Fall-Risk" Criteria
- Third Day of Admission, Still Noted As Low Fall Risk
- Reported as Confused With Attempts To Get Out Of Bed Unassisted
- Found By Family Member Lying On The Floor
- Patient Suffered An Intracranial Hemorrhage Caused By the Fall With Resulting Death

Source - Nurse-Exposure-Claim-Report-4th-Edition.pdf (cna.com)

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Neglect Examples

- Incorrect body positioning - leads to limb contractures and skin breakdown
- Lack of assistance with toileting or changing of disposable briefs –causes incontinence/ a resident sitting in urine and feces
- Lack of assistance with eating and drinking - leads to malnutrition and dehydration
- Lack of assistance with walking – leads to lack of mobility
- Lack of bathing – leads to indignity, and poor hygiene
- Lack of assistance with participating in activities of interest – leads to withdrawal and isolation
- Ignoring call lights or cries for help

The National Consumer Voice for Long-Term Care. abuse-fact-sheet.pdf (ltcombudsman.org)

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§483.12 Mental Abuse

- Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation
- Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend, or disability

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§483.12 Mental Abuse

- Examples of mental and verbal abuse include, but are not limited to:
  - Harassing a resident
  - Mocking, insulting, ridiculing
  - Yelling or hovering over a resident, with the intent to intimidate
  - Threatening residents, including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends
  - Isolating a resident from social interactions or activities

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- The facility failed to ensure that a resident was free from mental abuse and corporal punishment.
- A resident who had a cognitive disability carried a bunny around with her throughout the day.
- During an activity, the resident placed the bunny in a chair next to her and refused to allow another resident to use the chair.
- The staff slapped the resident's hand and removed the bunny so the other resident could sit down.
- The staff told the resident she could not attend any more activities with the bunny, or he would get rid of it and the resident would never see it again.

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Immediate Jeopardy

- The resident began to scream, cry for her bunny, and left the room.
- The resident will not leave her room to attend any activities for fear that the staff person will take her bunny.
- The resident's behavior has declined and now cries and expresses fear when taken for bathing and meals without her bunny.
- Based on the resident's behavior, it can be determined that the resident experienced severe psychosocial harm as a result of the mental abuse and corporal punishment

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Staff to Resident Abuse §483.5 Guidance §483.12

Nursing homes have **diverse populations** including, among others, residents with dementia, mental disorders, intellectual disabilities, ethnic/cultural differences, speech/language challenges, and generational differences.

When a nursing home accepts a resident for admission, the facility assumes the responsibility of ensuring the safety and well-being of the resident.

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Examples of Immediate Jeopardy North Dakota

Based on record review, review of facility documents, Medicaid Fraud Control Unit (MFCU) investigation and interview, review of facility policy, and staff interview, **the facility failed to ensure residents remained free from sexual and mental abuse.** Law Enforcement notified facility of an arrest of a staff member who had **inappropriate images/videos of possible residents on an electronic device**

North Dakota Nursing Homes | ProPublica

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Example of Immediate Jeopardy North Dakota

- Based on review of the facility reported incident (FRI) and investigation reports, record review, review of facility policy, and staff and resident interviews, the facility failed to provide an environment free of **verbal abuse from a staff member**

North Dakota Nursing Homes | ProPublica

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Example of Immediate Jeopardy South Dakota

CNAs witnessed the **alleged perpetrator kicked a resident** and a separate incident with a different resident where the alleged perpetrator **put a washcloth over a resident's mouth** to quiet the resident.

South Dakota Nursing Homes | ProPublica

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Example of Immediate Jeopardy Minnesota

- Based on observation, interview, and document review the facility failed to ensure system was in place to **prevent narcotic drug diversion** (misappropriation of resident property) of narcotics, analgesics and benzodiazepines that were diverted over 16 months for several residents

Minnesota Nursing Homes | ProPublica

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Example of Immediate Jeopardy Minnesota

Based on observations, interviews, and record review the **facility failed to protect 2 female residents resident's right to be free from sexual abuse and sexually inappropriate behaviors by male resident**

Minnesota Nursing Homes | ProPublica

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Resident-to-Resident Abuse §483.5 Guidance §483.12

Staff should monitor for any behaviors that may **provoke a reaction** by residents or others, which include, but are not limited to:

- **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**; and
- **Wandering into other's rooms/space**

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Resident-to-Resident Abuse §483.5 GUIDANCE §483.12

Facility Responsibilities:

- Resident **Assessment**
- **Care Planning Interventions** to address a resident's distressed behaviors such as physical, sexual or verbal aggression.
- **Evaluation of the effectiveness of interventions.**
- **Immediate Interventions** to assure the safety of residents, and to prevent resident to resident abuse.
- For example, **redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected**.

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Federal Regulations §483.5 Guidance §483.12

- Because some cases of abuse are not directly observed, understanding resident outcomes of abuse could assist in identifying whether abuse is occurring or has occurred.
- Possible indicators of abuse include, but are not limited to:
  - An injury that is suspicious because the source of the injury is not observed or the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time; and
  - Sudden or unexplained changes in the following behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.

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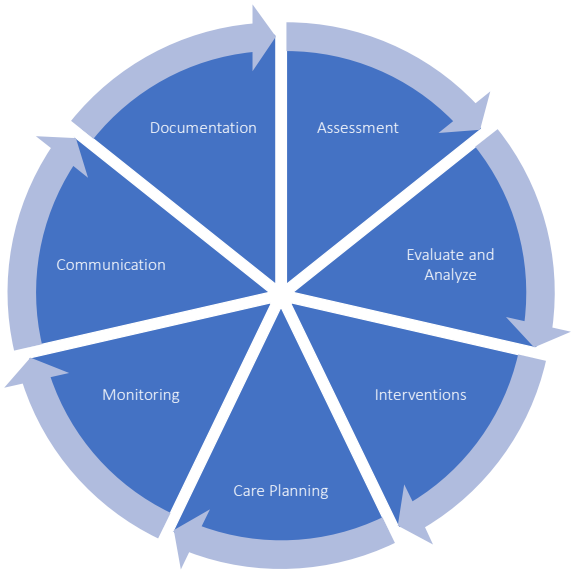
Risk Management Recommendations



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Facility Responsibilities

- Screening
- Training
- Prevention
- Identification
- Investigation
- Protection
- Reporting/Response

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Facility Responsibilities

Employee Screening:

- National Criminal Background Checks
- National Sex Offender Screening
- State Registry Checks

• Residents:

- National Sex Offender Screening
- Trauma Screening
- Social Services Evaluations

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Facility Responsibilities

Employee Training

- During Orientation and At Least Annually
- Signed Zero Tolerance Policy During Orientation and Annually
- Includes – Review of Policy, Abuse, Neglect and Exploitation/Misappropriation of Resident Property Definitions, Recognition of Signs and Symptoms of Abuse, Neglect and Exploitation, Reporting Requirements
- Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond.

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De-escalasting Behavior

Manage Voice Tone and Volume

Remain Calm

Safe Distance, Body Language

Maintain Personal Space

Avoid Pointing, Excessive Gestures

Obtain Help

Source - De-escalation Series | CISA

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Helping Hand

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Facility Responsibilities

Signed Employee Affirmation

- Obtain a Signed Employee Affirmation of No Knowledge of Abuse or Neglect at the Facility That is Obtained at least Annually

Pendulum Risk Management Services

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Prevention

- Current Policies and Procedures
- Trained Shift Leaders (Identification of Inappropriate Behaviors)
- Environmental Rounds
- Appropriate Staffing
- Staff assigned to care for a resident have knowledge of the individual residents' care needs and behavioral symptoms
- Ensuring the health and safety of each resident with regard to visitors

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Identification

- The facility must have written procedures to assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This would include identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services.

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Investigation

- Identification of **Staff Responsible** for the Investigation
- **Exercising caution in handling evidence** that could be used in a criminal investigation (e.g., not tampering or destroying evidence);
- **Investigating different types of alleged violations**;
- **Identifying and interviewing all involved persons**, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;
- **Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred**, the extent, and cause; and
- **Providing complete and thorough documentation of the investigation**

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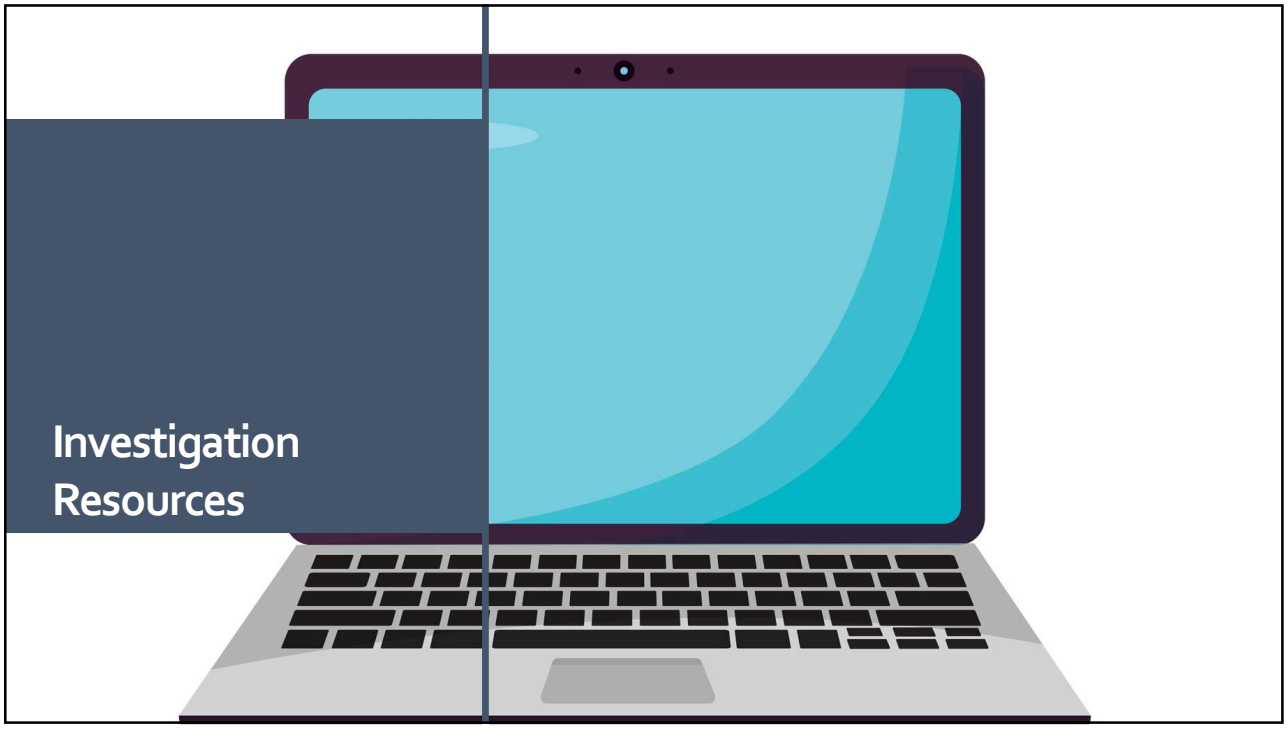

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Reporting Requirements

The facility must have written procedures that ensure that all residents are protected from physical and psychosocial harm during and after the investigation.

The facility must have written procedures that must include:

- Immediately reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes;
- Assuring that reporters are free from retaliation or reprisal;
- *Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint*;
- Reporting 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

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Protection

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Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following:

1. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;
2. Defining how care provision will be changed and/or improved to protect residents receiving services;
3. Training of staff on changes made and demonstration of staff competency after training is implemented;
4. Identification of staff responsible for implementation of corrective actions;
5. The expected date for implementation; and
6. Identification of staff responsible for monitoring the implementation of the plan.

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Action Steps

Taking steps to prevent further potential abuse

- Reporting the alleged violation and investigation within required timeframes
- Conducting a thorough investigation of the alleged violation
- Taking appropriate corrective action and
- The facility must revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse

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Reporting

- Providing residents and representatives, information on how and to whom they may report concerns, incidents and grievances
- Staff Training Mandatory Reporting Requirements – What, Where, When, Who, and to Whom
- Chain of Command

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Reporting Requirements

	42 CFR 483.12(b)(5) and Section 1150B of the Act	42 CFR 483.12(c)
What is to be reported	Any reasonable suspicion of a crime against a resident or an individual receiving care from the facility	1) All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigations of alleged violations
Who is required to report	Any covered individual, which means the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	State Survey Agency (SA) and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., the full range of potential responders to elder abuse, neglect, and exploitation including police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	The facility administrator and to other officials in accordance with State law, including to the SA and the adult protective services where state law provides for jurisdiction in long-term care facilities
When	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury- not later than 24 hours*	All alleged violations- 1) Immediately but not later than 2 hours*- if the alleged violation involves abuse or results in serious bodily injury 2) Not later than 24 hours*- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury Results of all investigations of alleged violations- within 5 working days of the incident

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

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Exploitation – Facility Responsibilities

- The facility failed to assure that a resident's personal property was safeguarded and that staff did not misappropriate resident's property.
- A resident, who had a medical condition in which she had loss of hair, owned two wigs which were personalized for her needs which she used consistently during the daytime hours.
- Staff documented that the resident was "crying loudly, shouting and was hysterical" and when investigated, she stated someone had stolen her wigs over the weekend.
- She stated she told staff and they discounted her complaints. The resident refused to leave her room or see anyone, was extremely agitated, and wanted the police called.
- During the facility investigation, two employees who had worked the evening shift over the weekend, were heard by other staff members, talking and laughing about how they had taken the resident's wigs.

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Exploitation – Facility Responsibilities

The **administrator is responsible** for the overall implementation of the facility policies/procedures to prohibit misappropriation of resident property and exploitation.

This includes the **obligation to report, investigate, protect the alleged victim, and take corrective actions, as necessary**, based upon the outcome of the investigation.

Obtain and review the copy of the investigation report, if any. When he/she was notified of the alleged exploitation/misappropriation, and when the initial report was made to the required agencies and law enforcement as required

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Exploitation – Facility Responsibilities

- **Who was/is responsible for the investigation**, whether it has been completed and the outcome, or whether the investigation is ongoing;
- **When the results of the investigation were reported** to the administrator and to the required agencies;
- **Whether the alleged perpetrator**, if an employee, had **previous warnings** or incidents at the facility;
- **How the alleged victim and other residents at risk of exploitation/misappropriation were protected** during the investigation;

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Exploitation – Facility Responsibilities

- What actions were taken to prevent misappropriation and exploitation after the investigation was completed;
- Whether any changes were necessary to the facility's policies and procedures;
- How the facility assures that retaliation does not occur when staff or a resident reports an allegation of misappropriation of resident property or exploitation;
- What actions have been taken for education of staff and residents regarding the facility's prevention plan and reporting requirements; and
- How does the facility protect the resident's property from loss or theft.

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The Gap

What Does the Policy/ Procedure Say?	What is General Practice?	What Happens During and After an Incident?	What are the Regulations/ Best Practices?	What was Covered in Orientation and Training?	What is the "Gap"?

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Surveyor Questions for Abuse

Abuse Critical Element Pathway

Department Of Health And Human Services Centers For Medicare & Medicaid Services

- Did you have knowledge of the alleged abuse? If so, describe.
- What actions, if any, did you take in response to the allegation?
- If you're familiar with the alleged victim, have you noticed any changes in the alleged victim's behavior as a result of the alleged abuse? If so, describe.
- How did the alleged perpetrator and victim act towards one another prior to and after the incident?
- Did the alleged perpetrator and/or victim exhibit any behaviors that would provoke one another? If so, what actions were taken to address this?
- If the alleged perpetrator was staff, had the alleged perpetrator exhibited inappropriate behaviors to the alleged victim or other residents in the past, such as using derogatory language, rough handling, or ignoring residents while giving care?
- If the alleged perpetrator was a visitor, did the visitor exhibit any inappropriate behaviors in the past or have any indication of risk to the resident(s)?

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Audience Participation

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Audience Participation

- What are the red flags?
- How should staff respond?
- What documentation is needed?

Physical Abuse: "The Bruised Silence"

- **Scenario:** A resident with dementia is found with bruises on her arms and back. When asked, she becomes visibly anxious and avoids eye contact. Staff claim she fell, but the pattern of bruising suggests otherwise.

Source: Microsoft Copilot

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Audience Participation

- What went wrong?
- How could this have been prevented?
- What are the legal implications?

Neglect: "The Forgotten Call Bell"

- **Scenario:** A wheelchair-bound resident is taken to the bathroom and told to ring the bell when ready. She rings repeatedly, but no one responds. Frustrated, she tries to transfer herself and falls, fracturing her hip

Source: Microsoft Copilot

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Audience Participation

•What constitutes emotional abuse?
•How should staff intervene?
•What support should be offered to the resident?

Source: Microsoft Copilot

Emotional Abuse: "The Shouting Match"

- **Scenario:** A nurse is overheard yelling at a resident who refuses to eat. The resident begins crying and later refuses meals altogether.

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Audience Participation

•What are signs of financial abuse?
•What steps should be taken to investigate?
•How can facilities protect residents' assets?

Source: Microsoft Copilot

Financial Exploitation: "Missing Money"

- **Scenario:** A resident's daughter notices frequent ATM withdrawals from her mother's account, even though her mother is bedridden and unaware of the transactions. A staff member is suspected.

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Audience Participation

•How do you recognize sexual abuse in vulnerable populations?
•What are the reporting protocols?
•How do you support the victim?

Sexual Abuse: "The Unspoken Trauma"

- **Scenario:** A resident with cognitive impairment shows signs of distress during bathing and has unexplained bruising in sensitive areas. Staff are unsure how to proceed.

Source: Microsoft Copilot

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Audience Participation

•What is institutional abuse?
•How can staff advocate for change?
•What are the ethical responsibilities?

Institutional Abuse: "Short-Staffed and Overwhelmed"

- **Scenario:** Due to chronic understaffing, residents are left in soiled clothing for hours, meals are delayed, and medications are missed. Complaints are dismissed by management.

Source: Microsoft Copilot

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Audience Participation

- Retaliation: "The Spitting Incident"
- Scenario: A resident spits at a caregiver during breakfast. In retaliation, the caregiver spits back and yells, "Don't you ever spit at me again!

•How should staff handle aggressive behavior from residents?
•What are appropriate disciplinary actions?
•How do you prevent escalation?

Source: Microsoft Copilot

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Today

Claim Trends
Definitions
North Dakota Regulations
Federal Regulations
Examples of Cited Abuse
Reporting Requirements
Risk Management Strategies
Scenarios

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Thank you!

Cyndi Siders

MSN, RN, CPHRM, CPPS, DFASHRM

Executive Consultant

Siders HealthCare Consulting, LLC

csiders@sidershealthcareconsulting.com

517.256.7803

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