F-609 Reporting of Alleged Violations – A Summary of CMS Guidance

This tool is intended to provide a summary of federal regulatory guidance as it applies to investigating allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and reporting Facility Reported Incidents (FRIs). The guidance offers scenarios and situations that may prove helpful in investigating allegations and understanding reporting requirements.

ALL language is sourced directly from the State Operations Manual (SOM) and has not been altered, amended, or paraphrased in any way. It remains the sole responsibility of the health professional, following the Centers for Medicare & Medicaid Services (CMS) requirements, to determine if a given scenario or situation meets requirements for reporting under federal and state regulations.

It may be helpful to review CMS QSEP training modules related to FRI reporting, complaint intake, SOM Chapter 5 requirements, and Abuse & Neglect. Applicable educational training modules are located at https://qsep.cms.gov/ProvidersAndOthers/home.aspx and include:

- Complaint and Incident Intake and Triage
- Complaint and Incident Intake Triage Overview
- Long Term Care Regulatory and Interpretive Guidance and Psychosocial Severity Guide Updates

Additional guidance and resources for use investigating alleged incidents of Abuse & Neglect can be found in CMS Critical Element Pathways (CEP). The Critical Element Pathways may be found using the Survey Resources Link in the Downloads section of the CMS Nursing Home webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.

- CMS-20059 Abuse
- CMS-20130 Neglect

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§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.

(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.

(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

The following table describes the different reporting requirements that are addressed under 42 CFR 483.12:

	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;	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

	prosecutors; medical examiners; investigators; and coroners)	
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

Staff to Resident Abuse

All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services, where state law provides for jurisdiction in nursing homes [see § 483.12(c)].

This includes, but is not limited to:

- All allegations/occurrences of physical, sexual, mental, and verbal abuse, including deprivation of goods and services by staff, and involuntary seclusion perpetrated by staff (See F600 and F603 for examples of types of abuse);
- Staff taking or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging; and
- All reports from residents of abuse perpetrated by staff; allegations must not be dismissed on the basis of a resident's cognitive impairment(s).

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Resident to Resident Altercations

Resident-to-resident altercations that must be reported in accordance with the regulations include any willful action that results in physical injury, mental anguish, or pain, as defined at §483.5. The tables below includes examples of resident to resident altercations and whether they are required to be reported.

Examples of Mental/Verbal Conflict:

Required to Report	**Not Required to Report** **(Unless it rises to the level of what's described in the first column)**
• Intimidation • Bullying- Aggressive behavior in which someone intentionally* and repeatedly causes another resident mental anguish or discomfort** (adapted from the American Psychological Association 2 • Communication that is motivated by an actual or perceived characteristic, such as race, color, religion, sex, disability, or sexual orientation that results in mental anguish or social withdrawal** • Threats of violence • Inappropriate sexual comments that are used in a deliberately* threatening manner • Inappropriate sexual comments that offend, humiliate, or demean a resident**; • Taking and/or distributing demeaning or humiliating photographs or recordings of residents through social media or multimedia messaging	• Non-targeted outbursts • Residents with certain conditions (e.g., Huntington's/Tourette's) who exhibit verbalizations • Arguments or disagreements, which do not include any behavior or communication identified in the "Required to Report" column
NOTE: * Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. ****** There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.	

Examples of Sexual Contact:

Required to Report	Not Required to Report (Unless it rises to the level of what's described in the first column)
• Unwanted touching of the breasts or perineal area • A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues • Sexual activities where one resident indicates that the activity is unwanted through verbal or non-verbal cues • Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown • Sexual assault or battery (ex. rape, sodomy, coerced nudity) • Instances where the alleged victim is transferred to a hospital for examination and/or treatment of injuries resulting from possible sexual abuse • Forced observation of masturbation, or pornography • Forced, coerced or extorted sexual activity • Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident	• Consensual sexual contact between residents who have the capacity to consent to sexual activity • Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or non-verbal cues • Sexual activity between residents in a relationship, married couples or partners, unless one of the residents indicates that the activity is unwanted through verbal or non-verbal

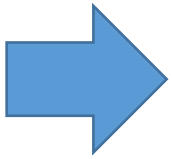
Examples of Physical Altercations

Resident-to-resident physical altercations that must be reported include, any willful action that results in physical injury, mental anguish, or pain. Examples include, but are not limited to, the following:

Examples of Physical Altercations WILLFUL ACTION*

Willful actions include, but are not limited to, the following:
- Hitting
- Slapping
- Punching
- Choking
- Pinching
- Biting
- Kicking
- Throwing objects
- Grabbing
- Shoving

***The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm**



That Results In:

PHYSICAL INJURY

A physical injury resulting from the willful action including, but not limited to, the following:
- Death
- Injury requiring medical attention beyond first aid (such as a cut requiring suturing or an injury requiring transfer to a hospital for examination and/or treatment)
- Fracture(s), subdural hematoma, concussion
- Bruises
- Facial injury(ies), such as broken or missing teeth, facial fractures, black eye(s), bruising, bleeding or swelling of the mouth or cheeks

MENTAL ANGUISH

Psychosocial outcomes resulting from the willful action including, but not limited to, the following:
- Fear of a person or place or of being left alone or of being in the dark, disturbed sleep, nightmares
- Changes in behavior, including aggressive or disruptive behavior toward a specific person
- Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts

***** There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident.

PAIN

Pain resulting from the willful action including, but not limited to, the following:
- Complaints of pain related to the altercation
- Onset of pain evidenced by nonverbal indicators, such as
  - o Groaning, crying, screaming
  - o Grimacing, clenching of the jaw
  - o Resistance to being touched
  - o Rubbing/guarding body part

The general examples of physical altercations below illustrate possible cases that would likely **NOT** need to be reported, as long as it is not a willful action that results in physical injury, mental anguish, or pain. Every case is fact specific and all facts, circumstances and conditions involving the event/occurrence would need to be examined.

- A resident lightly taps another resident to stop an irritating behavior or get attention, with no resulting physical injury, mental anguish, or pain.
- A resident who is slow, impedes the pathway of another resident, such as in the dining room, the other resident nudges the resident out of the way to get to his/her table faster, but there is no harm to the victim.
- A resident who swats at another resident who is trying to take some food off his/her plate, and no physical injury, mental anguish, or pain has occurred.

NOTE: Even if a physical altercation is not required to be reported, the facility should take into consideration that physical altercations can increase the risk for abuse to occur to residents involved in the altercation, and possibly other residents in the facility. The facility must meet requirements related to appropriate assessment (see § 483.20 – Resident Assessment), care planning by the interdisciplinary team (see § 483.21-Comprehensive Person-Centered Care Planning), and provide care and services according to acceptable standards of practice [see §483.21(b)(3)(i)- Tag F658] to prevent harm as a result of resident to resident altercations, as well as the development and implementation of policies and procedures to prevent abuse of residents [see § 483.12(b)(1)- Tag F607)].

Through these actions, the facility can determine areas of needed improvement in care/service provision, staff training or staff deployment.

Reporting Suspicious Injuries of Unknown Source

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when ALL of the following criteria are met:

- The source of the injury was not observed by any person; **and**
- The source of the injury could not be explained by the resident; **and**
- The injury is suspicious because of:
  a. The extent of the injury, or
  b. The location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or
  c. The number of injuries observed at one particular point in time, or
  d. The incidence of injuries over time.

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Examples of Injuries of Unknown Source Required to Report	**Not Required to Report** (**Unless it rises to the level of what's described in the first column)**
• Unobserved/Unexplained fractures, sprains or dislocations • Unobserved/Unexplained injuries that could have resulted from a burn, including blisters or scalds • Unobserved/Unexplained bite marks • Unobserved/Unexplained scratches and bruises found in suspicious locations such as the head, neck, upper chest or back • Unobserved/Unexplained swelling that is not linked to a medical condition • Unobserved/Unexplained lacerations with or without bleeding • Unobserved/Unexplained skin tears in sites found in suspicious locations (e.g., in sites other than the arms or legs) • Unobserved/Unexplained skin tears in patterns (e.g., bilateral, symmetrical skin tears on both arms) • Unobserved/Unexplained patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object • Unobserved/Unexplained bilateral bruising to arms, bilateral bruising of the inner thighs, "wrap around" bruises that encircle the legs, arms or torso, and multicolored bruises which would indicate that several injuries were acquired over time. • Unobserved/Unexplained facial injuries, including facial fractures, black eye(s), bruising, or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth • Unobserved/Unexplained bruising or other injuries in the genital area, inner thighs, or breasts • Unobserved/unexplained injury requiring transfer to a hospital for examination and/or treatment	• Bruising in an area where the resident has had recent medical tests/lab draws and there is no indication of abuse or neglect • Injuries where the resident was able to explain or describe how he/she received the injury as long as there is no other indication of abuse or neglect • Injuries that were witnessed by staff, where there is no indication of abuse or neglect **NOTE: Even if the injury is not one that requires a report, the facility should adequately assess and monitor the resident, notify the physician/resident representative as appropriate, and document the injury and investigation as a part of the resident's medical record.**

NOTE: Any injury that is explained and appears to be a result of abuse must be reported.	

Reportable Events Related to Potential Neglect

"Neglect," means "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." (See §483.5) In other words, neglect occurs when the facility is aware, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for resident care, comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress. There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's position would be impacted by the incident.

Examples of events to be reported include, but are not limited to, the following:

1. Failure to meet payroll or pay supplier bills resulting in residents not receiving goods or services, such as
   - Insufficient staff (including the night shift and weekends) resulting in the lack of provision for resident's care needs (e.g., residents who need continuous skilled nursing care or supervision, residents with cognitive deficits requiring continuous supervision); or
   - Lack of essential supplies or equipment such as incontinence supplies, wound care supplies, or oxygen equipment or adaptive equipment according to the needs of the resident(s); or
   - Lack of sufficient amounts of food to meet the residents' nutritional needs.

2. Staff repeatedly ignoring residents' needs for assistance with activities of daily living, resulting in residents remaining in bed when they want to be up and repeatedly missing activities; or residents being left in fecal material or urine.

3. Failure to oversee the management of pain for a resident resulting in a resident not receiving required medications or treatments, leading to prolonged excruciating pain.

4. Failure to implement and monitor care planned interventions, resulting in repeated failures to provide necessary care and services to prevent the development a new avoidable pressure ulcer that develops into a Stage 3 or 4 pressure ulcer.

NOTE: Noncompliance at the Resident's Rights/Quality of Care/Quality of Life tag alone does not automatically indicate noncompliance at F600, or F609. The survey team would need additional evidence that identifies that the facility knew, or should have known, to provide necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident's needs, but failed to take action, resulting in harm to the resident. For example, a survey team identifies that a facility had failed to perform a skin assessment for a resident, resulting in failure to implement interventions to prevent the development of an avoidable Stage 2 pressure ulcer for a resident. Upon further investigation, the survey team finds that the facility identified the pressure ulcer and treated it with no further worsening. While the survey team would identify noncompliance at F686, the facility would not be cited at F600 and the facility would not be expected to report this as an alleged violation of neglect.

Evaluating Elopement:

"Elopement" is defined by CMS within Appendix PP of the SOM as:

> "A situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.
>
> A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts."

Investigations of situations or allegations of elopement should utilize the Potential Neglect criteria, including CMS-20130 Neglect CEP, within findings driving decisions regarding reporting.

Reportable Allegations of Misappropriation of Resident Property and Exploitation

The facility must exercise reasonable care for the protection of the resident's property from loss or theft. See tag F584, 42 CFR §483.10(i)(1)(ii). The facility is expected to be responsive to a resident's concerns about lost items.

"Exploitation," as defined at §483.5, means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Misappropriation of resident property," as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

Examples of allegations of misappropriation of resident property and exploitation that must be reported include, but are not limited to:

- Theft of personal property, including but not limited to jewelry, computer, phone, and other valuable items such as eyeglasses and hearing aids;
- Unauthorized/coerced use by staff of resident's personal property;
- Theft of money from bank accounts;
- Unauthorized or coerced purchases on a resident's credit card;
- Unauthorized or coerced purchases from resident's funds;
- Staff who accept money from a resident for any reason including when staff have made the resident believe that staff was in a financial crisis or the resident believes that he/she is in a relationship with the staff person;
- A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion; and
- Missing prescription medications or diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain.

Examples of allegations that would not be reported are:

- Theft of nominal items with little to no monetary or sentimental value;
- Lost items that are not listed under "must be reported."

Reportable Allegations of Mistreatment

"Mistreatment," as defined at §483.5, is "inappropriate treatment or exploitation of a resident."

Allegations of mistreatment should be reported only if they meet the criteria for reporting alleged violations of abuse and/or exploitation, which are described under the Sections above.

For any allegation - Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602 and F603 as investigative tools

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Resources:

CMS State Operations Manual / Appendix PP Revised 02/03/2023 https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

CMS Survey Documents including Critical Element Pathways https://www.cms.gov/files/zip/survey-resources.zip

- **NOTE:** This link opens a zip file with a historical storage of all survey related documents.

LARA FRI Guidance Webpage https://www.michigan.gov/lara/bureau-list/bchs/nav-longterm-care/fri