**Purpose**

1. Each Ohio Living community will take measures to prevent abuse, neglect, misappropriation of property, seclusion, exploitation and mistreatment caused by anyone, including facility staff, other residents, consultants, visitors, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals
2. At any time resident/client abuse is suspected or alleged, an immediate investigation will take place and the proper authorities will be notified immediately.

**Definitions**

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| 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*.* |
| Neglect | 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. |
| Physical Abuse | Includes hitting, slapping, pinching, kicking. It also includes controlling behavior through corporal punishment |
| Mental Abuse | Willfully subjecting resident / client to humiliation, harassment, threats of punishment or deprivation |
| Verbal Abuse | The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability.  Examples of verbal abuse include:   * Threats of harm * Saying things to frighten a resident |
| Sexual Abuse | Sexual abuse is non-consensual sexual contact of any type with a resident. |
| Misappropriation of Property | The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent. |
| Involuntary Seclusion | Involuntary seclusion is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident’s will, or the will of the resident’s legal representative. |
| Exploitation | Exploitation means taking advantage of a resident for personal gain using manipulation, intimidation, threats, or coercion. |
| Mistreatment | Mistreatment is inappropriate treatment or exploitation of a resident. |
| Willful | Is defined as “means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm”. |
| Injury of Unknown Source | An injury of unknown source exits when the following conditions exist:   1. The source was not observed by any person or could not be explained by the resident **and** 2. The injury is suspicious due to the extent of the injury, the location of the injury, the number of injuries observed at one point in time, or the incident of injuries over time. |
| Adverse Event | An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. |

**Orientation and Training**

1. All Communities will train employees through orientation and ongoing sessions on issues related to abuse prohibition practices, including:
   1. All allegations of abuse, neglect and/or misappropriations are to be reported **immediately** (means as soon as they have knowledge of the abuse/allegation)to the staff nurse, supervisor in charge, Unit Manager, Director of Nursing or Administrator.
   2. Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property
   3. Dementia management and resident abuse prevention.
   4. Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents
   5. How staff should report their knowledge related to allegations without fear of retaliation against any employee who lawfully reports a reasonable suspicion of a crime
   6. How to recognize signs of burnout, frustration and stress that may lead to abuse, and
   7. What constitutes abuse, neglect, and misappropriation or resident property

**Screening of Employees**

1. Prior to hiring, Ohio Living completes the following screenings to eliminate persons with a past history of abuse or neglect of resident/ clients.
   1. Drug Screening
   2. Criminal background check with fingerprinting
   3. Reference checks (documented attempts for 2 references)
   4. Primary source verification of professional licensure
   5. Verify State Tested Nursing Assistant status with the Ohio Nursing Assistant Registry.
   6. Check Social Security number on other state’s Approved Nursing Assistant Registry if indicated

**Identification of Abuse**

1. All allegations of abuse, neglect and misappropriation will be reported immediately and will be investigated.
2. All injuries of unknown source will be fully investigated for possible abuse
3. The community will cooperate with appropriate law enforcement agencies to resolve the issue through legal means

**Resident to Resident Abuse**

1. Generally, the 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.
   1. A resident lightly taps another resident to stop an irritating behavior or get attention, with no resulting physical injury, mental anguish, or pain.
   2. 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 his/her table faster, but there is no harm to the victim.
   3. 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.
2. Occurrences or threats of resident to resident abuse will be:
   1. Diffused by separating the residents involved in the event
      1. In the event that a room change is needed:
         1. For one of the roommates, if neither roommate chooses to move voluntarily the resident who has been the aggressor will be moved
         2. If roommates are mutually aggressive the IDT will decide which resident will benefit the most from a move
   2. Maintained in separate locations until the situation is investigated and steps are taken to prevent reoccurrence which may include:
      1. Temporary room assignments or
      2. Close supervision during the investigation period
      3. Use of emergency restraints (physical or chemical)
      4. Discharge to a mental health or acute care facility
3. Any resident to resident abuse will be reported to:
   1. The legal representative or concerned family member
   2. The physician
   3. The community’s district state health department office if applicable

**Investigation of Allegations or Suspicion of Abuse**

1. To investigate a claim or suspected abuse, management staff should:
   1. Immediately provide for the safety of the resident/client through appropriate means. This might include any of the following:
      1. Remove from service any suspected employee, volunteer, consultant, or other service provider until the investigation is complete
      2. Suspend the employee alleged to be involved until completion of the investigation (HR Policy # 170.010). The employee must be informed that the suspension is for the length of time needed for the investigation, and that further disciplinary action may occur. This must be authorized by the Human Resources Department if it is for more than 3 working days.
      3. Remove the resident to another area if they or their sponsor agree to this arrangement
      4. Provide for supervision of resident to assure safety if suspect is a family member/ friend or unrelated party
   2. Notify the resident, legal guardian, or sponsor, of the allegation and process.
   3. Notify the Ohio Department of Health and follow the instructions in the section titled “Reporting Abuse,” under “External Reporting”
   4. The investigative process may include all or some of the following dependent upon the situation in question:
   5. Interview the resident/ victim
   6. Examine the resident for marks/ bruises / other indications of abuse/ neglect
   7. Interview the alleged wrongdoer. The individual suspected of abuse must be treated as “innocent until proven guilty.” They should be interviewed with the same care and confidentiality as the witnesses
   8. Interview facility staff / employees/ persons used by the facility, with first-hand knowledge of the incident
   9. Interview other residents with first-hand knowledge of the incident
   10. Interview other persons / family members with first-hand knowledge of the incident
   11. Obtain written statements from all those interviewed. The interviewer may document a written record if there is a telephone interview

**Reporting of Abuse**

1. Internal Reporting
   1. All staff members are trained to report abuse, including resident-to-resident abuse, **immediately** (means as soon as they have knowledge of the abuse/allegation)to the staff nurse, supervisor in charge, Unit Manager, Director of Nursing or Administrator.
   2. All employees who know or suspect that a resident or client has been abused or neglected, or that a resident’s property has been misappropriated, must report that knowledge or suspicion to their supervisor immediately.
   3. Staff, residents and their families are informed of:
2. The rights of residents to be free from abuse and neglect
3. How to report allegations of abuse or neglect
4. Facility grievance policy
5. The Corporate Compliance Hotline number 1-877-780-9366
6. The Ohio Department of Health Patient Abuse Hotline 1-800-64ABUSE (22873)
   1. The supervisor must immediately notify the Administrator, DON and/or Executive Director of all allegations of abuse. The Executive Director, DON or Administrator will direct the action to be taken
   2. The Community’s Director of Human Resources will be notified to assist in the investigative process, if this involves an employee
   3. The names of the persons reporting or providing information during investigation will be kept confidential within the community. Only those persons directing or implementing the investigative process will have access to these reports
   4. Results will be maintained as confidential and released only to authorized representatives of the regulatory or law enforcement agencies
7. Provide information on how to report incidents.

### Provide residents, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retaliation.

### Provide information that Ohio law prohibits persons from making false accusations against others.

### Post information in the Health Center and Assisted Living for reporting abuse/neglect and suspected abuse/neglect.

1. External Reporting of alleged abuse involving residents
2. *For allegations occurring in the Health Center,* Immediately but not later than 2 hours (reporting requirement under this regulation are based on real clock time, not business hours) if the alleged violation involves abuse or results in serious bodily injury. 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. The Administrator, Director of Nursing or designee must log on to the Department of Health EIDC reporting website at: <https://odhgateway.odh.ohio.gov/>
   1. Choose “Self Reported Incident” and complete as much as you can
   2. The results of a thorough investigation must be concluded within five (5) days of the incident.
3. *For allegations occurring in Assisted Living*, the reporter will log on to the Department of Health EIDC reporting website at: <https://odhgateway.odh.ohio.gov/>
   1. The incident must be reported and completed within five (5) days of the initial report
   2. If the resident is receiving Medicaid Waiver benefits the Ohio Department of Aging or its designee will be notified within one business day after becoming aware of any reasonable cause to believe an individual suffered abuse, neglect, or exploitation.
4. Reporting crimes occurring to residents or suspicion of crimes in the skilled nursing facility
5. Examples of crimes would include but are not limited to:
   * + 1. Murder
       2. Manslaughter
       3. Rape
       4. Assault & Battery
       5. Sexual Abuse
       6. Theft/Robbery
       7. Drug diversion for personal use or gain
       8. Identity Theft
       9. Fraud & Forgery
     1. Annually, covered individuals (each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility) will be notified of their obligation to report crime or suspicion of a crime occurring to residents and anyone receiving care in the facility to the Ohio Department of Health and one or more law enforcement agencies.
     2. The covered individual shall report 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.