Neglect Critical Element Pathway

Use this pathway for concerns in structures or processes that have led to resident outcome such as unrelieved pain, avoidable pressure injuries, poor grooming, avoidable dehydration, lack of continence care, or malnourishment. Neglect may be the outcome of systemic or repeated patterns of care delivery failures throughout the nursing home, such as insufficient staffing, or may be the effect of one or more delivery failures involving one resident and one staff person.

If conducting a complaint investigation regarding an allegation of neglect, utilize appropriate Critical Element Pathways for care issues, such as pressure ulcers, injuries, incontinence care, etc., in order to identify whether noncompliance for a care concern exists first. Then if structure or process failures are identified, refer to this pathway.

Refer to the Investigative Protocol for F607/F609-Reporting Reasonable Suspicion of a Crime, if a covered individual did not report a reasonable suspicion of a crime or an allegation of retaliation against staff for reporting. If the surveyor discovers a reasonable suspicion of a crime committed against a resident of, or an individual receiving services from, the facility and it has not been reported by a covered individual, the surveyor reminds the facility of the covered individuals' obligation to report suspected crimes to the appropriate agencies within the required timeframes. "Covered individual" is anyone who is an owner, operator, employee, manager, agent or contractor of the facility. If a covered individual reports the suspected crime to local law enforcement, the surveyor must verify that the report was made (e.g., obtain time/date of report, name of person who received report, case number, etc.). If the covered individual refuses to report, or the surveyor cannot verify that a report was done, the surveyor must consult with his/her supervisor immediately, and the SA must report the potential criminal incident to law enforcement immediately.

Review the Following in Advance:

- ☐ Identify information from investigation of the relevant care areas to determine whether additional observations, interviews, and record reviews are necessary to evaluate whether the facility has the structures and processes necessary to provide goods and services to residents.

Interviews with Staff Working During the Time the Alleged Neglect Occurred:

- ☐ Why do you think the alleged neglect occurred?
- ☐ How did staff respond when the resident requested assistance?
- ☐ What do you consider as neglect?
- ☐ What do you do if you suspect that a resident is not receiving necessary care and services?
- ☐ Were you aware of the care not being provided? If so, who and when did you report it to? What actions were taken by the nursing home? If you did not report your concerns, why not?
- ☐ Has retaliation occurred as a result of reporting neglect? If so, what actions were taken against staff?
- ☐ What training have you received from the facility on neglect identification, prevention, and reporting requirements? NOTE: If the staff member has not received training, ask other staff members whether they have received training.

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Supervisory Staff Interviews from Relevant Departments Related to the Alleged Neglect:

- ☐ How do you monitor and provide oversight in order to assure care and services are implemented based upon the care plan and the resident's identified needs, and if there is an acute change of condition?
- ☐ How do you monitor staff/resident interactions?
- ☐ How do you monitor for the deployment of sufficient numbers of qualified and competent staff across all shifts to meet resident needs?
- ☐ How do you determine staffing assignments based on the levels and types of care needed for the resident(s)?
- ☐ How do you and staff communicate across shifts?
- ☐ How do you monitor for staff burnout, which could contribute to neglect?
- ☐ How is orientation provided for temporary or pool staff?
- ☐ Why do you think the alleged neglect occurred?
- ☐ If there are concerns, such as insufficient staffing or lack of availability of food, medications or supplies, did you report this to administration? Why or why not? If reported, what was the response?

Facility Investigator Interview:

- ☐ Were you responsible for the initial reporting and the overall investigation of the alleged neglect? (Obtain a copy of the investigation report, if any.)
- ☐ When were you notified of the allegation and by whom?
- ☐ When and what actions were taken to protect the resident(s) from further potential neglect while the investigation was in process?
- ☐ What steps were taken to investigate the allegation? What was the timeline of events that occurred?
- ☐ What happened as a result of the investigation?
- ☐ Who received the results of the investigation and when?
- ☐ What related information regarding the allegation is not included in the investigation report?

NOTE: Refer to F609 for further investigation if the facility did not have a copy of the investigation report available.

Administrator Interview:

- ☐ When were you notified of the alleged neglect?
- ☐ What deficits in care/services/resources (e.g., insufficient staffing, lack of supplies) were you notified about?
- ☐ If you were notified, what actions did you take to respond to concerns?
- ☐ What actions were taken to prevent further potential neglect during and after the investigation was completed?
- ☐ How do you assure that retaliation does not occur when staff or a resident reports an allegation of neglect?

Quality Assurance Interview:

- ☐ How does the committee provide monitoring and oversight of cases of verified neglect?
- ☐ Did the QAA Committee make any recommendations and/or take any corrective actions based on the results of the investigation, such as policy revisions or training to prevent neglect?

- ☐ When did the QAA Committee receive the results of the investigation for the verified case of neglect?

Record Review:

- ☐ Review policies and procedures that identify the structures and processes in place to provide needed care and services. Review only those policies regarding the neglect that is being investigated.
- ☐ How does the facility determine and monitor sufficient numbers of staff, temporary staff, consultants, contractors, and volunteers?
- ☐ How does the facility determine the type of staff, such as qualified registered, licensed, certified staff (in accordance with State licensing rules) that are competent and have the knowledge and skills necessary for the provision of care and services that they are assigned?
- ☐ What are the duties of direct care staff to meet resident needs? Who is responsible for monitoring the delivery of care at the bedside?
- ☐ What type of orientation and training program exists for staff, including temporary staff, contractors, consultants, and volunteers, including but not limited to policies, specific resident care, services and treatments, neglect, dementia care, abuse and other interventions necessary to meet a resident's needs?
- ☐ How does the facility establish resident care policies and procedures to assure that staff have written direction in accordance with current standards of practice that address resident diagnoses and provide clinical and technical direction to meet the needs of each resident admitted?
- ☐ How does staff communicate relevant resident care information to other staff, health care practitioners, consultants, and the resident or resident representative?
- ☐ How are annual performance evaluations for direct care staff conducted and how is staff performance evaluated?
- ☐ How does the facility provide ongoing maintenance and calibration of resident care equipment and devices, based on manufacturer's instructions?
- ☐ How does the facility ensure a safe and sanitary environment, including all buildings, furnishings, equipment, provision of fire safety, maintenance department, laundry services, dietary services, rehabilitation, and other services?
- ☐ How does the facility provide adequate resident care supplies (e.g., food, medications, linens) to meet resident needs?
- ☐ Review processes including the actual care or services provided:
  - Were there initial and ongoing assessments that reviewed the clinical needs of the resident including any acute changes in condition? If not, describe;
  - Was a resident-specific plan of care in place, including the ongoing evaluation and revision of the care plan as necessary;
  - Was there ongoing monitoring and supervision of staff to ensure the implementation of the care plan as written; and
  - Was there effective communication between staff, health care practitioners, and the resident or resident representative?
- ☐ Review staff schedules:
  - Who was working at the time of the alleged neglect;
  - How is it determined how many staff are required to care for the residents and the actual number of staff assigned to the residents; and
  - What types of resident care are required, depending on resident acuity, resident needs, and the number of residents?

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☐ Review personnel records of staff present and directly involved in the allegation of neglect during the time of alleged neglect:

- Do they have a finding of abuse, neglect, misappropriation, exploitation, or mistreatment by a court of law? Have they had a finding entered into the State nurse aide registry? Has there been a disciplinary action in effect against the individual's professional license? If so, describe;
- Were annual performance reviews conducted? Was there a history of problems with care delivery? What disciplinary actions and/or training were provided related to performance deficits;
- How does the facility conduct competency evaluation and training for licensed staff including pool/temporary staff for the types of interventions required, as applicable, such as CPR, IV therapy, oxygen therapy, and mechanical ventilation; and
- What is the scope of practice for staff assigned to provide care and services during the alleged neglect?

☐ If pool/temporary staff were involved in the situation of neglect:

- What type of orientation was provided for pool/temporary staff regarding the facility policies/procedures?
- How does the facility ensure that pool/temporary staff have knowledge of resident-specific interventions as identified in the care plan? How does the facility assure that pool/temporary staff have completed training to perform CPR, as required, to residents in the facility?

Neglect Critical Element Pathway

Critical Elements Decisions:

1) Did the facility protect the resident's right to be free from neglect?
   If No, cite F600

2) Did the facility hire or engage staff who have:
   - Not been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law?
   - Not had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a disciplinary action taken by a state professional licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriation of resident property?
   - Not had a successful appeal of their disqualification from employment?

   AND/OR

   Did the facility report to the State nurse aide registry or licensing authorities any knowledge of actions taken by a court of law that would indicate unfitness as a staff member of a nursing home?
   If No, cite F606

3) Did the facility develop and implement written policies and procedures that prohibit and prevent neglect, establish policies and procedures to investigate any such allegations, include training as required at paragraph §483.95, establish coordination with the QAPI program required under §483.75, and post signage of employee rights related to retaliation against the employee for reporting a suspected crime?
   If No, cite F607

4) For alleged violations of neglect, did the facility:
   - Develop policies and procedures related to ensuring the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases) and notifying covered individuals annually of their reporting obligations;
   - Identify the situation as an alleged violation involving neglect, including injuries of unknown source;
   - Report immediately to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law; and
   - Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?

   If No, cite F609

5) For alleged violations of neglect, did the facility:
   - Prevent further potential neglect;
   - Initiate and complete a thorough investigation of the alleged violation;
   - Maintain documentation that the alleged violation was thoroughly investigated; and
   - Take corrective action following the investigation?

   If No, cite F610

6) Did the facility develop, implement, and maintain an effective training program for all new and existing staff that includes training on activities that constitute neglect, procedures for reporting incidents of neglect, and dementia management and resident abuse prevention?
   If No, cite F943

7) Does the facility's in-service training for nurse aides include resident abuse prevention?
   If No, cite F947

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Grievances F585, Sufficient and Competent Staffing (Task), Administration F835, Governing Body F837, Facility Assessment F838, Medical Director F841, and QAPI/QAA (Task).