

OFFICE OF LONG TERM CARE

LONG TERM CARE FACILITY RESIDENT-TO-RESIDENT MALTREATMENT REPORTING GUIDANCE

There are two issues here that arise from a report. The first is whether the facility acted negligently – this determines whether the facility is cited for a deficiency. The second is whether a staff member acted in a manner contrary to facility requirements – this determines whether a staff member receives a finding from OLTC and is barred from employment. Each needs to be addressed separately, although each possibility exists from any single event.

Regarding the first issue - determining whether a resident-to-resident event is considered maltreatment **by the facility** and thus reportable to OLTC – the issue is always whether there was neglect by the facility. That is, if the facility knew, or should have known, of a resident’s propensity or probability to attack and failed to protect other residents by not instituting measures reasonably designed to prevent those attacks, the facility is negligent and any attack would be reported. This is the case for all resident-to-resident events. It does not matter the nature of the attack – physical, sexual, emotional or verbal abuse – the issue will always be whether the facility knew or should have known of the likelihood of the attack, and whether the facility took all reasonable steps to prevent it. As an example, assume Resident A has periods of emotional outbursts coupled with physical aggression. Has the facility assessed Resident A to try and determine what triggers these events? Did the facility institute practices (not just policies, but actually set up safeguards) to prevent the event? Were those practices actually performed? If the answer is, “No” to **any** of those questions, then there is neglect.

It is the third question (were the practices followed) that leads to the second issue – whether the neglect was **staff** neglect or abuse. When a resident-to-resident event occurs, the matter should be reported to OLTC if there is reasonable cause to suspect that it resulted due to the acts or omissions of a staff member who was acting outside of procedures or practices. Assume that the facility has done all it was required to do – it assessed the resident, developed protocols to prevent an event, implemented the practices to actually prevent the event – and the event occurs anyway. A good example is when a facility institutes one-on-one staffing for a resident. If the staff member leaves the resident unattended, then the staff member (not the facility) was neglectful, and finding would be made against the staff member. The only exception to this is if the neglect was not the fault of the staff member. For example, if the facility institutes one-on-one, but then doesn’t staff sufficiently such that the staff member has to leave a resident unattended due to an emergency, then the staff member was not negligent – the facility was negligent. Another example would be if the facility institutes one-on-one, but doesn’t provide a protocol for “handing off” a resident from staff to staff. If the staff member leaves thinking that another

staff member was taking over, and the second staff members doesn't know or believe that the resident is the second staff member's responsibility, then the cause was the facility's failure to properly develop protocols. Again, the event must be reported **unless the facility is absolutely certain** that neglect by facility or staff was not a cause of the event.

Bear in mind, though, that the facility does not have the option of first investigating to determine the answer to those questions. That's the purpose of the time between the initial report and the final facility report or determination. So, if you have a resident that has never shown any indication of aggression, the facility does not have to report to OLTC **so long as the facility had no reason to suspect that resident would act aggressively or the facility has no reason to suspect that staff acted negligently or outside protocols**. Otherwise, the facility should report the event as a possible neglect, and detail the nature of the resident-to-resident aggression. OLTC will not make a finding based on the initial report alone, so the facility or staff doesn't face any deficiencies or findings at that point. If the facility then discovers through the investigation that the facility had assessed, instituted practices to prevent the event or to protect other residents, and that those practices were actually being performed at the time of the event, the facility would not face deficiencies and the staff would not face a finding. Note that while an initial report alone won't result in a deficiency or a finding, a poorly written or incomplete report could result in OLTC conducting an investigation that results in deficiencies or findings – that's why it's important that the facility document all information in the initial report – the nature of any injuries, the diagnoses of the resident or resident, what actions have been implemented to protect that resident and other residents from additional maltreatment while the investigation is being conducted, etc.

Another point to make is staff abuse as it contributes to resident-to-resident events. Assume that a staff member provokes a resident to attack another resident, or provokes a resident to the point that the resident acts out by attacking another resident – this would be staff **abuse** as opposed to neglect and is clearly reportable as abuse. Essentially, the staff member used a resident as a weapon against another resident – it's really no different than if the staff member picked up a club and struck a resident. Different weapon, but a weapon nonetheless.