

RESIDENT-TO-RESIDENT MISTREATMENT: LONG-TERM CARE OMBUDSMAN ADVOCACY

Terminology and definitions used to describe resident-to-resident mistreatment (RRM) vary, but for this reference guide RRM is defined as “negative and aggressive physical, sexual, or verbal interactions between long-term care residents that (as in a community setting) would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.”¹ Incidents of RRM include physical, verbal, and sexual abuse and are likely to cause emotional and/or physical harm. However, not all incidents of resident-to-resident mistreatment are considered “abuse,” meaning that the resident involved did not willfully harm the other resident. Other examples of RRM include: roommate conflicts, invasion of privacy and personal space, verbal threats and harassment, unwanted sexual behavior, using personal property without permission, and destroying personal property.

The purpose of this reference guide is to provide an overview of resident-to-resident mistreatment to assist Long-Term Care Ombudsman (LTCO) programs in effectively responding to complaints involving resident-to-resident mistreatment, as well as help prevent RRM and reduce the prevalence of these incidents.

Learn about Resident-to-Resident Mistreatment (RRM)

Incidents of resident-to-resident mistreatment occur in all types of long-term care facilities, including nursing homes, assisted living and other residential facilities. Although LTCO advocacy approaches may differ depending on the incident, residents involved, type of facility, and size of the facility, the LTCO advocacy strategies and recommendations to prevent and reduce incidents of RRM provided in this resource are applicable to all long-term care communities.

Resident-to-resident mistreatment is a serious issue that has a significant negative impact on all residents involved, but incidents are often not reported and investigated. Research regarding the prevalence of RRM is limited, yet information from a variety of sources suggests RRM occurs frequently. Despite these limitations a variety of possible risk factors for RRM have been identified.² A primary risk factor is cognitive impairment, in fact, one study found that “cognitive impairment, and worsening cognitive impairment in particular, conferred a five-fold risk of mistreatment in victims.”³

¹ Jeanne A. Teresi, Mildred Ramirez, Julie Ellis, Stephanie Silver, Gabriel Boratgis, Jian Kong, Joseph P. Eimicke, Karl Pillemer, and Mark S. Lachs. *A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial*. *International Journal of Nursing Studies* (2013), 644–656.

² Information in charts from: Division of Geriatrics and Palliative Care, Weill Cornell Medical College, Cornell University and Research Division, Hebrew Home at Riverdale. *Documentation of Resident to Resident Elder Mistreatment in Residential Care Facilities*. Mark Lachs, Jeanne A. Teresi, Mildred Ramirez, Karl Pillemer, Joy Soloman, and Kimberly van Hattisma (March 28, 2014) and Eilon Caspi, *Deaths as a Result of Resident-to-Resident Altercations in Dementia in Long-term Care Homes: A Needs for Research, Policy, and Intervention*. Editorial, *JAMDA* (2016).

³ Tony Rosen, Karl Pillemer, and Mark Lachs, *Resident-to-resident aggression in long-term care facilities: An understudied problem*, *Aggression and Violent Behavior* (2008), doi: [10.1016/j.avb.2007.12.001](https://doi.org/10.1016/j.avb.2007.12.001)

RISK FACTORS	
Resident Characteristics	Facility Characteristics (environmental and care)
Residents with significant cognitive impairments such as dementia and mental illness.	Inadequate number of staff.
Residents with behavioral symptoms related to dementia or other cognitive impairment that may be disruptive to others (e.g., yelling, repetitive behaviors, calling for help, entering other's rooms).	Lack of staff training about individualized care to support residents' needs, capabilities, and rights (e.g., resident-centered care, abuse prevention, care for those with limited capacity, dementia, and mental health needs).
Residents with a history of aggressive behavior and/or negative interactions with others.	High number of residents with dementia.
	Lack of meaningful activities and engagement.
	Crowded common areas (e.g., too many residents in one room, equipment/obstacles in common areas).
	Excessive noise.

Understand the Importance of Individualized Care in Preventing and Reducing RRM

A 2014 study of resident-to-resident mistreatment found that “a person-centered approach to the management and prevention of these incidents is crucial” and “it is through identifying incidents and documenting them, that patterns of resident’s behaviors can be identified, and individual strategies planned, implemented, and assessed.”⁴

As experts in residents' rights and person-centered care, it is critical that LTCOPs advocate for comprehensive assessment and care planning for residents to receive individualized care.

Regardless of the type of long-term care facility, all residents have the right to live in a safe environment that supports each resident's individuality and ensures they are treated with respect and dignity. Since there are no federal regulations for assisted living facilities (also known as board and care or residential care facilities) requirements are different in each state; however, all states require that residents be protected from abuse, neglect and exploitation. LTCOs are encouraged to be familiar with applicable state requirements for these facilities.

Federal requirements and surveyor guidance for nursing homes certified as a Medicare and/or Medicaid nursing home provider emphasize the importance of individualized care planning to prevent and reduce incidents of RRM. The Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP, Guidance to Surveyors for Long Term Care Facilities, states that the “facility is responsible for identifying residents who have a history of disruptive or intrusive interactions, or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility should identify the factors (e.g., pain, specific triggers in the environment, change in physical and/or emotional health, etc.) that increase the risks associated with individual residents, including those that could trigger an altercation. The interdisciplinary team reviews the assessment along with the resident and/or his/her representative, to address the underlying reasons for the behavioral manifestations and to identify interventions to try to prevent altercations.”⁵ The chart below provides recommendations to prevent and reduce incidents of RRM that LTCOs can share with all long-term care providers as they are applicable to residents in nursing homes and assisted living facilities.⁶

⁴ Lachs, M., Teresi, J., Ramirez, M. 2014. *Documentation of Resident to Resident Elder Mistreatment in Residential Care Facilities*. Doc. No. 246429. Award No. 2009-IJ-CX-0001.

⁵ CMS SOM Appendix PP F689. 42 CFR §483.25(d). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>

⁶ Recommendations from RRM research and CMS SOM Appendix PP. F689. Links to additional information, such as “Culture Change” and “Abuse, Neglect, and Exploitation in Long-Term Care Facilities” is available in the “Issues” section of the NORC website www.ltcombudsman.org.

Recommendations to Prevent and Reduce Incidents of RRM

Environmental Considerations	Care Practices
Clear common areas of clutter, reduce noise, and overcrowding.	Develop comprehensive care plans. Provide individualized, resident-centered care, and implement best practices for supporting residents with behavioral symptoms related to cognitive impairment.
Provide areas for supervised, unrestricted, safe movement.	LTC facility staff training (including training on person-centered care, dementia and mental illness) and facility policies regarding how to prevent, recognize, respond, report, and document RRM.
Identify environmental influences on behavior and adjust accordingly (e.g., temperature, lighting).	Identify residents with risk factors for RRM, and a history of RRM, and develop care plans to address their needs and monitor closely.
Promote meaningful activities and opportunities for engagement for all residents based on individual needs, interests, and abilities.	Identify root causes of behavioral symptoms and reduce or eliminate those causes (e.g., pain, boredom, loneliness).
	Implement consistent staffing assignments so staff and residents are more comfortable with each other and staff are more familiar with resident needs and changes in behavior.
	Ensure adequate staffing levels to meet resident needs and provide supervision.

Speak with Residents about Their Rights and RRM

LTC Ombudsman programs may provide residents (and Resident Councils) with information regarding their rights, especially their right to be free from harm, including resident-to-resident mistreatment. Fact sheets regarding residents' rights and individualized care, including a brochure and large font fact sheet about Resident-to-Resident Mistreatment, are available on the **National Consumer Voice for Quality Long-Term Care (Consumer Voice)** website.⁷

Discuss the Responsibilities of Long-Term Care Providers to Provide Individualized Care, Protect All Residents from Mistreatment, and Respond to Incidents of RRM

Share information and resources regarding the responsibilities of long-term care providers in supporting residents' rights, protecting residents from mistreatment, and reporting allegations of abuse.⁸

As stated earlier, there are no federal requirements for assisted living facilities so LTCOs are encouraged to become familiar with state regulations and share applicable information regarding provider responsibilities to ensure the safety of all residents and investigate and report incidents.

According to the CMS SOM Appendix PP, Guidance to Surveyors (F600 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation), in Medicare and/or Medicaid certified nursing homes, if a resident "willfully"

⁷ National Consumer Voice for Quality Long-Term Care (Consumer Voice) <http://theconsumervoice.org/issues/recipients> and the National Long-Term Care Resource Center (NORC) <http://www.ltombudsman.org>

⁸ Find links to the federal nursing home requirements on the CMS Nursing Home webpage (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>), and in the NORC Library (http://ltombudsman.org/library/fed_laws/federal-nursing-home-regulations)

harmed another resident the incident is to be reviewed as abuse by surveyors and reported as abuse by facility staff. However, if a resident did not intend to harm the other resident (or intent cannot be determined) the incident is to be considered a “resident-to-resident altercation” and would be reviewed by the survey under tag F689 [42 CFR §483.25(d)] to “determine if the facility ensured that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision to prevent accidents related to resident-to-resident altercations where the resident’s action is not willful.”⁹ Regardless of intent or whether the incident is considered abuse or a crime, “CMS expects long-term care facilities to take any necessary action to prevent resident-to-resident altercations to every extent possible.”¹⁰ In addition to sharing consumer fact sheets regarding RRM with providers, residents, family members, and others (link below in “Resources”), LTCO programs may offer to provide in-service training regarding residents’ rights, individualized care, and prevention of RRM and mistreatment.

Regardless of intent, all residents have the right to be protected from mistreatment and facilities are required to ensure the safety of all residents and investigate allegations of abuse and incidents of mistreatment.

Include Information about RRM in Training for LTCO Staff and Volunteers

Include information about RRM in training for LTCO program representatives (staff and volunteers), especially when discussing the role of LTCO in responding to allegations of mistreatment. Resources regarding resident mistreatment include: the **NORC Curriculum**, examples of LTCOP initial certification training manuals, and NORC training materials and webinars (link below in “Resources”).

LTCOP Advocacy Strategies

LTCOP responses to complaints involving resident-to-resident mistreatment may include, but are not limited to, the following:¹¹

- Request consent to pursue a complaint from the resident(s) or representative(s) of the resident(s).
- Determine appropriateness of what, if any, resident-identifying information can be disclosed, based on resident (or resident representative) consent;
- Ensure the facility has addressed the immediate safety needs of all impacted residents (to the extent possible in consideration of disclosure limitations).
- Communicate with your supervisor (e.g., a volunteer consults with their staff LTCO) and follow applicable state LTCO program policies and procedures regarding consultation, communication, and complaint investigation. For example, in a situation involving two residents consult with your supervisor to determine how best to advocate for all residents involved (e.g., do you advocate for both residents or does each resident need a separate advocate).
- Support the resident(s), as much as the resident(s) want you involved, during the complaint investigation process.
- Seek resident(s) direction for resolution and provide information about available services (e.g., facility social worker, counseling, behavioral health).

⁹ “Willful” as defined at §483.5 and as used in the definition of “abuse,” “means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...even though a resident may have a cognitive impairment, he/she could still commit a willful act.” CMS SOM Appendix PP. F689. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

¹⁰ CMS Survey & Certification Memo. S&C 11-3-NH. Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_30.pdf

¹¹ See Responding to Allegations of Abuse: Role and Responsibilities of Long-Term Care Ombudsmen for additional advocacy strategies. <http://ltcombudsman.org/uploads/files/support/ane-no-consent-ref-guide.pdf>

LTCOP Advocacy Strategies (continued)

- Advocate that the facility provides thorough a assessment and care planning, for each impacted resident after the incident. Planning should include measures to maintain resident safety, meet their needs after the incident (e.g. counseling), and prevent future incidents (e.g., modification of the environment, separation of residents, proper staff supervision).
- Discuss potential risk factors of RRM that may have been involved in the specific situation and how to address those factors (e.g., environmental considerations, behavioral symptoms, additional staff training needs).
- Remind the facility of their requirement to document, investigate, and report the incident per federal and/or state requirements, as applicable.
- Share information with the facility administrator and staff about responding to, and preventing future, incidents of RRM (such as the "Recommendations to Prevent and Reduce Incidents of RRM" chart from this brief).

Pertinent Federal Nursing Home Requirements

Information below is from the Centers for Medicaid and Medicare Services (CMS) State Operations Manual, Appendix PP, Guidance to Surveyors for Long-Term Care Facilities and adapted for length (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>).

§483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must—

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

GUIDANCE §483.12(a)(1)

Resident to Resident Abuse of Any Type

A resident to resident altercation should be reviewed as a potential situation of abuse. When investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term "willful".

The word "willful" means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate ("willful") action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. If it is determined that the action was not willful (a deliberate action), the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible, and that each resident receives adequate supervision (See F689).

The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection 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.

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.

Also, resident to resident abuse could involve a resident who has had no prior history of aggressive behaviors, since a resident's behavior could quickly escalate into an instance of abuse. For example, a resident pushes away or strikes another resident who is rummaging through his/her possessions.

F689

§483.25(d) Accidents.

The facility must ensure that –

(1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

GUIDANCE §483.25(d)

Resident-to-Resident Altercations

NOTE: A resident to resident altercation should be reviewed as a potential situation of abuse which should be investigated under the guidance for 42 CFR §483.12, (F600). The surveyor should not automatically assume that abuse did not occur for a resident identified as having a cognitive impairment or mental disorder, as it does not preclude the resident from deliberate (willful) or non-accidental actions. "Willful" as defined at §483.5 and as used in the definition of "abuse," "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." Even though a resident may have a cognitive impairment, he/she could still commit a willful act. If during the investigation of an allegation of abuse, it is determined that the action was not willful, the surveyor must investigate whether the facility is in compliance with the requirement to maintain an environment as free of accident hazards as possible, and that each resident receives adequate supervision using guidance at this tag, F689, Accidents.

It is important that a facility take reasonable precautions, including providing adequate supervision, when the risk of resident-to-resident altercation is identified, or should have been identified. Certain situations or conditions may increase the potential for such altercations, including, but not limited to:

- A history of aggressive behaviors including striking out, verbal outbursts, or negative interactions with other resident(s); and/or

- Behavior that may disrupt or annoy others such as constant verbalization (e.g., crying, yelling, calling out for help), making negative remarks, restlessness, repetitive behaviors, taking items that do not belong to them, going into others' rooms, drawers, or closets, and undressing in inappropriate areas. Although these behaviors may not be aggressive in nature, they may precipitate a negative response from others, resulting in verbal, physical, and/or emotional harm.

The facility is responsible for identifying residents who have a history of disruptive or intrusive interactions, or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility should identify the factors (e.g., pain, specific triggers in the environment, etc.) that increase the risks associated with individual residents, including those that could trigger an altercation. The interdisciplinary team reviews the assessment along with the resident and/or his/her representative, in order to address the underlying reasons for the behavioral manifestations and to identify interventions to try to prevent altercations.

The interventions listed below include supervision and other actions that could address potential or actual negative interactions:

- Evaluating staffing levels to ensure adequate supervision (if it is adequate, it is meeting the resident's needs) (refer to F725, §483.35(a)(1)(2), to evaluate staffing levels for any nursing services not related to behavioral health care or dementia care and F741, §483.40, for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder);
- Evaluating staffing assignments to ensure consistent staff who are more familiar with the resident and who thus may be able to identify changes in a resident's condition and behavior;
- Providing safe supervised areas for unrestricted movement;
- Eliminating or reducing underlying causes of distressed behavior such as boredom and pain;
- Monitoring environmental influences such as temperatures, lighting, and noise levels; and

Ongoing staff training, competencies and supervision, including how to approach a resident who may be agitated, combative, verbally or physically aggressive, or anxious, and how and when to obtain assistance in managing a resident with behavior symptoms (refer to F726, §483.35(a)(3)(4)(c), to evaluate staff competency for any nursing services not related to behavioral health care or dementia care and F741, §483.40, for any staff caring for residents with dementia or a history of trauma and/or post-traumatic stress disorder).



RESOURCES

National Long-Term Care Ombudsman Resource Center (NORC)

- **Abuse** <http://ltcombudsman.org/issues/abuse-neglect-and-exploitation-in-long-term-care-facilities>
- **Culture Change Issue page** (information regarding individualized care and LTCOP advocacy) <http://ltcombudsman.org/issues/culture-change>
- **Ombudsman Training** (NORC Curriculum, Training Programs and In-Services, LTCOP Certification Manuals, NORC Training and Webinars) <http://www.ltcombudsman.org/ombudsman-support/training>

National Consumer Voice for Quality Long-Term Care (Consumer Voice)

- **Resident-to-Resident Mistreatment Brochure** <http://theconsumervoice.org/uploads/files/issues/rrm-brochure-508-compliant.pdf>
- Information for LTC consumers, including fact sheets regarding individualized care (individuals living in nursing homes, assisted living, or receiving home and community-based services care) <http://theconsumervoice.org/issues/recipients>

- Resources for family members <http://theconsumervoic.org/issues/family>
- Resources for advocates (resident-directed care information and fact sheets) <http://theconsumervoic.org/issues/for-advocates>

National Center on Elder Abuse (NCEA)

- For additional information regarding elder abuse, neglect or exploitation visit the NCEA website at <https://ncea.acl.gov/> or call 1-855-500-3537.
- Locate a local or state elder abuse coalition or learn how to create or participate in an effective elder abuse taskforce: <https://ncea.acl.gov/resources/state.html>

CONTACT US

If you have questions about this brief or would like to share some of your LTCOP's activities or challenges regarding resident-to-resident mistreatment, please email ombudcenter@theconsumervoic.org or call 202-332-2275.

The National Long-Term Care Ombudsman Resource Center (NORC) is a program of the National Consumer Voice for Quality Long-Term Care (the "Consumer Voice"). This project was supported, in part, by grant number 900MRC0001-01-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.