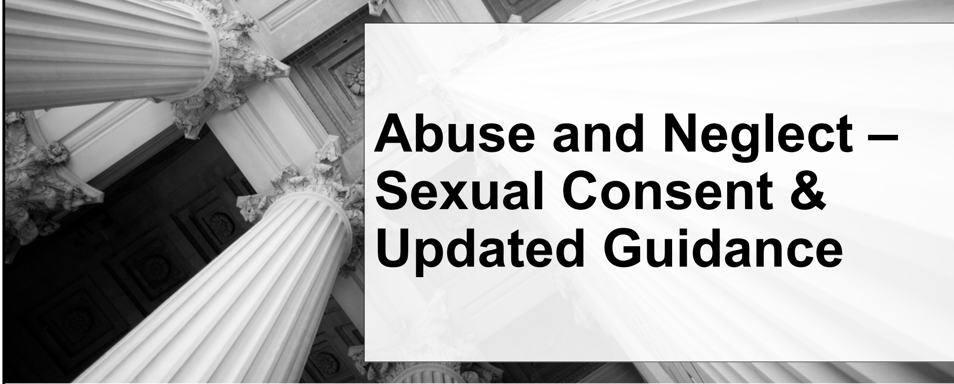
THCA Annual Convention & Trade Show



Abuse and Neglect – Sexual Consent & Updated Guidance

Presented by: Shelly Maffia, Director of Regulatory Services, Proactive LTC Consulting, Evansville, IN
Sean Fahey, Attorney, Hall Render, Indianapolis, IN

Objectives

- Understand new surveyor guidance on abuse and neglect prevention and reporting for nursing homes.
- Understand CMS guidance on how to determine if a resident has the capacity and ability to consent to sexual activity.
- Recent issues in abuse and neglect in DAB decisions.

Revised Surveyor Guidance

Abuse and Neglect Updates

QSO-22-19-NH Revised LTC Surveyor Guidance

- Issued June 29, 2022
  - Revisions to Phase 2 guidance
  - New guidance for Phase 3 RoP
  - New guidance on arbitration requirements
  - Revised guidance for Psychosocial Outcome Severity Guide
- Guidance effective as of Oct. 24, 2022

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-22-19-NH

DATE: **June 29, 2022**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: **Revised Long-Term Care Surveyor Guidance:**
Revisions to Surveyor Guidance for Phases 2 & 3, Arbitration Agreement Requirements, Investigating Complaints & Facility Reported Incidents, and the Psychosocial Outcome Severity Guide

Memorandum Summary

- **Revised Surveyor Guidance:** CMS is releasing the following guidance and associated training for nursing home surveyors:
  - Phase 2 and 3 Requirements: Clarifications and technical corrections of Phase 2 guidance issued in 2017, and new guidance for Phase 3 requirements which went into effect in November 28, 2019.
  - Arbitration Requirements: Guidance on the new requirements which became effective September 16, 2019.
- **Effective Date:** Surveyors will begin using this guidance to identify noncompliance on October 24, 2022. This will allow for ample time for surveyors and facilities to be trained on this new information.
- **Training Resources:** Training on guidance for surveyors and providers will be available upon release of this memorandum.
- **Complaint and Facility Reported Incidents (FRIs):** CMS revised the guidance in Chapter 5 and related exhibits of the State Operations Manual (SOM) to strengthen the oversight of nursing home complaints and FRIs. CMS also revised its guidance for all Medicare-certified provider/supplier types to improve consistency across the State agencies in their communication to complainants.
- **Psychosocial Outcome Severity Guide:** CMS revised guidance to clarify the reasonable person concept and examples across the different severity levels.

Page 1 of 6

F600 Freedom From Abuse, Neglect, & Exploitation Changes

- Clarifications regarding facility reportable events
  - Examples of situations that are reportable vs. not reportable
  - What information needs to be reported
  - Reporting timelines
- Reminds that not all resident-to-resident altercations result in abuse
- Must take steps to ensure resident is protected from abuse, including evaluating whether resident has capacity to consent to sexual activity.
- Prior to citing as past-noncompliance, surveyors must investigate thoroughly to determine if facility took all appropriate actions to correct noncompliance & determine date on which facility had returned to substantial compliance

F600 Freedom From Abuse, Neglect, & Exploitation Changes

- Neglect definition expanded
  - Includes cases where facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress
  - New example provided – "*Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives" (CMS, Appendix PP)*
- New language to be included in SOD for abuse citations:
  - *"Based on [observations/interviews/record review], the facility failed to protect the resident's(s') right to be free from [Type(s) of abuse: mental abuse/verbal abuse/physical abuse/sexual abuse/deprivation of goods and services] by [Perpetrator type: staff/a resident/a visitor]…."*
- New guidance for use of Psychosocial Outcome Severity Guide to determine severity of psychosocial outcome or potential outcome

F607 Develop/Implement Abuse Policies Changes

- New definitions added related reporting reasonable suspicion of crimes – covered individual, crime, law enforcement, serious bodily injury, criminal sexual abuse
- Abuse policy & procedures should address:
  - Post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint;
  - Prohibiting retaliation against an employee who reports a suspicion of a crime
  - How staff will communicate and coordinate situations of abuse/neglect with QAPI program
    - Physical or sexual abuse cases always require corrective actions & tracking by QAA committee

F609 Reporting of Alleged Violations

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; prosecutors; medical examiners; investigators; and coroners)*	*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*
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*

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- There are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to be reasonable suspicion of a crime.
  - In these cases, the facility is obligated to report to the administrator, to the state survey agency, and to other officials in accordance with State law (see F609).
  - Regardless, covered individuals still have the obligation to report the reasonable suspicion of a crime to the State Survey Agency and local law enforcement.

Sample Form for Initial Reporting – Exhibit 358

See Handout

Initial Report

It is important that the facility provide as much information as possible, to the best of its knowledge, at the time of submission of the report.

1. Facility Information

Facility Name:
CMS Certification Number (CCN):
Address:
Phone number:
Email address

2. Allegation Type

Select all that apply to the reporting incident.

Abuse specify whether:	Physical	Sexual	Mental/Verbal
Deprivation of Goods and Services by Staff			
Neglect	Misappropriation of Resident Property/Exploitation		
Injury of Unknown Source	Suspected Crime		

3. Information about when the Facility became aware of the incident

Date/Time/Name of when staff became aware of the incident
Date/Time administrator was notified of the incident and by whom

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Sample Follow-Up Investigation Report Exhibit 359

Exhibit 359

Follow-up Investigation Report

Within five (5) business days of the incident, the facility must provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified. It is important that the facility provide as much information as possible, to the best of its knowledge at the time of submission of the report. The facility should include any updates to information provided in the initial report and the following additional information, which should include, but are not limited to, the following:

1. Additional/Updated Information Related to the Reported Incident:

Provide a brief description of any additional information and/or updates, if applicable.

Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm
Whether the allegation was reported to the resident representative, and if so, date/time
Whether the allegation was reported to another agency (e.g., nurse aide registry or professional licensing boards if staff to resident abuse), and if so, which agency, date/time, and outcome if they conducted an investigation

2. Steps taken to investigate the allegation:

Provide a detailed summary of ALL steps taken to investigate allegation.

Summary of interview(s) with the alleged victim and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress
Summary of interview(s) with witness(es), what the individual observed or knowledge of the alleged incident or injury

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- Within 5 working days of the incident, must provide report with sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified
- Provide as much information as possible, to best of your knowledge
- Include any updates to information provided in initial report

F609 Reporting of Alleged Violations Staff to Resident Abuse

Type of Abuse	Required to Report	Not Required to Report
Mental/Verbal Conflict	• Intimidation • Bullying • Communication that is motivated by an actual or perceived characteristic (i.e., 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 required to report column

F609 Reporting of Alleged Violations Staff to Resident Abuse

Type of Abuse	Required to Report	Not Required to Report
Sexual Contact	• Unwanted touching of breasts or perineal area • Sexual activities where one resident indicates the activity is unwanted through verbal or non-verbal cues • Sexual activity or fondling where one of resident's capacity to consent is unknown • Sexual assault or battery (ex. Rape, sodomy, coerced nudity) • Instances where alleged victim is transferred to hospital for exam 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 purpose of sexual arousal or gratification resulting in degradation or humiliation of another resident	• Consensual sexual contact between resident who have capacity to consent to sexual activity • Affectionate contact such as hand holding, hugging, or kissing with resident who indicates consent to 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 cues

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:

*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* ○ *Groaning, crying, screaming* ○ *Grimacing, clenching of the jaw* ○ *Resistance to being touched* ○ *Rubbing/guarding body part*

NOTE:
** Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions.*

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F609 Reporting of Alleged Violations

F609 Reporting of Alleged Violations Reporting Suspicious Injuries of Unknown Source

Type of Abuse	Required to Report	Not Required to Report
Injuries of Unknown Source *NOTE: If there is a reasonable suspicion of a crime having occurred related to the injury, covered individuals must report to the State Survey Agency and law enforcement under required timeframes (See Tag F609).*	Unobserved/Unexplained • Fractures, sprains or dislocations • Injuries that could have resulted from a burn, including blisters or scalds • Bite marks • Scratches and bruises found in suspicious locations such as the head, neck, upper chest or back • Swelling that is not linked to a medical condition • Lacerations with or without bleeding • Skin tears in sites found in suspicious locations (e.g., in sites other than the arms or legs) • Skin tears in patterns (e.g., bilateral, symmetrical skin tears on both arms) • Patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object • 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. • 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 • Bruising or other injuries in the genital area, inner thighs, or breasts • Injury requiring transfer to hospital for exam and/or treatment NOTE: Any injury that is explained and appears to be a result of abuse must be reported.	• 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 injury is not one that requires a report, facility should adequately assess & monitor resident, notify MD/RP, and document injury & investigation as part of medical record

F609 Reporting of Alleged Violations Reportable Events Related to Potential Neglect

- Examples of events to be reported include, but are not limited to, the following:
  - Failure to meet payroll or pay supplier bills resulting in residents not receiving goods or services
  - 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.
  - 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.
  - 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.

F609 Reporting of Alleged Violations Reportable Allegations of Misappropriation of Property & Exploitation

Type of Abuse	Required to Report	Not Required to Report
Misappropriation of resident property & exploitation	• 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	• Theft of nominal items with little to no monetary or sentimental value; • Lost items that are not listed under "must be reported

Responding to Allegations

Abuse and Neglect

Response to Alleged Sexual Abuse

- If an allegation of sexual abuse has been reported, the facility must immediately:
  - ✓Protect the alleged victim(s) involved,
  - ✓Evaluate whether resident has the capacity to consent to sexual activity
  - ✓Report the alleged violations to the Administrator and appropriate State and local authorities, and
  - ✓Begin an investigation of the allegation.
- Do not tamper with evidence while conducting investigation
  - Examples of tampering include, but are not limited to:
    - washing linens or clothing,
    - destroying documentation,
    - bathing or cleaning the resident until the resident has been examined (including a rape kit, if appropriate), or otherwise impeding a law enforcement investigation.

Protection

- Monitoring of the alleged victim and other residents at risk, such as conducting unannounced management visits at different times and shifts;
- Evaluation of whether the alleged victim feels safe and if the he/she does not feel safe, taking immediate steps to alleviate the fear, such as a room relocation, increased supervision, etc.;
- Immediate assessment of the alleged victim and provision of medical treatment as necessary;
- Immediate notification of the alleged victim’s practitioner and the family or responsible party;
- Removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents;
- Notification of the alleged violation to other agencies or law enforcement authorities; and
- Informed and involve administrative staff, including the administrator, as necessary in the investigation

Corrective Actions

- Must take appropriate corrective action to protect resident
  - Oversee implementation of corrective action
  - Evaluate whether corrective action is effective
  - Determine whether more systemic actions may be necessary to prevent recurrence of situation
  - QAA committee involvement in monitoring the reporting & investigation, including assurances that residents are protected from further occurrences & that corrective actions are implemented as necessary

Coordination with QAA Committee

- QAA committee tracking & review of abuse allegations
  - Was a thorough investigation conducted?
  - Is the resident protected?
  - Was an analysis conducted as to why the situation occurred?
  - Risk factors that contributed the abuse
- Is there further need for systemic action?
  - Policy & procedure revisions
  - Increased training
  - Resident/Family education about how to report allegations
  - Measures to verify corrective actions implemented
  - Tracking patterns of similar occurrences

Capacity & Ability to Consent to Sexual Activity

Abuse and Neglect

Sexual Behaviors

- 2022 Survey – Kansas
- Among 60 administrations, 84% reported any sexual expression among residents in their community within the past year.
- The most common forms of behavior reported included sexual talk (67.2%) and individual sexual acts (62.7%), implied sexual acts (45.8%), interactional sexual acts (34.5%), sexual relationships (27.1%)
- 55% reported expressions involving an individual with cognitive impairment.
- These steps should include evaluating whether the resident has the capacity to consent to sexual activity.

Rights vs. Abuse

- Under the resident rights provisions, nursing home residents generally have a right to
  - a dignified existence
  - self-determination
  - personal privacy
  - share a room with their spouse who is also a resident of the facility if both of them consent
  - receive visitors at all times, including visits from a spouse or domestic partner.

F600 §483.12 Freedom from Abuse Capacity and Consent

- If suspect resident may not have capacity to consent to sexual activity, must take steps to ensure that the resident is protected from abuse
  - These steps should include evaluating whether the resident has the capacity to consent to sexual activity.

Considerations Concerning Evaluation of Capacity to Consent

- Unless adjudicated as lacking capacity, all individuals are presumed to have capacity for personal decisions
  - Neither advanced age or cognitive impairment in themselves are sufficient to declare incapacity to consent
- No universal set of criteria for sexual consent
- Legal standards & criteria for sexual consent vary across states
  - Most commonly endorsed criteria are:
    1. Knowledge of relevant information, including risks/benefits
    2. Understanding or reasoning which is consistent with individual values
    3. Voluntariness of consent, free from undue influence or coercion

Source: (AMDA, 2016)

Assessment of Capacity to Consent

1. Knowledge of relevant information, including risks/benefits
   - Does individual know:
     - The nature of the sexual activity in which they are engaging?
     - The risks of STDs?
     - How to tell if partner desires the activity?
     - Appropriate times and places for particular sexual activities?
     - With whom they are engaging the activity?
2. Understanding or reasoning which is consistent with individual values
   - Does he/she have capacity for the reasoning process inherent to sexual consent including:
     - Understanding of sexual options?
     - Consequences of sexual choices?
     - Consistency with his/her values and preferences?
3. Voluntariness of consent, free from undue influence or coercion
   - Is the sexual choice a voluntary choice?

Source: (AMDA, 2016)

Additional Considerations

- Diagnosis
  - Dementia – diagnosis itself is not necessarily indicative of incapacity
- Cognitive Factors
  - Attention
  - Memory
  - Executive function
- Psychiatric and Emotional Factors
  - Depression
  - Anxiety
  - Fear of abandonment/loneliness
- Personal Values

Source: (AMDA, 2016)

Assessment of Sexual Consent Capacity

- Resident's awareness of the relationship
  a) Is resident aware of who is initiating sexual contact?
  b) Does resident believe the other person is a spouse and, thus, acquiesces out of a delusional belief, or is he/she cognizant of the other's identity & intent?
  c) Can resident state what level of sexual intimacy he/she would be comfortable with?
- Resident's ability to avoid exploitation
  a) Is the behavior consistent with formerly held beliefs/values?
  b) Does resident have capacity to say no to uninvited sexual contact?
- Resident's awareness of potential risks:
  a) Does resident realize that this relationship my be time limited?
  b) Can resident describe how he/she will react when the relationship ends?
- Key: Ability to refuse sexual advances.

Source: (AMDA, 2016)

Recent Issues in DAB Decisions

Abuse and Neglect

Iowa Man Found Not Guilty of Sexually Abusing Wife With Alzheimer's

An Iowa jury on Wednesday found 78-year-old Henry Rayhons not guilty of charges that he sexually abused his wife by having sex with her in a nursing home after the staff told him her Alzheimer's rendered her cognitively unable to give consent.

Iowa Rape Case Raises Question of Whether a Wife with Dementia Can Consent to Sex

Consensual Sexual Interactions

- Iowa Code Section 709 was the basis of the sexual abuse charges.
- Sexual abuse in the third degree under Section 709.4 could be charged where a sex act "is done by force or against the will of the other person." That provision did not seem to apply.
- Charges could also be brought where the act is between persons who are not cohabiting as husband and wife, "if any of the following" is true: "The other person is suffering from a mental defect or incapacity which precludes giving consent."
- Section 709.1A of the Act defines "incapacitation" to include "mentally incapacitated" or "physically incapacitated" and neither quite seemed to apply.

Consensual Sexual Interactions

- Under Iowa law, "mentally incapacitated" means that a person is "temporarily incapable of apprising or controlling the person's own conduct due to the influence of a narcotic, anesthetic, or intoxicating substance." And "physically incapacitated" means that a person has a bodily impairment or handicap that substantially limits the person's ability to resist or flee."
- So, how was the husband charged?
- He was charged under Section 709.4 (2)(a) on the grounds that his wife, with whom he was not "cohabiting," suffered from a "mental defect" that precluded giving consent.

In the

United States Court of Appeals

For the Seventh Circuit

No. 18-2147

NEIGHBORS REHABILITATION CENTER, LLC,

Petitioner,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEPARTMENTAL APPEALS BOARD, and CENTERS FOR MEDICARE AND MEDICAID SERVICES,

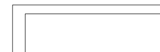
Respondents.

Consensual Sexual Interactions

- Facility allowed residents to have consensual sexual interactions and that supervisors told the facility’s staff that they were not to intervene or report sexual interactions unless a participant showed outward signs of non-consent.
- The staff did not follow up after the sexual interactions and continued to follow a non-intervention policy.

Consensual Sexual Interactions

- One of the facility’s staff members stated that, per the facility’s policy, she was taught to “just separate, if no one resisting then it is ok.”
- Another staff member said she was “taught to provide privacy and intervene if there is protesting by one of the residents.”
- The investigation centered on the sexual interactions between three residents with dementia and/or Alzheimer’s to determine if the facility had violated regulation.

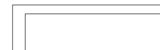


Consensual Sexual Interactions

- ALJ: Facility had taken “meager action” to determine whether the two residents consented to the interactions, only belatedly inquiring with the residents as to the nature of the interactions.
- One resident’s lack of memory as to the incidents was only reflective of his Alzheimer’s and could not be interpreted as consent.
- Other resident’s denial of any relationship with the resident should have caused concern because it was “at best, misleading.”
- Both resident statements “should have prompted further investigation.”

Court

- The Court of Appeals identified that:
  - the facility’s staff was familiar with the residents’ capabilities and behavior;
  - the facility did not undertake any investigation into whether the interactions were consensual or whether the residents had the capacity to consent;
  - the staff did not talk to the residents about their feelings about these “relationships”; and
  - the staff did not document the residents’ capacity for consent (or lack thereof).



CMP $83,000

- United States Court of Appeals for the Seventh Circuit released an opinion that confirmed a CMS assessment of an immediate jeopardy citation and an **$83,800 civil money penalty** against a nursing home for inadequately addressing sexual interactions between cognitively impaired nursing home residents.

Policy

- Survey: Facility had a policy regarding sexual expression? 40.0%.
- Define – Sexual Expression
  - actions motivated by the desire for sexual gratification
- Rights
  - to engage in sexual expression.
  - to access explicit content
  - to access private spaces

POLICIES AND PROCEDURES

CONCERNING SEXUAL EXPRESSION

Policy

POLICIES AND PROCEDURES

CONCERNING SEXUAL EXPRESSION

- Assessment
  - involving cognitively impaired residents, the relevant Interdisciplinary Care Team will make clinical determinations weighing the relative benefits or potential harm associated with the resident's sexual expression
- Staff
  - function and responsibility of staff to uphold and facilitate resident sexual expression
  - maintain awareness of sexual expression
  - when to intervene
  - recommend use of private space

References

- AMDA The Society for Post-Acute & Long-Term Care Medicine. (2016). Capacity for sexual consent in dementia in long-term care. https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care
- Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists. American Psychological Association and American Bar Association. Available at http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf. Accessed 01/03/23.
- Centers for Medicare and Medicaid Services. (2017). Nursing homes- Centers for Medicare and Medicaid Services. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html