# Preventing Resident-to-Resident Abuse

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September 22nd, 2026 – Virtual

LARA
LICENSING AND REGULATORY AFFAIRS

# Why Are We Talking About This?

- F600 is now among the Top 10 most-cited federal regulations.
- Nursing home populations are changing.
- Prevention is just as important as response.

# Today's Objectives

- Describe the F600 regulation related to resident-to-resident abuse.
- Define resident-to-resident abuse under F600.
- Identify resident risk factors and warning signs.
- Discuss prevention strategies and effective interventions.

# Resident Rights Under F600

**Residents have the right to be free from:**

- Abuse,
- Neglect,
- Exploitation,
- And Misappropriation.

**Facility Responsibilities:**

- Prevent,
- Protect,
- Investigate,
- Correct.

Resident #1 and Resident #2 are cognitively intact roommates. They disagree several times a week over the television, the temperature of the room, and the lights in the room. Staff hear them exchanging insults and tell them to, “work it out.”

Over several weeks, the arguments increase. One day, R1 throws R2’s belonging into the hallway. R2 responds by pushing R1, who falls and fractures their hip.

# Intent vs. Willful

**CMS focuses on *Willful*, not *Intent:***

- Swinging an object at a resident.
- Striking a resident with an object.
- Punching.
- Pushing.
- Kicking.
- Slapping.
- Inappropriate and unwanted touch.
- Verbal.

# Residents at Risk

- Wandering.
- Wrong room entry.
- Verbal threats.
- Delusions.
- Poor impulse control.
- Prior aggression.
- Taking items from other residents.

# Wandering Is Not Always Harmless

**Wandering becomes concerning when residents:**

- Enter other residents' rooms.
- Touch belongings.
- Wake sleeping residents.
- Refuse to leave.
- Invade personal space.

## Resident-to-Resident Abuse Is Not Limited to Dementia

- Cognitive impairment is not required.
- F600 applies regardless of diagnosis.
- Focus on behaviors, risk, and resident protection.
- Individualized assessment and interventions.

# Care Planning: Does It Match the Resident?

**Common Survey Findings:**

- Behaviors are not care planned.
- Care plans do not reflect actual behaviors.
- Interventions are too vague.
- Staff are not aware of the plan.

# Effective Interventions

- Increased supervision during high-risk times.
- Redirect before wrong room entry.
- Meaningful activities.
- Structured routines.
- Separate, re-evaluate seating.
- Environmental modification.
- Behavior tracking.
- Frequent staff communication.
- Increase staffing.

# Ask Yourself...

**Because these questions are what surveyors will be asking:**

- Can the CNA tell me the interventions?
- Does agency staff know?
- Are interventions actually happening?
- Is everyone communicating?

# A Summary of What Surveyors Are Investigating

- Was the potential risk for resident-to-resident abuse recognized?
- Were assessments completed?
- Were interventions individualized?
- Were they implemented?
- Were they revised?
- Were vulnerable residents protected?

# Last Thoughts

- Recognize warning signs early.
- Communicate.
- Care plan.
- Reassess.
- Protect residents.

**References:**

State Operations Manual  Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Critical Element pathway for F600.
Textbook source: Understanding and Preventing Harmful Interactions Between Resident with Dementia written by Eilon Caspi Ph.d (Published 10/25/21).
Guidelines-for-assessment-and-interventions.pdf
Resident-to-resident aggression in long-term care facilities: Prevalence and risk factors - Yan - 2023 - Journal of the American Geriatrics Society - Wiley Online Library

# Resident-To-Resident Case #1

## Prevention, Intervention, and QAPI

Recognize Earlier. Respond Safely. Improve Continuously.

Sandy Lemier

LEARNING OBJECTIVES

# Five Skills: Turn Awareness Into Prevention

1

**Identify**

Risk Factors And Warning Signs

2

**Recognize**

Common Triggers

3

**Apply**

Intervention Strategies

4

**Develop**

Prevention Approaches

5

**Use**

QAPI To Reduce Incidents

From Recognition → Response → Sustained Improvement

RISK FACTORS

# Risk Grows Where Resident Needs Meet Environmental Pressure

## RESIDENT

01 Dementia

02 Mental Health Diagnoses

03 Aggressive Behaviors

04 Communication Difficulties

## ENVIRONMENT

Shared Spaces 01

Noise 02

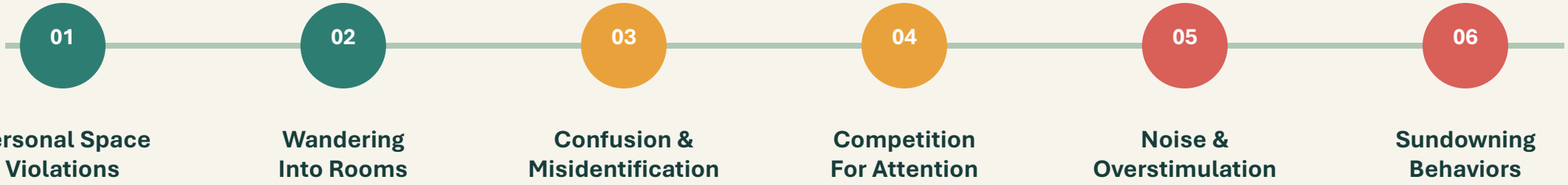
Boredom 03

Routine Changes 04

Risk Is Rarely One Factor Alone.

COMMON TRIGGERS

# Triggers Often Begin With Space, Confusion, or Stimulation




Observe What Happened Immediately Before The Behavior.

IMMEDIATE INTERVENTIONS

# In The Moment: Protect First, Then Assess

1. **Stay Calm**
   Model Control
2. **Separate Safely**
   Create Distance
3. **Redirect**
   Shift Attention
4. **Assess**
   Injury or Distress
5. **Preserve Dignity**
   For Both Residents

**Keep Voice, Posture, And Language Calm.**

# Effective Interventions Are Individualized

## INDIVIDUAL

| | | |
|---|---|---|
| 01 | **Monitor Behavior** | Identify Patterns and Triggers |
| 02 | **Stabilize Routine** | Reduce Avoidable Uncertainty |
| 03 | **Root Cause** | Utilize IDT to Find Root Cause |
| 04 | **Plan For Safety** | Add Support While Preserving Dignity |

# The Environment Can Lower The Temperature

Small Environmental Changes Can Prevent Repeated Escalation.



# Prevention Is A Team Sport




Nursing

Leadership

Social Services

Therapy Services

Activities

Shared Observations • Aligned Interventions • Consistent Follow-Through

# Care Plans Convert Insight Into Prevention

1

**Identify**

At-Risk Residents

2

**Document**

Triggers

3

**Individualize**

Interventions

4

**Review**

The Care Plan Regularly

Observe Plan Act Learn

# QAPI Asks: What In The System Allowed Recurrence

**SYSTEMS**

*Not Blame*

01 **Identify Trends And Patterns**

02 **Focus On Process Gaps**

03 **Support Continuous Improvement**

**Ask: “What Can The System Change Next?”**

# Track The Incident, Then Look For The Pattern

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| FREQUENCY | LOCATION | TIME | TRIGGERS | EFFECTIVENESS |
| **How Often?** | **Where?** | **When?** | **What Came First?** | **What Worked?** |

What Pattern Is Emerging — And What Opportunity Does It Reveal?

DISCUSSION CASE

# Case Study 1: Conflict Over Food Trays

61 Year Old Male

- Alzheimer's Disease
- Obsessive- Compulsive Disorder
- Anxiety Disorder
- Cognitive Communication Deficit

Discuss Without Blame. Focus On What Preceded The Incident And What Can Change.

01 **Triggers**

What Preceded The Conflict?

02 **Interventions**

What Should Happen Now?

03 **Care Planning**

What Needs To Be Individualized?

04 **Adjustments**

What Worked? What Needs To Change?

# Audience Poll: Choose The First Move And Likely Trigger

## 1 What Would Be Your First Intervention?

- A Redirect To A Preferred Activity
- B Increase Supervision
- C Modify The Environment
- D Other

## 2 What Is The Primary Trigger?

- A Confusion / Disorientation
- B Unmet Needs
- C Boredom
- D Environmental Stimulation
- E Combined Disease Process

**Vote First. Then Explain The Reasoning.**

DISCUSSION CASE

# Case Study 2: When The Relationship Is Part Of The Risk

| | |
|---|---|
| **Triggers** | What Is Changing Between Them? |
| **Immediate Response** | How Do We Separate Safely? |
| **Environment** | What Can Reduce Friction? |
| **Long-Term Plan** | How Can Care Remain Individualized? |

83 Year Old Female
- Alzheimer's Disease
- Parkinson's Disease
- Delusional Disorder
- Generalized Anxiety Disorder

84 Year Old Male
- Dementia
- Generalized Anxiety Disorder

Balance Immediate Safety, Relationship History, Environmental Fit, And Each Person’s Care Plan.

# Best Practice Is A Closed Learning Loop

**KNOW** — Resident Triggers

**SHARE** — Across Disciplines

**PREVENT** — Escalation

**MONITOR** — Effectiveness

**Learn → Adapt → Repeat**

KEY TAKEAWAYS

# Prevention Wins When Learning Becomes Routine

01 Prevention Is More Effective Than Reaction.

02 Individualized Interventions Are Essential.

03 QAPI Supports Sustained Improvement.

**Recognize Earlier. Respond Safely. Improve Continuously.**

# Resident-to-Resident Case #2

RESIDENT AGGRESSOR WITH MULTIPLE RESIDENT-TO-RESIDENT PHYSICAL INTERACTIONS ON A MEMORY CARE/BEHAVIORAL UNIT.

Presenter: Colette Belcourt

# Notes & Learning Objectives

- Presentation of a real case involving potential resident-to-resident abuse in a Memory Care and Behavioral Unit setting. This was a complex case involving multiple resident interactions, significant behavioral challenges, limited referral information, regulatory reporting requirements, QAPI review, and ultimately successful outcomes.
- By the conclusion of the presentation, participants should be able to:
  - Identify risk factors for resident-to-resident abuse.
  - Discuss care planning strategies when behavioral health concerns are present.
  - Understanding investigative and reporting considerations.
  - Explore opportunities for performance improvement through QAPI.
  - Recognize the value of interdisciplinary and external partnerships.

# The Admission

- Starting at the beginning – The Admission!
  - Immediately, staff observed concerns.
  - Limited information at the time of admission and within the referral.
  - Pending legal guardian – temp. guardian in place.
  - No family involvement.
  - Roommates.
  - Psychiatric medications without clear documentation for their use.
  - Aggressive with transportation staff.

How many providers have experienced this kind of situation? Does this sound familiar?
-Type response in the chat, or thumbs up emoji "react"

# Care Planning – New Admission

- The admission assessment quickly revealed concerns:
  - Staff noted:
    - Resistance to care.
    - Swatting at caregivers.
    - Loud verbal outbursts.
    - Significant need for personal space.
    - Difficulty providing reliable history.

Considering this scenario, what are some baseline care planning ideas you would put into place for this resident to address potential psychiatric concerns and behaviors?
- Drop some ideas in the chat.

# Behavior Management

- Recognizing the risks, the team initiated several interventions immediately.
  - Increased supervision.
  - Behavioral monitoring.
  - Psychiatric consultation requests.
  - Additional medical record requests.
  - Environmental evaluations.
  - Staff communication regarding observed triggers.

# Resident-to-Resident – Physical Contact #1

A pattern begins to emerge:

- Resident becomes increasingly territorial.
- Watching roommate closely.
- Monitoring others on the unit.
- Becoming upset when residents enter perceived personal space.
- Verbal aggression.
- Increased behaviors during evening hours.

First resident-to-resident occurs:

- Resident struck roommate.
- No injury.
- IDT initiates incident report and investigation.
- Review and implementation of interventions.

# Resident-to-Resident – Physical Contact #2

- Resident returns from psychiatric evaluation.
- Medication changes and room changes ineffective.
- Second resident-to-resident occurs.
- Continued struggle to identify root cause of behaviors.
- Continued struggle with identifying potential diagnosis to care plan appropriately.

# Resident-to-Resident – Physical Contact #3

- Behaviors continued to escalate.
- Resident is highly protective of doorway and room.
- New concerns:
  - Blocking access.
  - Refusing staff entry.
  - Throwing objects.
  - Religious-based verbal statements.
  - Attempting to strike staff.
- Staff identify religious programming as a stressor.
  - Importance of re-evaluation of stressors and triggers constantly.
  - Resolve interventions that are not effective.

# Resident-to-Resident – Physical Contact #4 & #5

- All the resources have been deployed – continued challenges.
- The resident had experienced:
  - Multiple psychiatric stays.
  - Medication Adjustments.
  - Room changes.
  - One-to-one supervision.
  - Environmental modifications.
- Interventions not preventing resident-to-resident incidents.
- Alternative placement options – no one is accepting the referral.

# Stabilized

- Additional resident information is finally received.
  - Prior aggressive behaviors.
  - Use of physical restraints and chemical restraints.
  - Significant abuse history.
- Family involvement later revealed deep history of trauma.
- Resident's final inpatient psychiatric stay stabilizes behaviors through appropriate medications.
- Interventions are created that help sustained reduction in behavioral concerns for this resident.

# QAPI

- Ad Hoc QAPI & Routinely Scheduled QAPI reviews.
  - Where did it start, what was the root cause(s).
    - Referral Review & Admissions.
      - Collaboration/Communication.
    - Wholistic assessment of the unit in which this resident admitted to.
      - Environment, Behavior Trending, Diagnosis Assessment.
    - Care Planning from the time admission.
      - More involvement from IDT.

What change would you implement through QAPI? What questions would you ask to do a deep dive into the root cause? Who would you need to be a part of QAPI specific to this case/scenario?
-Add commentary to the chat.

# QAPI – Plan Examples & Ideas

- Behavior Management:
  - Focused Measurable Metrics over a period.
  - Number of significant behavioral incidents over a time from admission.
  - Purpose – Identify successes and opportunities.
  - Goals – reduction of issues for new admissions.
  - Systemic change to achieve goals – Referral review process & resident specific interventions through IDT review.

# Medical Director Involvement



ASSISTANCE WITH PETITIONS FOR PSYCHIATRIC STAY.



CHART AND REFERRAL REVIEW FOR CHALLENGING CASES WITH RECOMMENDATIONS.



PARTICIPATION WITH COLLABORATION WITH HOSPITALS WHEN FACING CHALLENGES WITH OBTAINING DOCUMENTATION.



ASSISTING WITH SURVEY WHERE NEEDED AND APPROPRIATE TO DISCUSS THEIR ROLE IN THE SITUATION.

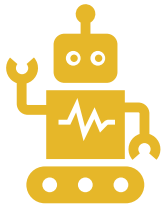


MAKE SURE TO COMMUNICATE WITH THEM THE IMPORTANCE OF THEIR PARTICIPATION AND INPUT ON HIGH-RISK SITUATIONS – SHARING HIGH LEVEL DETAILS ALLOWS THEM THE ABILITY TO DO THEIR JOB AS THE MEDICAL DIRECTOR AND ASSIST.

# 2026 – AI as a Resource.



**If this incident had occurred recently – Different resources are available.**



**AI as a resource:**

Producing interventions.
Drafting QAPI plans.
Creating Audit Tools.
Trending data.
Suggestions for next steps.
Drafting QAPI updates and reports.



**Organization approval for use & protections.**

If you are using AI, have you found it useful as a provider? In what ways are you using it and what are some benefits?
- Drop some commentary in the chat.

# Survey

- This case including all 5 incidents were investigated onsite.
- Investigative files – created as if it WOULD be surveyed.
- Transparency and stick to the facts.
- No issues with compliance found at the survey outcome.

# Conclusion

- The Good:
  - Swift action to adjust care planning and respond each time there was an incident.
  - Due diligence to gain history came through assisting with better care planning and finding a family member for support.
  - Resident received care needed to stabilize and was able to live out their time at the community with out further issues or distress to self.
  - Positive survey outcome despite high-risk, high stress situation.
  - No one was hurt.
  - QAPI plan & medical director involvement.

# Conclusion

- The Bad:
  - Minimal care planning ability and behavior management – challenging to identify the right path.
  - Three separate petitions needed for the resident.
  - Resident showing up as a new admission and it is evident from the first moment there is going to be a challenge.
  - Multiple interventions, including room changes, & 1:1 supervision.
  - Religious mania.

# Conclusion

- The Ugly:
  - No documentation in a referral that was accepted about use of physical and chemical restraints, behaviors, need for antipsychotic/psychotropic medications.
  - Robust history of abuse at group homes, by residents' family, etc. unknown to the community prior to admission.
    - Creating delay in care planning to alleviate distress at the root of the behaviors.
  - 1:1 supervision in place when resident-to-resident occurred.
  - Escalating behaviors for a resident that lead to 5 different instances of potential resident-to-resident abuse.

# Resident-to-Resident Case #3

Presenter: Pennie Westers, LNHA

# Case Background

- Spent month in hospital.
- Lived in AFC home prior.
- From constipation to catatonia.
- Discharged from hospital with G-tube.
- Diagnoses included:
  - Metabolic Encephalopathy,
  - Autistic Disorder,
  - Schizophrenia,
  - Convulsions/Seizures.
- No acute risks of harm to self or others.
- No behavioral concerns.
- Guardian out-of-state.

# Behavioral Indications

- Became aggressive during care.
- Frequently remorseful afterward.
- Vulgar statements to staff.
- Outbursts & impulsiveness.
- Auditory command hallucinations.
- Preferred laying on the floor.

# The Incident

- Room change.
- Ran from room into hallway and hit resident in the face.
- Laid himself on floor and is unresponsive.
- Hospital transfer for psych and medical exam.
- Returns with “anger management” materials.
- IDT and care plan interventions.

# The Incident – Take 2

- 35 days – no physical aggression.
- State survey team visit.
- Impulsive run from room into hallway and hit same resident.
- Lays on floor unresponsive.
- Hospital transfer for psych exam.
- 1:1 supervision initiated.

# The Aftermath

- Supervision benefits.
- No more aggression toward residents.
- G-tube removal.
- CMH finds AFC home that accepts resident.
- 7-month stay = 7 ER visits; 2 resident-to-resident interactions.

# Audience Question

- How equipped is your staff to work with autistic schizophrenic behaviors?
  - A. Not at all.
  - B. Somewhat.
  - C. Making progress.
  - D. Ready to roll.

# Survey Outcomes

- Hard lessons:
  - No new interventions.
    - Plans not documented.
  - No proof of 15-minute check intervention measure on day two of second incident.
    - Missing document.
    - Need for process improvement.

# QAPI Conversations & The IDT

- Identified need for more behavior training with staff.
  - Not equipped for autism and range of behaviors.
  - Implemented training.
- IDT to identify triggering behaviors early with new admissions.
  - Determine interventions.
  - Communicate to staff.
  - Do the follow up – are interventions being utilized.
- Utilize weekly behavior meetings more effectively for updating care plan interventions.
- Evaluate the role of admissions in referral review process.

# The Good, The Bad, The Ugly

- The Ugly
  - Referral stated “no acute risk of harm to self or others – no behavioral concerns."
  - Resident was hit in the face on two different occasions.
  - Had to use 1:1 supervision for three months.
  - Citation was received: F600.

# The Good, the Bad, the Ugly

- The Bad
  - Multiple staff were hit or grabbed.
  - Impulsive running led to resident injuries from falls.
  - Resident was sent to ER seven times.
  - Unable to get resident admitted to inpatient psych.
  - Resident hearing voices and being scared of them.
  - Lack of new interventions as behaviors changed.
  - Missed opportunity pre-admission to on-site patient.
  - Survey team in middle of investigation when 2nd repeat incident occurred.
  - Length of time to get everyone on same page about G-tube removal.

# The Good, the Bad, the Ugly

- The Good
  - Improved resident's quality of life and ability to safely transfer to AFC.
  - Resident was not injured after being hit in the face twice.
  - Many interventions worked.
  - Resident eventually expressed what was triggering impulsive running.
  - Involvement of sister/guardian even though out-of-state.
  - Valuable lessons were learned.
  - Prompted more behavioral educational opportunities.

# Questions?