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MDS Alert

Compliance: Here's How to Avoid Involuntary Seclusion

Emphasize resident well-being over staff convenience.

It's the nursing home stereotype: Residents propped up in chairs in their rooms or in a hallway, quiet, dazed, and disengaged. Surveyors are out to investigate and prevent instances of facilities involuntarily secluding residents, and they're citing facilities, too.

Surveyors want to make sure that any secluded residents are there of their (or their respective representative's) own volition, and that there is a documented clinical reason for the practice.

Become Familiar with These Categories

Surveyors are looking for evidence of involuntary seclusion based on several categories, according to the State Operations Manual Appendix PP. Surveyors are looking for "separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative," according to Appendix PP. If they find substantial evidence, surveyors can levy Ftag 603.

See Additional Changes to MDS Draft for 2020

The Centers for Medicare & Medicaid Services (CMS) have released more prospective changes for the draft version of the MDS, which will update in October 2020.

One highlight: Section G (Functional Status) is gone. "Note: All Section G items have been retired from all assessments except the OSA. The following items remain on the OSA: G0110A1, G0110A2, G0110B1, G0110B2, G0110H1, G0110H2, G0110I1, and G0110I2," CMS says in a release tracking the item changes.

Section GG (Functional Abilities and Goals) has had quite a few minor tweaks, including new questions about the ability to put on footwear and clarification on some of the language surrounding mobility and assessment thereof.

See all of the changes
here: www.cms.gov/files/document/2020mds-30v118item-set-change-history20200123pdf.pdf.

Basically, surveyors define involuntary seclusion as a means of minimizing or otherwise controlling the ways in which a resident can engage with others, especially staff. Appendix PP says:

"Involuntary seclusion may take many forms, including but not limited to the confinement, restriction or isolation of a resident. Involuntary seclusion may be a result of staff convenience, a display of power from the caregiver over the resident, or may be used to discipline a resident for wandering, yelling, repeatedly requesting care or services, using the call light, disrupting a program or activity, or refusing to allow care or services such as showering or bathing to occur."

Surveyors are especially wary of staff making decisions about residents for convenience or out of frustration. They are instructed to observe the general tone of interactions between staff and residents and then investigate anything suspicious through interviews. They're looking to confirm that staff are putting residents' needs first and are always treating residents with respect.

Identify these Scenarios as Problematic

Linda Elizaitis, RN, RAC-CT, BS, president and founder of **CMS Compliance Group** in Melville, New York, shares these examples of actual situations where facilities were cited by surveyors for putting residents in involuntary seclusion:

- A resident pushes the call light. A staff member comes into the room. She puts the call light in a drawer and closes it. "The Interpretive Guidance (IG) states that residents who are physically placed in an area without access to call lights and/or other methods of communication have been put in a secluded/isolated environment," Elizaitis says.
- Two residents are in the activity room. A staff member moves a chair into the doorway and then sits. "The IG states that involuntary seclusion includes attempts to isolate residents to prevent them from leaving an area or involuntarily confines them in an area by staff placing carts or furniture in front of means of egress/doorways," she says.

Both of these situations involve staff members imposing their wills on residents, and your facility's staff training should emphasize the importance of staff members prioritizing residents' well-being over convenience. "Staff need to understand their responsibilities regarding following the resident's individual plan of care and how they can create a situation of involuntary seclusion if they don't understand acceptable standards of practice," she says.

Some facilities get into trouble with surveyors when trying to contain an infectious disease. While protocols to prevent transmission are important for the health and well-being of everyone, your facility should be careful to focus on what is clinically necessary. "Precautions must be the least restrictive, and the plan of care should include interventions to ensure the resident can still participate in room-based activities that are of interest to him/her," Elizaitis says.

Also beware of secured or locked areas, and make sure that any residents living in those situations have documentation that includes clinical justification. Many facilities have been cited after surveyors found residents who did not have dementia, for example, but were living in secured areas, Elizaitis says. She recounts one example of a cognitively intact resident who could not get to appointments outside of the facility without staff letting him in and out of the unit; surveyors cited the facility with F603.

Note: If a resident chooses to live in a secure or locked area but does not have any kind of clinical reason to do so - such as a resident whose spouse has dementia but wants to continue living together - the cognitively intact spouse should be able to enter or leave the secure area independently, Appendix PP says. "The chosen method for opening doors (e.g., distribution of access code information) is not specified by CMS. Staff should be aware of which residents have access to opening doors and monitor their use of the access to ensure other residents' safety," Appendix PP specifies.

Prioritize Safety - and Documentation

However, some residents do require secure living conditions to make sure they stay safe - or to make sure other residents and staff are safe. Elizaitis recommends making sure that facilities use only diagnoses to place residents requiring a particular living situation, like residing in a secure area. If a resident's family or representative requests the resident reside in a secure area but there is no clinical justification, then granting that request could put a facility under survey scrutiny for involuntary seclusion.

If a resident's behavior has changed abruptly and they are putting others at risk, reach out to the resident's physician with an update on the resident's behavior, Elizaitis says. Remember that facilities have other tools available for navigating behavioral changes, like increasing staff supervision - there are other compliant options that don't involve isolating the resident in question.