Wisconsin Association of Homes and Services for the Aging, Inc.

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To: Members, WAHSA Task Force on Reporting Injuries of Unknown Source
From: John Sauer, Executive Director

Subject: Summary of the 6/29/04 Task Force Meeting

The June 29, 2004 Task Force meeting included an informative discussion with several representatives of the Department of Health and Family Services' (DHFS) Office of Legal Counsel and Bureau of Quality Assurance (BQA) on the requirements and expectations related to reporting incidents involving caregiver misconduct and injuries of an unknown source. A list of attendees is attached.

The following is a summary of the issues discussed and conclusions reached during our meeting. The term "misconduct" is used; it includes abuse and neglect of clients and misappropriation of client's property.

- **Immediate Reporting:** BQA broadly interprets the requirement that nursing facility staff must immediately report an allegation of abuse, neglect or misappropriation of property to the administrator to mean that the staff should immediately report an allegation to a designated supervisor who has the authority to take the steps required to protect the residents. This supervisor, for example, must have the authority to immediately suspend or reassign any staff members named in the allegation. It is not required that the supervisor be granted the authority to immediately terminate an employee. The facility, as soon as practicable, should inform the administrator of the allegation. {Note: A draft memo expected to be released later this year from the federal Centers for Medicare and Medicaid Services (CMS) is expected to define "immediately" as *within 24 hours*.} As soon as an allegation is made, the facility should immediately begin its evaluation (investigation) following established, written facility procedures. Providers are reminded that they have five working days to inform BQA of alleged caregiver misconduct.

- **Good-Faith Decisions:** BQA reiterated that surveyors will honor "good faith decisions" made by facilities to not report an incident to BQA, based on the facility's review of the reporting requirements and after a **thorough** investigation. Providers are reminded to review F-tag 225 (comprehensive federal regulation related to caregiver employment and misconduct, and the investigation and reporting of incidents) and the interpretive guidelines

utilized by surveyors when reviewing their reporting decisions. This F-tag is often cited when facility staff fail to promptly report allegations internally or, once reported by staff, the facility fails to thoroughly investigate and document the incident. A facility's best defense against such citations is to thoroughly investigate and to thoroughly document its investigation and its basis for not reporting the incident. Note: BQA reminds providers that surveyors will generally view as inadequate facility investigations that simply ask the resident, "What happened?"

- **Scope of the Investigation:** The level of investigation should be appropriate to whether the injury was expected (based on the resident's care plan, and observations of the resident's condition, cognition and treatment). There is no mandated or expected timeframe with respect to how far back in time the investigation should cover. Also, the size or degree of the resident's injury alone should not determine whether an investigation is undertaken by the facility. However, the intensity and depth of a facility's investigation should be commensurate with the severity and result of the incident. In all cases, the facility should thoroughly document the investigation.

- **What is Not Abuse or Neglect:** Facilities should closely review the definitions of abuse and neglect in HFS 13 when evaluating and investigating incidents. The definitions specifically state that the following are not considered abuse or neglect: "an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as a result of inability, incapacity, inadvertency, or ordinary negligence in isolated instances, or good faith errors in judgment or discretion." **Facility administrators and their key staff should refer to the Wisconsin Caregiver Program Manual for examples, definitions and other information to guide their decisions with respect to investigating, evaluating and reporting injuries of unknown origin and allegations of caregiver misconduct (See http://dhfs.wisconsin.gov/caregiver/index.htm.)**

- **"Expected Injuries":** BQA suggested that facilities ask the question "Was the incident expected?" when reviewing resident injuries of an unknown source. For example, if a bruise is found on a resident, the facility should evaluate whether the resident has a medical condition or a behavior pattern that makes them prone to bruising. Is the resident taking medication that makes him or her susceptible to bruising? Has the resident been assessed as having extremely fragile skin? Does the resident frequently push his/her wheelchair too close to the doorway or nightstand? An injury that is consistent with documented patterns or conditions may be subject to an abbreviated review and, depending on the results of the investigation, may not have to be reported to BQA. Facilities are reminded that an abbreviated review does **not** mean that no review is required; it should never be assumed that a bruise on a person who bruises easily occurred because s/he must have bumped him/herself.

- **Standard for Ruling Out Caregiver Misconduct:** DHFS Legal Counsel and BQA staff have clarified the "Entity Investigation and Reporting Requirements" flow chart included in BQA memo 00-071, dated October 12, 2000. Step 4 on this flow-chart states, "Can the

entity ***affirmatively*** rule out the incident as one that would meet the definition of caregiver misconduct?" (emphasis added) It appears that some providers have interpreted the word "affirmatively" as meaning the facility must be 100% certain that the incident does not meet the definition of caregiver misconduct and, if there is ***any*** uncertainty, the incident must be reported. **A level of absolute certainty is not the standard assumed by BQA**. Instead, Step 4 of the current flowchart provides that if the facility, after completing its investigation and reviewing the resident's condition and related documentation, determines that it can **reasonably conclude** that the incident does not meet the definition of caregiver misconduct, then the incident does not need to be reported to BQA. BQA is redrafting its 00-071 memo to further clarify this standard (see below). Further, even if the facility cannot rule out caregiver misconduct, the incident does not need to be reported if it has a "minor" effect on the resident. (See below for more information on this topic.)

- **Minor Injuries:** Some minor injuries do not have to be reported to BQA. Under BQA Memo 00-071, an incident is considered to have a minor effect if it "causes no apparent physical, emotional, or mental pain or suffering to a client." Again, the Wisconsin Caregiver Program Manual provides additional guidance on this matter. Facilities are urged to use the "Entity Investigation and Reporting Requirements" flow chart to determine whether the incident involving "minor injuries" must be reported to BQA.

- **BQA Review:** When reviewing allegations of caregiver misconduct, BQA considers evidence of the following:

    1. Appropriate policies and procedures are in place with respect to reporting allegations of resident abuse, neglect and misappropriation of property;

    2. Staff understand the facility's policies and procedures and received training on these issues and these policies and procedures are followed by the facility;

    3. When asked by BQA surveyors, staff are able to identify the supervisor to whom they are to report allegations or incidents; and

    4. As observed by BQA, the facility has created a climate in which residents' quality of life, safety and dignity are promoted and honored by staff and all personnel are encouraged to report any allegation or incident.

- **BQA Citations:** At the time of a survey, BQA may not cite a facility for failure to report an allegation if a "good faith investigation" was undertaken by the facility and the incident was reported to the supervisor/administrator. However, the incident could and often does trigger a BQA citation. For example, while an incident may not have been the result of caregiver misconduct and therefore did not have to be reported, the surveyors may contend that the incident itself constituted a violation of applicable regulations.

- **Facility Liability for Employee Misconduct:** Wisconsin surveyors, generally, will not cite F223 (residents have the right to be free from abuse) simply because abuse occurred. If a facility did all it could to prevent abuse (e.g., properly screened an employee, properly trained and supervised the employee) and the facility had no reason to believe that the employee would abuse a resident, then BQA surveyors, generally, will not cite F223 if that employee abuses a resident. The state agency will evaluate whether the facility took all necessary steps to prevent abuse and also took appropriate actions after the abuse occurred. BQA will consider similar factors concerning alleged neglect and misappropriation of property in determining whether to cite F224 (staff treatment of residents) and F225.

- **BQA Actions and Insights:** (1) Within the next several weeks, BQA will issue a new memo on reporting allegations of caregiver misconduct; (2) BQA staff believes that resident neglect is becoming a more significant and unreported concern, more so than abuse incidents; and (3) In instances in which caregiver misconduct is substantiated and mitigating circumstances are present (e.g., the caregiver with an exemplary work history uncharacteristically utilized bad judgment and ignored facility policies, resulting in a resident injury), the DHFS legal counsel may use "deferred finding agreements" allowing caregivers to conditionally retain their ability to work in the long term care setting. These agreements typically may require the caregiver to complete additional training or counseling and maintain a clean performance record over a period of time in order to keep a finding of caregiver misconduct off the registry.

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WAHSA Task Force on Reporting
Injuries of Unknown Source
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Madison, Wisconsin

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