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DATE: March xx, 2010 DQA Memo 10-xxx

TO: Nursing Homes NH - xx

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VIA: Otis Woods, Director
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**UPDATE: Nursing Home Reporting Requirements
For Alleged Incidents of Abuse, Neglect and Misappropriation**

The Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) Memo 05-09 at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf>, clarified mandatory reporting requirements for participating Medicare and Medicaid providers. DQA issued Memo 05-004 and 05-012 to all nursing homes to provide direction on how to report alleged violations to DQA; however, DQA Memo 05-012 is obsolete as of the issuance of this memo.

Per CMS direction, all nursing homes must report **all alleged violations** involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property within 24 hours to the facility administrator and to the Division of Quality Assurance (DQA). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further incidents while the investigation is in progress. The results of all investigations must be reported to the administrator and to the DQA Office of Caregiver Quality (OCQ) within 5 working days of the incident. Additionally, if the alleged violation is verified, the facility must take appropriate corrective action.

The purpose of this memo is to clarify the reporting requirements for all nursing homes in Wisconsin. For purposes of this memo, "mistreatment" includes any incident or allegation involving abuse or neglect of a resident, misappropriation of a resident's property, or injuries to a resident of unknown source. This memo contains important clarification regarding:

- Nursing Home Reporting Requirements;
- Definitions under Federal and State Law; and
- Required Online 24 Reporting & Incident Report Form.

Nursing Home Reporting Requirements

All nursing homes must develop written procedures specifying:

- What incidents are to be reported and when;
- How and to whom staff are to report incidents;
- How internal investigations will be completed for different types of investigations;
- What constitutes a “thorough” investigation;
- How residents will be protected from further incidents while an investigation is conducted;
- How staff will be trained on the procedures related to allegations of misconduct; and
- How residents (and guardians, as appropriate) will be informed of those procedures.

All nursing homes must ensure that employees, contractors, volunteers, and residents are knowledgeable about the nursing home’s reporting procedures and requirements. Staff must be trained to immediately report to the administrator or designee all incidents of misconduct, including abuse or neglect of a resident, misappropriation of a resident’s property, or injuries to a resident of unknown source. Immediately upon learning of an incident, nursing homes must take the necessary steps to protect residents from possible further incidents of misconduct or injury.

Effective immediately, **all nursing homes** must report **all alleged violations** involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property **within 24 hours** to the Division of Quality Assurance (DQA) **via the online reporting system** at <https://doa.wi.gov/DHSSurveys/TakeSurvey.aspx?SurveyID=96MI3ml4>. In addition to federal and state reporting requirements, providers should notify local law enforcement authorities of any situation where there is a potential criminal offense.

Note: Nursing homes must update their written procedures to reflect this requirement to avoid a deficiency under 42 CFR § 483.13 (c) (F226) at an F level, which is Substandard Quality of Care.

Definitions under Federal and State Law

The attached document, entitled “Misconduct Definitions,” provides a comparison of the federal and state definitions in nursing home settings. Participating Medicare and Medicaid nursing homes must first review the federal definitions; if an incident potentially meets the federal definition, it is not necessary to review the state definitions.

Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Because the federal definitions do not specify that the incident has to involve a caregiver, nursing homes are required to submit allegations of mistreatment by anyone, **including resident-to-resident incidents**, to DQA within 24 hours.

Note that the federal definition of abuse indicates that the act must be “willful” and that it needs to have resulted in physical or psychosocial harm to the resident or would be expected to have caused harm to a “reasonable person” if the resident cannot provide a response. For a definition

of "willful," please refer to the interpretive guidelines at F323 where, under Resident-to-Resident Altercations, it notes, "An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance for 42 CFR §483.13(b) at F223. "Willful" means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under F323."

Required Online 24 Reporting & Incident Report Form

Online Alleged Nursing Home Resident Mistreatment Report

Effective immediately, completion of the **online form** at <https://doa.wi.gov/DHSSurveys/TakeSurvey.aspx?SurveyID=96MI3ml4> is required to meet the requirements in Federal regulation 42 CFR 483.13(c)(2). Nursing homes must **immediately report all incidents** of alleged mistreatment, abuse and neglect of residents, misappropriation of resident property and injuries of unknown source to the DQA. CMS defines "immediately" to be as soon as possible but not to exceed 24 hours after discovery of the incident. Failure to provide the information to DQA within 24 hours of discovering an incident may result in a citation under federal or state codes.

All nursing homes must also immediately begin a thorough investigation of all incidents and document the findings for each incident. A thorough investigation may include:

- Collecting and preserving physical and documentary evidence;
- Interviewing alleged victim(s) and witness(es);
- Interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source;
- Interviewing other residents to determine if they have been abused or mistreated;
- Interviewing staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused;
- Interviewing staff who worked previous shifts to determine if they were aware of an injury;
- Collecting other information that corroborates or disproves the reported incident; and
- Involving other regulatory authorities who may assist, e.g., local law enforcement, elder abuse agency, Adult Protective Service agency.

Note: Nursing homes should no longer use the F-62617 form for 24 hour reporting because it is now obsolete. Federally certified nursing homes **must not** use the caregiver misconduct reporting flowchart and worksheet as these decision making tools do not apply to participating Medicare and Medicaid nursing homes.

Misconduct Incident Report (F-62447) <http://dhs.wisconsin.gov/forms1/F6/F62447.pdf>

Complete the *Misconduct Incident Report* form, F-62447 when:

- You submitted an online Alleged Nursing Home Resident Mistreatment Report within 24 hours of an incident; or

- You concluded that an incident did not meet federal definitions so you did not submit an online Alleged Nursing Home Resident Mistreatment Report but upon further review, the incident does meet state definitions; or
- You are a state-only licensed nursing home (not a participating Medicare and Medicaid provider). The federal reporting requirements do not apply to state-only licensed nursing homes, which may continue to follow the requirements in DQA Memo 04-028.

Follow these steps to report the results of an investigation to DQA:

1. Thoroughly complete the *Incident Report* form (F-62447), and attach relevant investigation documents.
2. Ensure the completed Incident Report is submitted within five (5) working days of the incident, or the date the entity became aware of the incident.
3. For allegations involving all perpetrators (staff member, resident, family member, friend, visitor, stranger, etc.), submit to:

**Division of Quality Assurance
Office of Caregiver Quality
PO Box 2969
Madison, WI 53701-2969**

OCQ forwards all reports to the DQA Bureau of Nursing Home Resident Care (BNHRC). In addition, OCQ refers reports involving:

- Facility issues (resident to resident incidents, policy and procedure issues, etc.) to the appropriate DQA BNHRC Regional Office;
- Non-caregiver accused (family member, friend, visitor, etc) to the appropriate county adult at risk agency; and
- Credentialed staff (Physician, RN, LPN, Social Worker, etc.) to the Department of Regulation & Licensing (DRL).

Resources & Questions

See the following investigation resources:

- Conducting Internal Investigations of Caregiver Misconduct Training – Webcast Series
<http://dhs.wisconsin.gov/caregiver/training/intInvstTrng.htm>
- Conducting Internal Investigations Training – Materials
<http://dhs.wisconsin.gov/caregiver/training/conIntInvstTrg.htm>
- Investigation Protocol
<http://dhs.wisconsin.gov/caregiver/training/pdfcaregvrng/conMiscdctInvst.pdf>

If you have questions about reporting or investigation requirements, or are unsure if a specific incident should be reported, please contact the Office of Caregiver Quality at DHSCaregiverIntake@wisconsin.gov or (608) 261-8319.

Attachment: Misconduct Definitions

MISCONDUCT DEFINITIONS

Federal Language 42 C.F.R. §488.301	WI Caregiver Law Ch. DHS 13
<u>ABUSE</u>	<u>ABUSE</u>
<p>Abuse – the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.</p> <p>This includes the deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.</p> <p>This presumes that instances of abuse of all residents, even those in a coma, cause physical harm or pain or mental anguish.</p> <ul style="list-style-type: none"> • Verbal abuse – the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. • Sexual abuse – includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. • Physical abuse – includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. • Mental abuse – includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. <p>Note that the federal definition of abuse indicates that the act needs to be "willful" and that it needs to have resulted in physical or psychosocial harm to the resident or would be expected to have caused harm to a "reasonable person" if the resident cannot provide a response.</p> <p>For a definition of "willful," please refer to the interpretive guidelines at F323 where, under Resident-to-Resident Altercations, it notes, "An incident involving a resident who willfully inflicts injury upon other resident should be reviewed as abuse under the guidance for 42 CFR 483.13(b) at F223.</p> <p>'Willful' means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act."</p>	<ol style="list-style-type: none"> 1. <u>An act or repeated acts by a caregiver or nonclient resident</u>, including but not limited to restraint, isolation or confinement, that, when contrary to the entity's policies and procedures, not a part of the client's treatment plan and <u>done intentionally to cause harm</u>, does any of the following: <ol style="list-style-type: none"> a. Causes or could be reasonably expected to cause pain or injury to a client or the death of a client, and the act does not constitute self-defense as defined in s. 939.48, Stats. b. Substantially disregards a client's rights under ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client. c. Causes or could reasonably expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or a fear of harm or death, or a combination of these behaviors. This subdivision does not apply to permissible restraint, isolation, or confinement implemented by order of a court or as permitted by statute. 2. An act or acts of <u>sexual intercourse or sexual contact</u> under s. 940.225, Stats., by a caregiver and involving a client. 3. The <u>forcible administration of medication</u> or the <u>performance of psychosurgery, electroconvulsive therapy or experimental research</u> on a client with the knowledge that no lawful authority exists for the administration or performance. 4. <u>A course of conduct or repeated acts</u> by a caregiver which serve no legitimate purpose and which, when <u>done with intent to harass, intimidate, humiliate, threaten or frighten a client</u>, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened or frightened. <p>Abuse does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency, or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.</p>

MISCONDUCT DEFINITIONS

FEDERAL LANGUAGE 42 C.F.R. §488.301	WI CAREGIVER LAW CH. DHS 13
<p><u>NEGLECT</u></p> <p>Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.</p>	<p><u>NEGLECT</u></p> <p>An <u>intentional omission or intentional course of conduct by a caregiver</u> or a nonclient resident, including but not limited to restraint, isolation or confinement, that is contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence, does any of the following:</p> <ol style="list-style-type: none"> a. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client. b. Substantially disregards a client's rights under either ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client. c. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, fear of harm or death, or a combination of these behaviors. This paragraph does not apply to permissible restraint, isolation or confinement implemented by order of a court or as permitted by statute. <p>Neglect is the intentional carelessness, negligence, or disregard of policy, or care plan, which causes, or could be reasonably expected to cause pain, injury, or death.</p> <p>Neglect does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.</p>

MISCONDUCT DEFINITIONS

FEDERAL LANGUAGE 42 C.F.R. §488.301	WI CAREGIVER LAW CH. DHS 13
<p style="text-align: center;"><u>MISAPPROPRIATION OF RESIDENT PROPERTY</u></p> <p>The deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.</p>	<p style="text-align: center;"><u>MISAPPROPRIATION OF PROPERTY</u></p> <ol style="list-style-type: none"> 1. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a <u>client's movable property</u> without the client's consent and with the intent to deprive the client of possession of the property. 2. Obtaining property of a client by intentionally deceiving the client with a <u>false representation</u> which is known to be false, made with the intent to defraud, and which does defraud the person to whom it is made. "False representation" includes a promise made with the intent not to perform it if the promise is a part of a false and fraudulent scheme. 3. By virtue of his or her office, business or employment, or as trustee or bailee, having <u>possession or custody of money or of a negotiable security, instrument, paper or other negotiable writing of a client</u>, intentionally using, transferring, concealing, or retaining possession of money, security, instrument, paper or writing without the client's consent, contrary to his or her authority, and with the intent to convert it to his or her own use or to the use of any other person except the client. 4. Intentionally using or attempting to use <u>personal identifying information</u> as defined in s. 943.201 (1)(b), Stats., or a client's birth certificate or financial transaction card as defined in s. 943.41(1)(em), Stats., to obtain credit, money, goods, services or anything else of value without the authorization or consent of the client and by representing that he or she is the client or is acting with the authorization or consent of the client. 5. Violating s. 943.38, Stats., involving the property of a client, or s. 943.41, Stats., involving fraudulent use of a client's <u>financial transaction card</u>.
<p style="text-align: center;"><u>INJURY OF UNKNOWN SOURCE</u></p> <p>An injury should be classified as an "injury of unknown source" when both of the following conditions are met:</p> <ul style="list-style-type: none"> • The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; <u>and</u>, • The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. 	<p style="text-align: center;"><u>INJURY OF UNKNOWN SOURCE</u></p> <p>Refer to federal definition.</p>



WISCONSIN DEPARTMENT OF HEALTH SERVICES

Alleged Nursing Home Resident Mistreatment Report

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Mandatory Reporting Requirements for Nursing Homes

Completion of this form is required to meet the requirements in Federal regulation 42 CFR 483.13(c)(2). Nursing homes must immediately report incidents of alleged mistreatment, abuse and neglect of residents (including injuries of unknown source), and misappropriation of resident property to the Division of Quality Assurance (DQA), the state survey and certification agency. The Centers for Medicaid and Medicare Services (CMS) defines "immediately" to be as soon as possible but not to exceed 24 hours after discovery of the incident. Failure to provide the following information to DQA within 24 hours of discovering an incident may result in the issuance of a statement of deficiency.

Because the federal definitions do not specify that an incident has to involve a caregiver, nursing homes are required to submit allegations of mistreatment by anyone, including residents.

Note that the federal definition of abuse indicates that the act needs to be "willful" and that it needs to have resulted in physical or psychosocial harm to the resident or would be expected to have caused harm to a "reasonable person" if the resident cannot provide a response.

For a definition of "willful," please refer to the interpretive guidelines at F323 where, under Resident-to-Resident Altercations, it notes, "An incident involving a resident who willfully inflicts injury upon other resident should be reviewed as abuse under the guidance for 42 CFR 483.13(b) at F223. 'Willful' means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act."

1. Facility Name*

2. State License Number*

3. Street Address*

4. City*

5. County*

6. Zip Code*

7. Date Occurred


mm/dd/yyyy

8. Time Occurred (include AM or PM)

9. Date Discovered *


mm/dd/yyyy

10. Allegation Type*

Enter ABUSE, NEGLECT, MISAPPROPRIATION or INJURY

11. Resident's Name*

12. Name of accused *

Enter UNKNOWN if accused is not known or INJURY if injury of unknown source.

13. Title of accused (nurse aide, nurse, caregiver, resident, family, stranger, etc.)*

Enter UNKNOWN if accused is not known or INJURY if injury of unknown source.

14. Summary of Incident*



15. Person Preparing Report*

16. Email Address*

17. Phone Number*

Questions about this completed form may be directed to the DQA Office of Caregiver Quality at DHSCaregiverIntake@dhs.wisconsin.gov or 608-261-8319.

Upon completion of the facility's investigation and within 5 days of the date discovered, the nursing home must submit an Incident Report F-62447 with supporting documentation to the DQA Office of Caregiver Quality.

Done

Cancel

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* indicates a required field