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**Date:** November 15, 2006 OQA Memo 06-028

**To:** Certified Mental Health and AODA Programs CMHA - 04  
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Rural Health Clinics RHC - 04

**Cc:** County [Elder] Adult-at-Risk Agencies

**From:** Otis Woods, Director  
Office of Quality Assurance

**Adult-at-Risk, including Elder Adult-at-Risk, Reporting Requirements  
For Entities Regulated by the Office of Quality Assurance**

Effective December 1, 2006, Wisconsin Act 388 revises the reporting of, and responses to, abuse, neglect and exploitation of adults-at-risk (vulnerable adults age 18 and older), including elder adults-at-risk (age 60 and up). See <http://www.legis.state.wi.us/2005/data/acts/05Act388.pdf>.

To ensure entities understand their responsibility to report both allegations of caregiver misconduct and other incidents involving adults-at-risk; this memo reviews the requirements outlined in BQA Memos 05-012 (nursing homes) and 04-028 (all other regulated entities), and explains the new Adult-at-Risk reporting requirements.

This memo contains important clarification regarding:

- Reporting Caregiver Misconduct Incidents;
- Reporting Adult-at-Risk Incidents; and
- Response to Reports.

**Reporting Caregiver Misconduct Incidents**

State Statute 146.40(4r)(am)1. and HFS 13.05(3) require that an entity report to the Department any allegation of misappropriation of property of a client; or of neglect or abuse of a client by any person employed by, or under contract with, the entity if the person is under the control of the entity. There are no changes to these caregiver misconduct reporting requirements.

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Entities should continue to follow the guidance provided at:

- Caregiver Misconduct Complaints  
<http://www.dhfs.state.wi.us/caregiver/contacts/Complaints.htm>; and
- The Caregiver Program Manual  
<http://www.dhfs.state.wi.us/caregiver/publications/CgvrProgMan.htm>.

### **All Entities (except nursing homes)**

Reference: BQA Memo 04-028, Revised Caregiver Misconduct Reporting Requirements for BQA Entities

### **Nursing Homes Only**

Reference: BQA memo 05-004, Requirements for Reporting Allegations of Abuse, Neglect, Misappropriation, Injuries of Unknown Source  
BQA memo 05-012, UPDATE - Requirements for Reporting Allegations of Abuse, Neglect, Misappropriation, Injuries of Unknown Source

For **caregiver misconduct allegations involving all staff** (noncredentialed and credentialed), submit the Incident Report to:

Office of Quality Assurance (OQA)  
Office of Caregiver Quality  
2917 International Lane, Suite 300  
Madison, WI 53704

OQA will review reports involving noncredentialed staff (nurse aides, caregivers, housekeepers, etc.) for possible investigation. OQA will refer reports involving credentialed staff (doctors, RNs, LPNs, social workers, etc.) to the Department of Regulation & Licensing (DRL) for review.

### **Reporting Adults-at-Risk**

State statutes 46.90(4)(ab)1 and 55.043(1m) (a) require that **any employee of any entity report** allegations of abuse, neglect or exploitation if the adult-at-risk is seen in the course of the person's professional duties and **one** of the following conditions is true:

- The adult-at-risk has requested the person to make the report;

This first condition is self-explanatory: any entity employee must make a report if they are asked to do so.

- There is reasonable cause to believe that the adult-at-risk is at **imminent risk of serious bodily harm, death, sexual assault, or significant property loss** and is unable to make an informed judgment about whether to report the risk.

This second condition requires a concern about future, serious risk; it is not applicable to situations that involve past incidents only.

- Other adults-at-risk are at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by the suspected perpetrator.

This third condition applies to reporting past abuse perpetrated on an adult-at-risk only if there is a possibility of harm to others. (For example, an entity employee must report if he or

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she is made aware of a situation involving a specialized transportation van driver who allegedly sexually assaulted a client. Even if the client no longer uses the transportation service, other adults-at-risk would likely be riding with that van driver in the future.)

No reporting is required in two instances:

- If the professional believes that filing the report would not be in the best interest of the adult-at-risk, and the professional documents the reasons for this belief in the suspected victim's case file; or
- If a health care provider provides treatment by spiritual means through prayer for healing in lieu of medical care in accordance with his or her religious tradition, and his or her communications with patients are required by his or her religious denomination to be held confidential.

If you conclude that you must report an incident involving an adult-at-risk, including an elder adult-at-risk:

1. Complete an *Incident Report* form (DDE-2447) and attach relevant internal investigation documents; and
2. For **allegations involving all perpetrators** (family member, friend, visitor, resident, stranger, etc.), submit the Incident Report within five days to:

Office of Quality Assurance  
Office of Caregiver Quality  
2917 International Lane, Suite 300  
Madison, WI 53704

This new reporting process is streamlined to eliminate reporting to different agencies. All incident reports are submitted to OQA staff who will forward reports to other agencies such as the county department, the elder/adult-at-risk agency, state or local law enforcement agency, or the board on aging and long-term care, as appropriate. You may also submit a report directly to one of these agencies.

### **Immunity Provision**

Due to the increased reporting provisions, the law enhances protections for good-faith reporters of incidents involving adults-at-risk. Immunity provisions apply to all reporters, including situations when a report is filed with an incorrect agency, if the reporter had a good-faith belief that the initial report was filed appropriately.

If an employee of the entity, following the entity's incident response protocol, reports the necessary information concerning the allegation to someone who is expected to report on behalf of the entity, e.g., Director of Nursing, Facility Administrator, etc., and that individual does report the information to the proper authorities, e.g., Office of Quality Assurance, the employee does not also have to report to OQA. However, if the entity fails to report and the situation meets one of the three conditions that trigger limited-required reporting, the employee must make direct contact with OQA. If the employee does not, the immunity provisions will not apply.

To ensure immunity, an employee must report directly to OQA, a county department, the Elder/Adult-at-Risk Agency, state or local law enforcement agency, or the Board on Aging and Long-Term Care.

The new law creates a rebuttable presumption that any discharge or act of retaliation or discrimination taken against a reporter within 120 days of making the report is retaliatory. The penalty for retaliating against a reporter is increased to \$10,000.

**Response to Reports**

The DHFS Office of Quality Assurance responds to two types of health care complaints. They are:

1. Complaints regarding entity activity (inappropriate or inadequate activity by an entity); and
2. Complaints of caregiver misconduct (inappropriate activity by a caregiver, e.g., abuse, neglect or misappropriation).

The OQA Office of Caregiver Quality (OCQ) may conduct a caregiver misconduct investigation by conducting on-site visits, in-person interviews, or telephone interviews. The entity's OQA regulatory program (Assisted Living Section, Health Services Section or Resident Care Review Section) may also conduct a parallel investigation regarding the incident, to determine if the entity's program requirements were met, and if the entity bears culpability regarding the incident.

Again, all incident reports must be submitted to OQA who will refer reports to agencies including the Department of Regulation & Licensing, the Department of Justice, county departments, adult-at-risk agencies, local law enforcement agencies, and others, as appropriate. One or more of these agencies may also respond to an allegation investigated by OQA.

**Questions**

Contact the Office of Caregiver Quality (OCQ) at [Caregiver\\_Intake@dhfs.state.wi.us](mailto:Caregiver_Intake@dhfs.state.wi.us) or (608) 243-2019.