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Guidance for Investigating & Reporting Alleged Violations in Nursing Homes

The purpose of this memo is to clarify what constitutes a reportable alleged violation, including a violation of resident-to-resident abuse that should be reported to the Division of Quality Assurance (DQA), Office of Caregiver Quality (OCQ). For purposes of this memo, an incident includes any allegation involving mistreatment, 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 Investigation Requirements & Guidance, including:

- Injury of Unknown Source;
- Initial Evaluation;
- Thorough Investigation criteria;
- Resident-to-Resident Altercations; and
- Resources.

Per Centers for Medicare and Medicaid Services (CMS) direction, all nursing homes must immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the facility administrator and to DQA. CMS defines "immediately" to be as soon as possible but not to exceed 24 hours after discovery of the incident.

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 (or their designee when the administrator is absent from the building) and to OCQ within 5 working days of the incident. If the alleged violation is verified, the facility must take appropriate corrective action.

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 abuse or mistreatment by anyone, including resident-to-resident incidents, to DQA immediately.

Investigation Requirements & Guidance

Reference:

- [CMS S&C Memo 05-09](#)
- [DQA Memo 10-008](#) with [Misconduct Definitions](#)

Facilities should continue to follow the guidance provided in DQA Memo 10-008 with the additional guidance found in this memo. All nursing homes must develop written procedures regarding allegations of abuse, neglect or misappropriation 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 and 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 all 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 his or her designee when the Administrator is absent from the building) 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.

Injury of unknown source

Reference: Injury of Unknown Source Flowchart

CMS requires that nursing homes report all injuries to a resident of unknown source. The federal interpretative guidelines for 42 CFR § 484.13(c)(2) and (4) define injuries of unknown source to mean an injury that:

- was not observed by any person or the source of the injury could not be explained by the resident, and

- is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an areas not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (S &C 05-09)

Both elements of the definition must be met for the incident to be defined as an injury of unknown source and be reported to the Division of Quality Assurance. There are several factors to consider when determining if an injury is suspicious. An injury may be suspicious based on the extent of the injury, for example the size or severity of the injury such as a large bruise, a skin tear or a broken bone. An injury may also be suspicious due to the location of the injury, such as bruising to the inner thigh, the back or any area not generally susceptible to trauma. Suspicious injuries also include multiple injuries such as bruising, or multiple injuries over a period of time. If the injury is suspicious and was not observed or the resident is unable to explain what happened, the injury meets the federal definition of an injury of unknown source and must be reported to DQA.

Initial Evaluation

In limited circumstances it may be unclear whether the circumstances surrounding an allegation meet the definition of a reportable incident. Nursing homes may then conduct an initial evaluation of the allegation prior to reporting to DQA. Generally initial evaluations occur only regarding allegations involving misappropriation of a resident's property, injuries of unknown source, or some resident-to-resident altercations

Missing Item Example:

Resident Carl reports to CNA Joan that someone has stolen his bathrobe. Joan reports the allegation immediately to her supervisor, Louise. Louise knows that Carl's family often does his laundry. Louise calls Carl's daughter who confirms that she took the bathrobe home with her yesterday for laundering.

In this case, the initial evaluation determines that no misappropriation of Carl's property occurred. It is not necessary to report the allegation to DQA.

Injury Example:

RN Monique observes one small bruise on the right hand of Resident Linda. Monique asks Linda how she got the bruise. Linda replies that she doesn't know. Monique checked with other staff and no one is aware of how Linda bruised her hand. Although Monique is unable to determine how the bruise occurred, she does not find the injury suspicious because the bruise is small and is in an area of the body that is susceptible to injury.

In this case, the initial evaluation confirms that the bruise does not meet the federal definition of an injury of unknown source. Although Monique cannot determine the source of the injury, the injury is not suspicious and therefore does not need to be reported to DQA.

An initial evaluation should be well documented. In the above examples, the initial evaluation revealed it was not necessary for the entity to immediately report or investigate further. An initial evaluation should be concluded quickly and does not extend the timeline for reporting.

Thorough Investigation

All nursing homes must immediately begin a thorough investigation of any reported incident, collect information that corroborates or disproves the incident, and document the findings for each incident. A thorough investigation may include:

- Collecting and preserving physical and documentary evidence
- Interviewing alleged victim(s)
- Identifying and interviewing other staff or residents in the immediate area at the time of the incident who may have witnessed what occurred
- Interviewing the accused individual(s)
- 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 abuse or mistreatment by the accused
- Interviewing staff who worked previous shifts to determine if they were aware of an injury or incident and
- Involving other regulatory authorities who may assist, e.g., local law enforcement, elder abuse agency, Adult Protective Service agency.

CMS does not specifically identify what information must be included in a thorough investigation. Nursing homes have some discretion in determining what information to collect to complete their investigation. A thorough investigation is an investigation that adequately addresses the circumstances of the allegation. The investigation should include the facts necessary to form a reasoned conclusion as to what happened. In some cases a facility may not be able to determine what actually occurred. The facility should document their investigation and the reasons for their conclusion. The goal of an investigation is to enable the facility to prevent future occurrences.

The following important elements of an investigation serve as guidelines. Be sure to consider the appropriate elements each time an investigation is conducted:

- What is the specific allegation? This is the basis of the investigation. Compare the allegation to the definitions of misconduct. Ask if the information being gathered is related to the incident and addresses the elements of the offense.
- Who was present at the time of the incident? (Victim, perpetrator, witnesses?)
- Who else might have information about the incident? (Other caregivers on duty, supervisors, visitors, maintenance or kitchen staff, social workers?)
- Include all persons who are connected in any way with the incident under investigation. Identify each person separately in such a manner that he/she cannot be confused with any other individual, including full name, nicknames, demographic and contact information.

- Interview other staff who might know or have information about the behaviors of the residents or the staff person in question.
- Where did it happen? (Specify the exact location.)
- When (date and time) did it happen?
- How did it happen? (Recreate the alleged incident. Could it have happened the way the reporter stated?)
- Why did it happen? What was happening immediately prior to the incident? What happened immediately afterward?

Additional elements must be included based on the type of misconduct:

Physical Abuse

- Written and signed statements by witnesses, which include a description of the amount of physical force used. This may include, but isn't limited to, the acceleration of force; the range of motion of the perpetrator; open hand or closed fist.
- A description of the victim's reaction to the physical force. For example, the victim fell backwards, victim vocalizations, or indications of pain.

Verbal Abuse/Psychological Abuse

- A statement of the exact words used to the best of the witnesses' or victim's recollection
- The volume (loud or soft) and tone of voice (e.g. sarcastic, sneering) of the accused, , a description of the accused's body language or any accompanying gestures
- The effect of the words on the victim, e.g. fearful, crying, angry, etc.

Sexual Abuse

- The results of any physical assessment conducted by a medical professional including doctors or Sexual Assault Nurse Examiners (SANE nurses)
- The results of any psychological assessment conducted by a mental health professional or social worker
- A copy of the police report
- All medical information related to the incident

Neglect

- Documentation of the treatment, service, care, goods or supervision required but not provided
- Documentation verifying the caregiver's duty to provide care to the individual
- Verification that the act or failure to act resulted in or could reasonably have resulted in harm

Misappropriation

- A description of any stolen items
- Copies of all financial records related to the incident including cancelled checks or credit card statements
- A copy of the police report
- Verification that the stolen items belonged to the victim
- Verification that the victim did not/could not give consent to the individual

Resident-to-Resident Altercations

- Documentation of each resident's cognitive abilities, diagnosis, etc.
- Analysis of the altercation to determine if the resident(s) had willful intent (e.g., through immediate interviews of residents and eyewitnesses, observations, etc.).
- Consideration of the resident's ability to form intent or to act knowingly
- Determination of a resident's ability to understand the possible outcome of his/her actions.
- Documentation of the outcome to the victim.

Resident-to-Resident Altercations

Reference: Resident-to-Resident Altercation Flowchart

An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as a potential situation of abuse under the guidance for 42 C.F.R. § 483.13(b) at F223. 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," refer to the interpretive guidelines at F323 Resident-to-Resident Altercation 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."

All altercations must be immediately reported to the administrator; further, all incidents must be reported to DQA if facility staff members determine that the aggressor's actions were willful or if the facility cannot immediately rule out willful intent and if the altercation resulted in pain, physical injury or psychosocial harm. Providers may immediately conduct an initial evaluation to analyze a resident-to-resident altercation to determine if it meets the definition of abuse (i.e., the resident(s) had willful intent and the altercation resulted in physical or psychosocial harm to a resident).

Neither CMS nor DQA mandate a specific evaluation tool or method. Facilities use a variety of assessments in determining a resident's mental status. Questioning the resident about his/her understanding of the consequences of his /her actions is important. This interview should take place immediately after the occurrence, if possible:

- If the resident cannot understand cause and effect, cannot remember the incident or understand what is being referred to, it is unlikely that the resident is/was able to form intent.
- If the resident remembers the occurrence, knows that his/her actions could have harmed another person, or verbalized intent (e.g., "I'm going to get you"), then the resident is/was

able to form intent. Under these circumstances, the incident is reportable if pain, injury, or psychosocial harm has occurred or the likelihood of pain, injury or psychosocial harm using the reasonable person concept has occurred.

A diagnosis of dementia or Alzheimer's does not rule out the ability of a person to form intent. The facility needs to determine if the resident has the ability to understand the possible outcome of his/her actions. Does the resident understand that if s/he hits, bites, pushes, etc. another person, that person could be injured? If the resident does not understand, the incident is not reportable. If the resident does understand, or if the facility does not rule out intent (either because the facility did not try to determine intent or was unable to rule out intent), then the incident should be reported if injury, or the potential for psychosocial injury using the reasonable person concept, has occurred. According to federal hearing decisions, a "resident does not need to have intended harm for the resident's actions to be willful." For an action to be "willful," the resident needs to have intended the action (e.g., the push or hitting) and needs to understand that such an action could have consequences.

Example A

Two residents, each with a diagnosis of dementia are involved in an altercation. Staff heard the residents yelling and found resident A standing over resident B. Resident A was shouting, "I told you to stay out of my room." Resident B was lying on the floor of resident A's room and had sustained a one-centimeter laceration to his arm. When questioned, resident B was unable to relate what happened. Resident A stated that he struck resident B when he failed to leave the room. Resident B has a history of wandering and resident A has a history of being very territorial.

Analysis: Both elements of abuse - injury (1-cm. laceration) and intent - are present, so this is reportable. Resident A was able to state that he had hit resident B and gave the reason for striking him. This would indicate an ability to form intent. The resident had an injury, a laceration to his arm.

In addition to reporting, the facility is responsible for assessing the situation, identifying measures to keep residents safe, and for updating the care plans of Resident A and/or B.

Example B

While being pushed in her wheelchair in the hallway, resident A, who has dementia and a history of striking out, swats resident B on the arm as she passes her. Resident B states she is not hurt (no pain) and that she is not afraid of resident A. When asked why she hit resident B, resident A does not recall having done this.

Analysis: Neither of the elements of abuse are present, and this is not reportable. It does not appear that resident A is/was able to form intent. Resident A's care plan shows that she has a history of unprovoked striking out and her assessment shows that she does not understand that

this could hurt someone. Injury has not occurred; resident B denies pain, does not have a laceration, and states she is not afraid of Resident A.

Even though this is not reportable, the facility is still responsible for assessing the situation, identifying measures that may be needed to keep other residents safe from Resident A, and updating the care plan as necessary.

Example C

A staff member observed a male resident fondling the breasts of a female resident. The female resident was interviewed but has severe dementia and could not relate what happened. The male resident has a psychiatric diagnosis but was able to be interviewed. He denied fondling the resident.

Analysis: This is reportable. The female resident has a history of severe dementia and is unable to give consent. There is nothing in the record to indicate that these two residents have an intimate history and that this was a consensual act. Using the “reasonable person” concept, because the female resident cannot describe her feelings or reactions, psychosocial harm has occurred. Although the male resident has a psychiatric diagnosis, the facility was able to interview him and believed that he knew what he was doing.

Regardless of whether this was a reportable incident, the facility is responsible for assessing the situation, identifying measures to keep residents safe, and for updating the care plan(s) of the residents involved.

Example D

Staff overheard resident A, who is alert and oriented, shout at his roommate (resident B), “Shut the hell up. You moan all the time. Shut up or I’ll shut you up.” Resident B responds by crying and tells staff he is afraid of his roommate.

Analysis: This is reportable because verbal abuse has occurred. Resident A has knowingly threatened resident B. Intent to cause harm is present. Federal interpretative guidelines define “verbal abuse” as the use of oral, written or gestured language and include “threats of harm”, regardless of the age, ability to comprehend, or disability of the victim.

In addition to reporting, the facility is responsible for assessing the situation, identifying measures that may be needed to keep other residents safe from Resident A, and updating the care plan as necessary.

Example E

A resident's daughter reported that her mother's ruby ring, which she last saw two days ago, was missing. The resident has mild dementia, but the daughter insisted the resident would not

willfully remove the ring from her finger. The daughter implied a staff member was responsible.

Analysis: At this point the facility could conduct an initial evaluation to search for the ring. If staff do not find the ring during this initial search (which must be done immediately), this is reportable.

Example F

The facility was given \$21.00 by three different families on Wednesday in payment for a zoo outing on Friday by their respective family members/residents. The person at the desk took the money and gave it to the nurse, who locked it in the medicine drawer. On Friday morning, the Social Worker asked the nurse for the money for the three residents to go to the zoo. There was no money in the medicine drawer.

Analysis: The facility could not immediately determine what had happened to the money because the staff members who were questioned denied any knowledge of the missing money. This is reportable. The money was a gift that belonged to the residents. The money was in a locked drawer and only the staff had a key to the drawer.

Resources

See the following investigation resources:

- [Wisconsin Caregiver Abuse and Neglect Prevention Project](#)
- [Investigation Protocol](#)
- [Conducting Internal Investigations of Caregiver Misconduct Training – Webcast Series](#)
- [Suggested Sexual Assault Response Protocol](#)

Attachment: [Injury of Unknown Source Flowchart](#)
[Resident-to-Resident Altercation Flowchart](#)