The Division of Quality Assurance (DQA) established consistent requirements that apply to all entities (except nursing homes) covered under the Caregiver Law to conduct thorough internal investigations and report allegations of caregiver misconduct and injuries of unknown source. These requirements are fully outlined in DQA publication P-00038, *Wisconsin Caregiver Program Manual*, found at [http://www.dhs.wisconsin.gov/publications/p0/p00038.pdf](http://www.dhs.wisconsin.gov/publications/p0/p00038.pdf). Entities should refer to the *Wisconsin Caregiver Program Manual* for all Caregiver Law questions, including background checks and reporting requirements. See Chapter 6 of the *Wisconsin Caregiver Program Manual* for the detailed reporting requirement information.

Note: Nursing homes should refer to DQA publication P-00981, *Nursing Home Reporting Requirements for Alleged Incidents of Abuse, Neglect, and Misappropriation*, for appropriate reporting requirements.

This publication contains important clarification regarding:
- Review of the caregiver misconduct reporting requirements
- Misconduct Incident Report (DQA form F-62447)
- DQA’s response to incident reports

**REVIEW OF THE CAREGIVER MISCONDUCT REPORTING REQUIREMENTS**

Entities are required to develop **written procedures** specifying:
- How and to whom staff are to report incidents
- How internal investigations will be completed
- How staff will be trained on the procedures related to allegations of caregiver misconduct
- How residents will be informed of those procedures

You must ensure that your employees, contractors, volunteers, clients, and non-client residents are knowledgeable about your entity’s misconduct reporting procedures and requirements. Your staff must be trained to immediately report to the appropriate person all allegations of misconduct, including abuse or neglect of a client or misappropriation of a client’s property.

**Immediately** upon learning of an incident, you must take the necessary steps to protect clients from possible subsequent incidents of misconduct or injury. In addition to DQA reporting requirements, you are encouraged to notify local law enforcement authorities of any situation where there is a potential criminal offense.

As an entity regulated by DQA, you must immediately conduct a thorough **internal investigation** of all allegations or incidents and document the findings for each allegation or incident. A thorough internal investigation may include:
- Collecting and preserving physical and documentary evidence
- Interviewing alleged victims and witnesses
- Collecting other corroborating/disproving evidence
- Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency)
- Documenting each step taken during the internal investigation

Your entity should take these steps as part of your initial attempt to determine what, if anything, happened, and to determine the complete factual circumstances surrounding the alleged incident. Your entity’s internal investigation will assist in determining if you must report an incident to DQA. If you report the incident to DQA, your entity’s internal investigation becomes part of the DQA caregiver misconduct investigation.
Reporting Decision Tools

The following documents can help you determine if an incident must be reported to DQA:

- DQA form F-00161A, Flowchart for Investigating and Reporting Caregiver Misconduct or Injuries of Unknown Source (Except Nursing Homes), at: http://www.dhs.wisconsin.gov/forms/f0/f00161a.pdf

Incidents MUST be reported to DQA when:

- You have reasonable cause to believe you have sufficient information or evidence, or another agency could obtain the evidence, to show the alleged incident occurred and
- You have reasonable cause to believe the incident meets, or could meet, the definition of abuse, neglect, or misappropriation.

Caregiver Misconduct Definitions

See these references for the complete definitions of abuse, neglect, and misappropriation:


Injury of Unknown Source

The definition of “injury of unknown source” has been revised to the following federal definition:

- The source of the injury was not observed by any person or the source of the injury cannot be explained by the resident, and
- 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).

Refer to Chapter 6 of the Wisconsin Caregiver Program Manual for case examples and investigation strategies.

REPORTING INCIDENTS OF CAREGIVER MISCONDUCT

If you conclude that you must report the incident to DQA, complete DQA form F-62447, Misconduct Incident Report, located at: http://www.dhs.wisconsin.gov/forms1/f6/f62447.pdf

Follow these steps to report an incident to DQA:

1. Thoroughly complete DQA form F-62447, Misconduct Incident Report, and attach relevant internal investigation documents.
2. Ensure the completed Incident Report is submitted according to the appropriate timeframe.

   - Nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs), certified to receive Medicare and Medicaid funds, must submit reports of alleged caregiver misconduct to DQA within five (5) working days (Monday through Friday, except legal holidays) of the date the entity knew or should have known of the incident.
   - All other entities must submit reports of alleged caregiver misconduct to DQA within seven calendar days of the date the entity knew or should have known of the incident.
3. For allegations involving all staff (non-credentialed and credentialed), submit the *Misconduct Incident Report* to DQA at:

**Department of Health Services**  
**Division of Quality Assurance**  
**Office of Caregiver Quality**  
P.O. Box 2969  
Madison, WI 53701-2969

You may also send forms via email to DHSCaregiverIntake@dhs.wisconsin.gov or by fax to 608-264-6340.

Note: In the past, you were required to submit the report either to DQA or to the Department of Safety and Professional Services (DSPS). This process has been streamlined to eliminate reporting to two different agencies. All caregiver misconduct reports are submitted to DQA, who will forward reports involving credentialed staff (doctors, RNs, LPNs, social workers, etc.) to the DSPS for review.

**Entity Reporting Requirement Sanctions**

An entity may be sanctioned for failing to meet caregiver misconduct reporting requirements if the entity fails to take the following actions:

- Maintain written policies and procedures regarding caregiver misconduct, including internal reporting requirements
- Train all staff on those written policies and procedures
- Immediately takes steps to protect the client(s)
- Begin its internal investigation immediately upon learning of an incident
- Conduct a thorough internal investigation and documents the results
- Make good-faith decisions in determining whether or not to report an incident

Entities must maintain the results of the 30 most recent internal investigations that were not forwarded to DQA. Upon reviewing the results of unreported incidents, DQA survey staff may still refer the allegations to the Office of Caregiver Quality (OCQ) for possible investigation.

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**DQA RESPONSE TO INCIDENT REPORTS**

DQA responds to two types of health care complaints:

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

When DQA receives a complaint of caregiver misconduct from an entity or another source, the report is screened by DQA’s Office of Caregiver Quality (OCQ) to determine whether further investigation is warranted. Investigation screening decisions are made on a case-by-case basis. OCQ sends notification letters to the accused person, entity, staffing agency (if applicable), and complainant as to whether an investigation will be conducted by OCQ.

DQA may conduct a caregiver misconduct investigation by conducting on-site visits, in-person interviews, or telephone interviews. OCQ consumer protection investigators complete caregiver misconduct investigations. Not all reported incidents are investigated by DQA. However, DQA does track and monitor all incident reports. When DQA observes a pattern of reported incidents involving a caregiver, an investigation may be opened at a later date.

In order for the Department to substantiate a finding of misconduct against a caregiver, the incident must meet the definition of caregiver abuse, neglect, or misappropriation. After completing a caregiver misconduct investigation, DQA determines whether there is sufficient evidence to substantiate the complaint. An incident may violate the work rules or procedures of a facility but, at the same time, not meet the definitions or the evidentiary standards of DHS Chapter 13.
Therefore, it is possible an employer may appropriately discipline or terminate a caregiver for a particular incident, but DQA may determine the incident does not constitute caregiver misconduct.

The entity’s DQA regulatory program (Bureau of Assisted Living, Bureau of Health Services Section, or Bureau of Nursing Home Resident Care) 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.

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**WISCONSIN CAREGIVER MISCONDUCT REGISTRY**

The Wisconsin Caregiver Misconduct Registry is a record of the names of nurse aides and other non-credentialed caregivers with a substantiated finding of caregiver misconduct. Entities should review on a monthly basis the caregivers whose names have been most recently added to the Wisconsin Caregiver Misconduct Registry due to a substantiated finding. Some individuals, who did not have a finding upon hire, may receive one while employed. Individuals sometimes fail to report the finding to the employing entity. Accordingly, the only way to know of such findings is to check the updated Misconduct Registry each month.

These monthly additions of caregivers with a finding of misconduct on the Wisconsin Caregiver Misconduct Registry are posted by the 15th of the month and may be viewed on the Internet at: [http://www.dhs.wisconsin.gov/caregiver/misconduct.htm](http://www.dhs.wisconsin.gov/caregiver/misconduct.htm)

Federal regulations require that nurse aides with a finding of caregiver misconduct be permanently barred from working in any capacity in federally regulated nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs). The Caregiver Misconduct Registry identifies each caregiver by name, date of birth, and type of caregiver.

More detailed information is available at Wisconsin’s Internet-based Nurse Aide Registry at: [http://www.pearsonvue.com/](http://www.pearsonvue.com/)

Go to “Quick Links,” and, then, “Search the Nurse Aide Registry.”

- **For a nurse aide (NA):** Information will be provided regarding the aide’s employment eligibility and whether a finding of misconduct has been placed under the aide’s name.
- **For any other non-credentialed caregiver (CGE):** Due to Wisconsin state regulations, an individual, such as a personal care worker, maintenance worker, or laundry aide, is identified as a CGE with a finding on the Caregiver Misconduct Registry and may not be employed as a caregiver (as that term is defined in §50.065 or §48.685, Wis. Stats.) in any entity regulated by the Wisconsin Department of Health Services unless approved through the Rehabilitation Review process.

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**QUESTIONS**


You may also contact the Office of Caregiver Quality (OCQ) at [DHSCaregiverIntake@dhs.wisconsin.gov](mailto:DHSCaregiverIntake@dhs.wisconsin.gov) or 608-261-8319.