



# NURSING HOME REPORTING REQUIREMENTS FOR ALLEGED INCIDENTS OF ABUSE, NEGLECT, EXPLOITATION, AND MISAPPROPRIATION

Wisconsin Department of Health Services / Division of Quality Assurance  
P-00981 (11/2017)

The Division of Quality Assurance (DQA) has issued this publication to all nursing homes to provide direction on how to report alleged incidents of abuse, neglect, exploitation, and misappropriation to DQA.

Per direction from The Centers for Medicare & Medicaid Services (CMS), all nursing homes must immediately report to DQA all alleged violations involving mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property. If the events that cause the allegation involve abuse or result in serious bodily injury, nursing homes must report the violation to the administrator of the facility and DQA no later than two hours after the allegation is made. All other allegations that do not involve abuse and that do not result in serious bodily injury must be reported no later than 24 hours after the allegation is made. CMS defines "immediately" to be as soon as possible but not to exceed 24 hours after discovery of the incident. In addition, nursing homes must report to DQA and law enforcement any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

CMS Survey and Certification (S&C) has issued memos which clarify mandatory requirements for participating Medicare and Medicaid providers regarding the reporting of and prevention of resident abuse, neglect, exploitation, and misappropriation. Refer to the "Resources and Questions" section at the end of this publication for a listing of CMS memos which clarify mandatory reporting requirements.

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) and to the DQA Office of Caregiver Quality (OCQ) within five working days of the incident. If the alleged violation is verified, the facility must take appropriate corrective action.

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

- Nursing home reporting requirements
- Definitions under federal and state Law
- Required online reporting and DQA form F-62447, *Misconduct Incident Report*

---

## NURSING HOME REPORTING REQUIREMENTS

All nursing homes must develop written policies and procedures specifying:

- **Screening** of potential employees for a history of the abuse, neglect, or mistreatment of residents which includes attempting to obtain information from previous employers and/or current employers, and checking with appropriate licensing boards and registries
- **Training** for employees through orientation and on-going sessions on issues related to the mistreatment of residents, including what constitutes abuse, neglect, and misappropriation of resident property, the procedures related to allegations of misconduct, and how residents (and guardians, as appropriate) will be informed of those procedures
- Strategies for the **prevention** of incidents of abuse, neglect, or mistreatment including training in dementia management and resident abuse prevention
- Strategies for the **identification** of events, occurrences, patterns, and trends, such as suspicious bruising of residents, that may constitute abuse in order to determine the direction of the investigation
- **Investigation** of different types of incidents, including the identification of the staff member responsible for the initial reporting, investigation of alleged violations, and reporting of results
- How residents will be **protected** from harm and prevent further potential abuse, neglect, exploitation, or mistreatment while an investigation is in progress
- How and to whom staff is to **report** incidents and the **response** to alleged violations, such as an analysis to determine what changes are needed, if any, to policies and procedures to prevent further occurrences

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 their designee) all incidents of misconduct, including abuse, exploitation, 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.

**All nursing homes** must immediately report **all alleged violations** involving mistreatment, neglect, exploitation, or abuse, including injuries of unknown source and misappropriation of resident property to DQA using DQA form F-62617, *Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report*. Alleged violations must be reported immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury **or** not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Refer to the misconduct definitions to determine if an alleged incident constitutes a violation. In addition to federal and state reporting requirements, providers must notify local law enforcement authorities of any situation where there is a potential criminal offense. See form F-62617 at [www.dhs.wisconsin.gov/forms/f62617.docx](http://www.dhs.wisconsin.gov/forms/f62617.docx).

---

## DEFINITIONS UNDER FEDERAL AND STATE LAW

A comparison of the federal and state misconduct definitions in nursing home settings is available in DQA publication P-00976, *Misconduct Definitions*. 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. See publication P-00976 at [www.dhs.wisconsin.gov/publications/p00976.pdf](http://www.dhs.wisconsin.gov/publications/p00976.pdf).

Each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. 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 to DQA immediately, including resident-to-resident incidents.

Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also 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. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, and mental anguish. It includes verbal, sexual physical, and mental abuse, including abuse facilitated or enabled through the use of technology. 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.

"Willful" means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Even though a resident may have 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 F689. Refer to the interpretative guidelines at F689 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 § 483.12 (F600)."

---

## REQUIRED ONLINE REPORTING AND INCIDENT REPORT FORM

### 1. Alleged Nursing Home Resident Mistreatment Report (F-62617)

Completion of DQA form F-62617, *Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report*, is required to meet the requirements in federal regulation 42 CFR § 483.12(c)(1). Nursing homes must **immediately report all incidents** of alleged mistreatment, abuse, exploitation, and neglect of residents, misappropriation of resident property, and injuries of unknown source to DQA. If the events that cause the allegation involve abuse or result in serious bodily injury, nursing homes must report the violation no later than two hours after the allegation is made. 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. See form F-62617 at [www.dhs.wisconsin.gov/forms/f62617.docx](http://www.dhs.wisconsin.gov/forms/f62617.docx). To print a copy of the report form, click on the browser's print button before clicking the "Done" button.

All nursing homes must also 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:

- Conducting observations of alleged victim, including identification of any injuries, the location where the alleged incident occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents, as appropriate
- Collecting and preserving physical and documentary evidence, including conducting record review for pertinent information related to the alleged violation, as appropriate (e.g., progress notes, financial records, incident reports, reports from hospital emergency room records, laboratory or x-ray reports, medication administration records, photographic evidence, and reports from other investigatory agencies)
- Interviewing alleged victim(s) and witness(es)
- Interviewing accused individual(s) allegedly responsible for mistreatment or suspected of causing an injury of unknown source, including staff, visitors, resident's relatives, etc.
- 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 or incident
- Involving other regulatory authorities who may assist (e.g., local law enforcement, elder abuse agency, adult protective service agency)

Even if an alleged violation was reported to law enforcement as a reasonable suspicion of a crime committed against a resident, the facility must still conduct its own internal investigation to the extent possible, in consultation with the law enforcement authority.

## 2. Misconduct Incident Report (F-62447)

Completion of the *Misconduct Incident Report* (DQA form F-62447), available online at [www.dhs.wisconsin.gov/forms1/f6/f62447.pdf](http://www.dhs.wisconsin.gov/forms1/f6/f62447.pdf), is required when:

- You submitted an online *Alleged Nursing Home Resident Mistreatment Report* (DQA form F-62617) within 24 hours of an incident (or within two hours if the events that cause the allegation involve abuse or result in serious bodily injury).
- You concluded that an incident did not meet federal definitions, so you did not submit an online *Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report* but, upon further review, the incident does meet state definitions.
- 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 publication P-00907, *Reporting Requirements for All Entities Regulated by the Division of Quality Assurance (Except Nursing Homes)*, available at [www.dhs.wisconsin.gov/publications/p00907.pdf](http://www.dhs.wisconsin.gov/publications/p00907.pdf).

**Note:** Nursing homes must complete the *Misconduct Incident Report* (DQA form F-62447) for reporting the results of an investigation. 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.

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

1. Thoroughly complete the *Misconduct Incident Report* and attach relevant investigation documents.
2. Ensure the completed *Misconduct Incident Report* is submitted within five working days of the incident or on 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 by mail, fax, or email to:

**Division of Quality Assurance  
Office of Caregiver Quality  
PO Box 2969  
Madison, WI 53701-2969  
608-264-6340 (fax)  
[DHSCaregiverIntake@wisconsin.gov](mailto:DHSCaregiverIntake@wisconsin.gov)**

OCQ notifies the DQA Bureau of Nursing Home Resident Care (BNHRC) of all reports. Allegations of caregiver misconduct may be investigated by OCQ and/or BNHRC. BNHRC may conduct separate investigations related to facility issues. 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 or elder-at-risk agency
  - Credentialed and licensed staff (physician, RN, LPN, social worker, administrator, etc.) to the Department of Safety and Professional Services (DSPS)
- 

## RESOURCES AND QUESTIONS

### CMS S&C Memos Clarifying Mandatory Reporting Requirements

- S&C-05-09: Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property  
[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter05-09.pdf)
- S&C-11-15-ICF/MR: Clarification of Reporting Mistreatment, Neglect and Abuse and Injuries of Unknown Source at 42 CFR § 483.420(d)(2) –Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)  
[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11\\_15.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_15.pdf)
- S&C-11-30-NH: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act  
[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11\\_30.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter11_30.pdf)
- S&C-12-44-NH: “Hand in Hand: A Training Series for Nursing Homes,” on Person-Centered Care of Persons with Dementia and Prevention of Abuse  
[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-44.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-44.pdf)
- S&C-16-33-NH: Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff  
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-33.pdf>

### Investigative Resources

DQA publication P-00038, *Wisconsin Caregiver Program Manual*, Chapter 6  
[www.dhs.wisconsin.gov/publications/p0/p00038.pdf](http://www.dhs.wisconsin.gov/publications/p0/p00038.pdf)

### Questions About Reporting or Investigation Requirements

Contact the Office of Caregiver Quality at [dhscaregiverintake@wisconsin.gov](mailto:dhscaregiverintake@wisconsin.gov) or by calling **608-261-8319**.