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**To:** Nursing Homes    NH 01

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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, both memos are now obsolete as of the issuance of this memo.

Per 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 the Division of Quality Assurance (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) and to the DQA Office of Caregiver Quality (OCQ) within 5 working days of the incident. 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, 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:

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

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## 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 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 their 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 immediately report **all alleged violations** involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property to the Division of Quality Assurance (DQA) **via the online reporting system** at <http://4.selectsurvey.net/DHS/TakeSurvey.aspx?SurveyID=96MI3ml4>. Refer to the misconduct definitions to determine if an alleged incident constitutes a violation. 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. Nursing homes must update their written procedures to avoid a possible deficiency under 42 CFR § 483.13 (c) (F226) at an F level, which is Substandard Quality of Care (SQC).

## 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 immediately.

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 Reporting & Incident Report Form**

### **1. Online Alleged Nursing Home Resident Mistreatment Report**

Effective immediately, completion of the **online form** at <http://4.selectsurvey.net/DHS/TakeSurvey.aspx?SurveyID=96MI3m14> 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. To print a copy of the report, 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:

- 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 or incident; and
- Involving other regulatory authorities who may assist, e.g., local law enforcement, elder abuse agency, Adult Protective Service agency.

**Note:** Nursing homes must not use the F-62617 form for immediate 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.

### **2. 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  
FAX: (608) 264-6340**

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](#)
- [Conducting Internal Investigations Training – Materials](#)
- [Investigation Protocol](#)

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](mailto:DHSCaregiverIntake@wisconsin.gov) or (608) 261-8319.

Attachment: [Misconduct Definitions](#)