

Select originating cluster

Cathy Cooper

Authorized Signature

Number: SPD-IM-05-066
Issue Date: 09/01/05

Topic: Protective Services

Subject: Provider Guide for Nursing Facility Abuse Reporting and Investigation

Applies to (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> All DHS employees
<input checked="" type="checkbox"/> Area Agencies on Aging
<input type="checkbox"/> Children, Adults and Families
<input type="checkbox"/> County DD Program Managers | <input type="checkbox"/> County Mental Health Directors
<input type="checkbox"/> Health Services
<input checked="" type="checkbox"/> Seniors and People with Disabilities
<input type="checkbox"/> Other (please specify): |
|---|---|

Message: SPD has developed a guide for Nursing Facility providers outlining their responsibilities, per statute, to self-report incidents of alleged abuse or neglect. This guide includes interpretive guidance for the Oregon Administrative Rules related to abuse or neglect in licensed Nursing Facilities. The guide can be accessed from the DHS forms server at <http://dhsforms.hr.state.or.us>, search for the document by form number 0818. The guide includes a recommended form for Nursing Facilities to use for self-reporting to local APS. This guide is being distributed to all of Oregon Nursing Facilities, APS staff should become familiar with its' content.

If you have any questions about this information, contact:

Contact(s):	Elaine Young		
Phone:	503-945-6456	Fax:	503-378-8966
E-mail:	Elaine.Young@state.or.us		

Oregon Nursing Facility
Abuse Reporting and
Investigation
Guide for Providers



Oregon Department of Human Services
Seniors and People with Disabilities
Office of Licensing and Quality of Care
500 Summer Street NE, E13
Salem, OR 97301
1-503-945-5832 • 1-800-232-3020

DHS 0818 (Rev. 8/05)

Table of Contents

Introduction.....	Page 3
Definitions.....	Page 4
Oregon Administrative Rules and Interpretive Guides.....	Pages 5-11
Facility Reporting and Investigative Process.....	Pages 12-18

Appendix A

Flow Chart - Reporting and Investigation of Incidents

Appendix B

Nursing Facility Incident Self-Report Form (DHS 0819)

Introduction

The Incident Reporting Guidelines for Nursing Facilities provides an overview of how to report to the local office of Adult Protective Services (APS) incidents of abuse or suspected abuse and how to investigate such incidents. **Incidents involving physical, sexual, verbal, or mental abuse; neglect of care; involuntary seclusion; corporal punishment; and illegal or improper use of resident resources must be reported and subsequently investigated by the facility to determine if abuse has occurred.**

Federal and state regulations require the immediate reporting of those incidents if abuse is suspected or alleged. The facility must investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out.

This guide is intended for use by facility management and professional staff, and is available for review by Department of Human Services (DHS) partners and public. Facility personnel will find resources and tools in the guide to successfully use the state's abuse reporting system. In an effort to provide easy access to the system, this guide describes the reporting process.

APS and Client Care Monitoring Unit (CCMU) process and triage each reported incident to ensure resident safety and a complete investigative process. An on-site investigation may occur to evaluate the facility's compliance with federal and state regulations. A written report of the APS or CCMU investigation will be provided to the facility along with the Letter of Determination. Follow-up visits to the facility may occur when federal or state deficiencies have been cited by CCMU.

Working in partnership and using this guide, Nursing Facilities, APS and DHS/CCMU will not only fulfill federal and state requirements, but will also maintain professional standards and contribute to resident protection and prevention of abuse. Applicable regulations include:

1. Federal: 42 CFR 483, Subpart B - Requirements for Long-Term Care Facilities
2. State: Oregon Administrative Rules - Chapter 411, Divisions 085 through 089 - Licensing of Nursing Facilities

Definitions

Date of Discovery - The calendar date (month/day/year) and time that the first facility staff mandatory reporter observed, found, or learned of an incident or injury.

Date of Incident - The calendar date (month/day/year) that an incident or injury occurred.

Incident - For the purpose of this guide, an occurrence involving a resident in which abuse is alleged or suspected, and in the case of injuries of unknown cause, where an immediate facility investigation cannot rule out abuse. Abuse can include physical, sexual, verbal or mental abuse; neglect of care; corporal punishment; involuntary seclusion; and exploitation of resident resources.

Injuries of Unknown Cause - Any injury should be classified as an “injury of unknown cause” when the source of the injury was not observed by any person and the source of the injury could not be explained by the resident.

Letter of Determination (LOD) - A letter prepared by the Oregon Department of Human Services that states the Department’s determination concerning each incident or problem alleged in the complaint, including whether a substantiated incident was abuse or a violation of a licensing rule. If it is determined that abuse has occurred, the letter states whether the facility or an individual, or both, was responsible.

Self-Reported Incident - A mandated notification of abuse or suspected abuse (including injuries of unknown cause, if abuse cannot be ruled out), to the local office of Adult Protective Services from a self-reporting provider (i.e., the administrator or authorized official).

Oregon Administrative Rules and Interpretive Guides

411-085-0005(1) "Abuse" means:

411-085-0005(1)(a) Any physical injury to a resident which has been caused by other than accidental means. This includes injuries which a reasonable and prudent person would have been able to prevent such as hitting, pinching or striking, or injury resulting from rough handling;

Interpretive Guide:

- These instances of abuse are presumed to cause physical harm, including pain, to all residents, even those in a coma or otherwise incapable of expressing harm.
- Includes instances of corporal punishment.

411-085-0005(1)(b) Failure to provide basic care or services to a resident, which failure results in physical harm or unreasonable discomfort or serious loss of human dignity;

Interpretive Guide:

- Failure to provide basic care or services to a resident, which failure results in physical harm, unreasonable discomfort or serious loss of human dignity. Abuse under this definition includes the deprivation by an individual, including a caregiver, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.
- Physical harm, as used in this definition, includes: physical injury of any severity; avoidable decline in condition; and failure to maintain or improve physical condition.

- Unreasonable discomfort and serious loss of dignity require significant negative outcomes. For residents unable to recognize the abuse or respond appropriately, the severity of the outcome will be evaluated using the reasonable and prudent person test. Lesser outcomes are generally considered resident rights issues.
- This definition includes miscellaneous facility categories of abuse, such as abandonment and improper use of restraints, if they resulted in physical harm, unreasonable discomfort or serious loss of dignity.
- Facility failure to assess and intervene in inappropriate resident to resident behavior, including sexual behavior, is also included in this definition. The residents are both considered to be Reported Victims and the facility/staff is considered to be the Reported Perpetrator.
- Inappropriate sexual contact between residents is evaluated under (1)(b) of the abuse rule and, when foreseeable and predictable, is considered to be a failure to provide appropriate care and services on the part of the facility. The residents are both considered to be Reported Victims.

411-085-0005(1)(c) Sexual contact, including fondling, with a resident caused by an employee, agent or other resident of a long-term care facility by force, threat, duress or coercion, or sexual contact where the resident has no ability to consent;

Interpretive Guide:

- Sexual contact with a resident, including fondling, by an employee, agent or other resident of a long-term care facility by: physical force; physical or verbal threat of harm or deprivation to the resident or others; use of position, authority or mis-information to compel a resident to do what that resident would not otherwise do; or where the resident has no ability to consent. For the purpose of this rule, consent means a voluntary agreement or concurrence of wills and may be demonstrated by resident behavior as well as by verbal acknowledgment. Consent is not to be implied from the resident's failure to object.

- Inappropriate sexual contact by a cognitively intact resident against other residents may need to be investigated as a community abuse complaint as well as referred to law enforcement.
- Without evidence of consent, in cases of staff/resident sexual contact, it is considered to be abuse.

411-085-0005(1)(d) *Illegal or improper use of a resident's resources for the personal profit or gain of another person; or borrowing resident funds; or spending resident funds without the resident's consent; or if the resident is not capable of consenting, spending resident funds for items or services from which the resident cannot benefit or appreciate; or spending resident funds to acquire items for use in common areas when such purchase is not initiated by the resident;*

Interpretive Guide:

- Theft or diversion of a resident's property, including money, personal property and medications. Nothing in this rule shall be construed to prevent an owner, administrator or employee from acting as a representative payee for the resident.
- Abuse will be found regardless of the amount and type of resource or property involved and facility action before, during or after the exploitation.

411-085-0005(1)(e) *Verbal abuse as prohibited by federal law, including the use of oral, written or gestured communication to a resident or visitor that describes a resident(s) in disparaging or derogatory terms;*

411-085-0005(1)(f) *Mental abuse as prohibited by federal law including humiliation, harassment, threats of punishment or deprivation directed toward the resident;*

Interpretive Guide:

- Verbal or mental abuse, as prohibited by federal law, which includes, in extreme forms: the use of oral, written or gestured communication that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend or disability; humiliation; harassment; threats of punishment or deprivation directed toward the resident; and unwanted or inappropriate crude or sexual language, questions, comments or other communication.
- Examples of verbal and mental abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again; and making unwanted sexual comments about a resident's body.
- Verbal or mental abuse are distinguished from resident rights violations by the extreme and/or offensive nature of the communication.

411-085-0005(1)(g) Corporal punishment; or

Interpretive Guide:

- Included under 411-085-0005(1)(a). See page 5 of this guide.

411-085-0005(1)(h) Involuntary seclusion for convenience or discipline.

Interpretive Guide:

- Involuntary seclusion is defined as the separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will or the will of the resident's legal representative.
- Emergency or short-term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited

period of time as a therapeutic intervention: as part of an inter-disciplinary care plan after other planned interventions have been attempted; or to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

411-085-0005(2) "Abuse complaint" means any oral or written communication to the Division, one of its agents or a law enforcement agency alleging abuse.

411-085-0360(1) Abuse is Prohibited. The facility employees, agents and licensee shall not permit, aid, or engage in abuse of residents under their care.

411-085-0360(2) Reporters and Mandatory Reporters. All persons are encouraged to report abuse and suspected abuse. The following persons are **required** to immediately report abuse and suspected abuse to the Division or law enforcement agency:

- (a) Physicians, including any resident physician or intern;
- (b) Licensed practical nurse or registered nurse;
- (c) Employee of the Oregon Department of Human Services, Area Agency on Aging, county health department or community mental health program;
- (d) Nursing facility employee or any individual who contracts to provide services in a nursing facility;
- (e) Peace officer;
- (f) Clergy;
- (g) Licensed social worker;
- (h) Physical, speech or occupational therapist; and
- (i) Family member of a resident or guardian or legal counsel for a resident.

411-085-0360(3) Facility Reporting of Abuse or Suspected Abuse.

- (a) The nursing facility administration shall immediately notify the Division, local designee of the Division, or local law enforcement agency of any incident of abuse or suspected abuse. Physical injury of an unknown cause shall be reported to the Division as suspected abuse, unless an immediate facility investigation reasonably concludes the physical injury is not the result of abuse.
- (b) The local law enforcement agency shall be called first when the suspected abuse is believed to be a crime (for example: rape, murder, assault, burglary, kidnapping, theft of controlled substances).
- (c) The local law enforcement agency shall be called if the offices of the Division or designee are closed and there are no arrangements for after hours investigation.

411-085-0360(4) Abuse Complaint. The oral or written abuse complaint shall include the following information when available:

- (a) Names, addresses and phone numbers of alleged perpetrator(s), resident(s) and witness(es);
- (b) The nature and extent of the abuse or suspected abuse (including any evidence of previous abuse);
- (c) Any explanation given for the abuse or suspected abuse; and
- (d) Any other information which the person making the report believes might be helpful in establishing the circumstances surrounding the abuse and the identity of the perpetrator.

411-085-0360(5) Privilege. In the case of abuse of a resident, the physician-patient privilege, the husband-wife privilege, and the privileges extended under ORS 40.225 to 40.295 shall not be a ground for excluding evidence regarding the abuse, or the cause thereof, in any judicial proceeding resulting from an abuse complaint made pursuant to this section.

411-085-0360(6) Immunity and Prohibition of Retaliation.

- (a) The facility licensee, employees and agents shall not retaliate in any way against anyone who participates in the making of an abuse complaint, including but not limited to restricting otherwise lawful access to the facility or to any resident, or, if an employee, to dismissal or harassment.
- (b) The facility licensee, employees and agents shall not retaliate against any resident who is alleged to be a victim of abuse.
- (c) Anyone who, in good faith, reports abuse or suspected abuse shall have immunity from any liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint. Any such person shall have the same immunity with respect to participating in judicial or administrative proceedings relating to the complaint.

411-085-0360(7) Investigation by Facility. In addition to immediately reporting abuse or suspected abuse to the Division or law enforcement agency, the facility shall promptly investigate all reports of abuse and suspected abuse and shall take measures necessary to protect residents from abuse and prevent recurrence of abuse.

Facility Reporting and Investigative Process

--Protect

The first priority must be the immediate protection of residents from further harm. Protecting residents from further harm means keeping the residents safe. Each situation will be different, but here are some examples of actions that might be implemented:

- Ensure the reported perpetrator is kept away from the resident and/or other residents.
- Have a trusted person stay with the resident(s).
- Have the resident(s) stay in a safe area (for example, the nurses' station).
- Safeguard the resident(s)' well-being and property.
- Implement other interventions as appropriate.

--Report

Two types of incidents must be reported to Adult Protective Services (APS):

- **Abuse or suspected abuse** (physical, sexual, verbal or mental abuse, neglect of care, involuntary seclusion, illegal or improper use of resident resources), **must be reported immediately, BEFORE initiating an investigation**, and
- **Physical injuries of unknown cause**, must be reported **unless** an immediate facility investigation concludes that the physical injury is not the result of abuse.

Incidents involving a criminal act must be reported first to law enforcement, then immediately to APS.

Physical injuries of unknown cause are considered to be suspected abuse and reported to APS, **unless** facility investigation concludes the injury was not the result of abuse. In that case, it is not necessary to report to APS. If an investigation concludes that abuse did occur, or it is not possible to rule abuse out, it must be reported as soon as that determination is made. The facility's determination about the injury of unknown cause must be documented in the resident's record. Following are some examples of situations involving physical injury of unknown cause:

Example A: A resident with mild dementia is heard calling for help and found on the floor next to his bed. He had a skin tear and a bruise on his arm. No one witnessed the apparent fall. Staff check the resident for other injuries, level of consciousness, vital signs, etc., treat the skin tear, make sure the resident is comfortable and safe, and begin an investigation.

It is determined that although the resident was assessed to be at risk for falls, he had never fallen before and had never tried to get out of bed without assistance. He was not ill and had not had an obvious change in cognition level. Staff had provided care, and assisted the resident to the bathroom and back to bed only ten minutes before the incident. The resident could not remember exactly what happened, but said something about going to the bathroom.

Evidence supports that all care planned interventions were in place. Interviews were conducted and support that no other staff/residents were in the area. Because the investigation found that no abuse occurred, this incident would not need to be reported to APS. However, the facility would be expected to document the investigation, re-assess the resident's cognitive status and other relevant areas, and update the care plan with measures to prevent recurrence.

Example B: A resident with moderate dementia and a history of falls is found on the floor in her room. She had a nosebleed and a bruise on her forehead. No one witnessed the incident. Staff had assisted her to bed earlier.

Staff immediately assessed the resident's physical condition, performed appropriate treatment, and ensured her comfort and safety. The resident's care plan directed that a personal alarm was to be in place when in bed. No staff remembered hearing the alarm sound. The alarm was found to be attached to the bed, but not to the resident's clothing, and was determined to be in working order. The aide who had assisted the resident to bed stated that she had properly attached the alarm, and did not know how it could have come off and not sounded.

The investigation could not clearly determine whether abuse in the form of neglect of care had occurred or not. This incident would need to be reported to APS as soon as it was determined that abuse could not be ruled out.

Example C: A resident with advanced dementia is found on the floor in his room, next to a tipped-over commode. No one witnessed the incident.

In the immediate investigation, it was found that a staff person acknowledged helping the resident onto the commode earlier, stating that she told the resident to push his call bell when he was finished. The resident's care plan directed that he required one-person assist for transfers, and that he was not to be left alone on the commode. The staff person stated she had been in a hurry, did not remember that directive, and thought he was capable of remembering to use the call bell.

Because neglect of care, which is considered abuse, occurred, this incident would need to be reported to APS immediately upon obtaining the above information.

To report to APS, the enclosed Nursing Facility Self-Report Form is recommended to be completed and faxed to the local APS office. In describing the incident, provide as much detailed information as possible, answering who, what, where, when, why and how. Then **immediately** begin a thorough investigation.

--Investigate

All incidents require a thorough investigation to determine what occurred and to implement measures, as needed, to prevent recurrence. A thorough investigation

is a systematic (consistent and ordered) collection of information that describes and explains an incident or series of incidents. The investigation seeks to determine if abuse occurred, how the incident occurred, and how to prevent further occurrences. Critical components of any investigation include:

- the timely initiation of the investigation;
- the objectivity of the investigator;
- the preservation of evidence; and
- the thoroughness of the investigation.

Timeliness

Staff must immediately report and investigate all incidents in accordance with federal and state regulations, and facility policy. To help organize and allow the investigative process to proceed with speed and efficiency, staff training and written policies are required of the facility. Policies should define the responsibilities of staff who conduct investigations.

A prompt response to an incident is critical for protection of the resident(s), treatment of injury or adverse effects, and the collection of accurate data.

Objectivity of the Investigator

The investigator of any incident must remain objective and maintain neutrality during the course of the investigation. Investigations should not begin with a presumption of guilt or innocence of individual(s) reported as perpetrator(s). The investigator's approach should be from an impartial perspective to collect accurate, appropriate data and come to a conclusion. Conclusions should not be made based on incomplete information.

Preservation of Evidence

Evidence collected during the investigation may include, but is not limited to, some or all of the following:

- **Testimonial evidence:** witness statements, telephone notes, e-mails, faxes;

- **Documentary evidence:** alert charting/24 hour report, change of shift log, staffing log, in-room care plans, medication and treatment sheets, chart notes, x-rays, lab results, flow charts, orders, interview notes, post-its, medical records, care plans, incident reports, internal investigation, hospital records, maintenance logs, work documents, personnel records, contact information, financial records, police reports, overbed postings, in-service/training records;
- **Pictorial evidence:** drawn diagrams, photographs; and/or
- **Direct or physical evidence:** clothing, personal effects, linens, tissues, side rails, wheelchairs, foot rests, equipment, oxygen tanks, furniture.

Preservation of evidence is especially important when dealing with criminal or other serious incidents. Evidence identified during the course of an investigation must be preserved and made available upon request to APS, CCMU, local law enforcement and other authorities as appropriate.

Thoroughness of Investigation

A thorough investigation will enable the nursing facility to identify and document who, what, where, when, why and how the incident happened, including the cause or source of the incident.

Each investigation must seek to answer who, what, where, when, why and how, through interviews, comprehensive record review, and observations. Interviews may include but are not limited to: reported victim(s), reported perpetrator(s), CNA/NA(s), staff in immediate area or who provided services, roommate(s), visitors and/or family.

The following sample questions are not all-inclusive and should be used as they relate to the facts and circumstances of the incident that is being investigated.

Each investigation must be documented.

Who:

- is/are the reported victim(s)?
- is/are the reported perpetrator(s)?
- witnessed the incident?
- first spoke to the reported victim(s)/perpetrator(s) regarding the incident?
- has information related to the incident?
- reported the incident?

What:

- happened?
- is the chronology of actions leading up to the alleged incident?
- are the injuries or negative consequences to the resident(s)?
- was done to protect the resident(s) from further harm?
- information can the reported victim(s) share?
- did the discovering person(s) or witness(es) see, hear or smell?
- was done upon discovery of the incident?
- information do other staff members have surrounding the incident?
- was the functional, mental and cognitive status of the reported victim(s)/perpetrator(s) before and after the incident?
- is the resident's current medical condition (labs, progress notes, resident assessment instrument, care plan, injury trends)?
- diagnoses may have contributed to the incident, if any?
- recent changes in treatment and physician's orders may have contributed to the incident?
- is the resident's current physical status?
- is the impact of the environment to the incident?
- is the history of the resident(s)? Was the incident foreseeable?
- is the resident's condition/need? Is the assessment and care plan reflective of the resident's needs? Was the care plan being followed?

Where:

- did the incident happen? Be specific: room number, wing, hall, floor, or other specific location.
- were the witnesses in relationship to the incident or residents?

When:

- did the incident happen? (date, time, shift)
- was facility supervisory/management staff first contacted about the incident?

Why/How:

- How did the incident occur?
- Why did the incident and/or injury occur?

An investigation may be expanded to determine how widespread abuse is/was, and to identify other potential affected residents and/or perpetrators. It is important that conclusions not be reached without adequate information.

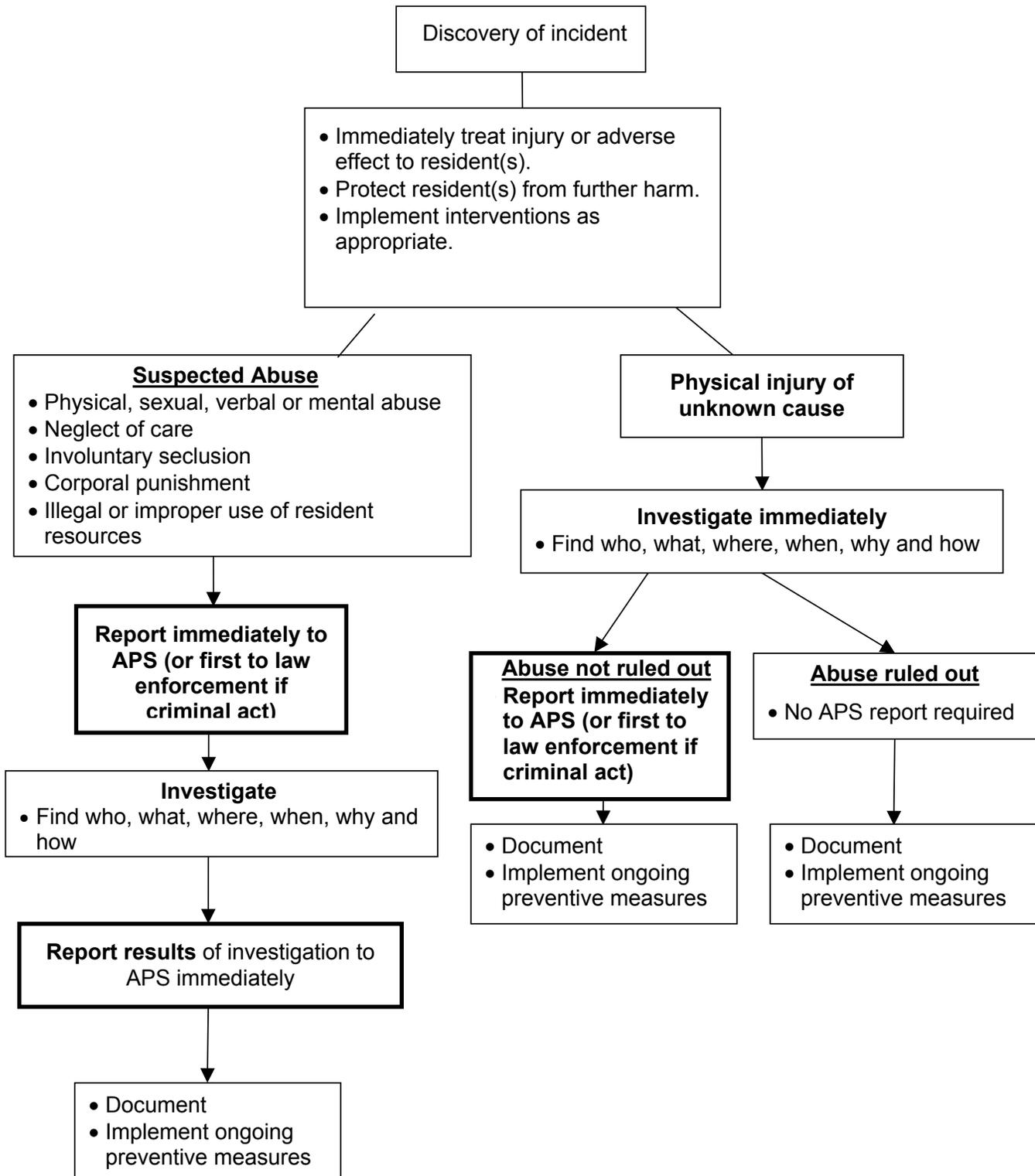
The following elements may be included in an expanded investigation, as appropriate:

- Further examine events which preceded and followed the incident.
- Repeat interviews to clarify information.
- Interview additional potential witnesses, such as: medical personnel, contract personnel, volunteers, family, visitors, clergy, vendors, etc.
- Interview additional residents who may have had contact with the reported perpetrator.
- Conduct follow-up investigation of newly discovered information.
- Consult with other professionals.

Results of the investigation should be reported to APS in a timely manner after the initial reporting.

Appendix A

REPORTING AND INVESTIGATION OF INCIDENTS



Appendix B



Seniors and People with Disabilities

Nursing Facility Incident Self-Report Form

Facility name: _____ Phone: (____) _____

Address: _____

Person reporting the incident: _____

Title: _____

Incident:

Date: _____ Time: _____ am pm Date discovered: _____

Location of incident: _____

Residents involved in incident: *(Attach additional pages if necessary.)*

Name: _____ Gender: M F

Medicaid? Yes No

Relevant diagnoses: _____

Name: _____ Gender: M F

Medicaid? Yes No

Relevant diagnoses: _____

Reported Perpetrators: (Not residents) *(Attach additional pages if necessary.)*

Name: _____ Title: _____

Phone: (____) _____ License or certificate #: _____

Name: _____ Title: _____

Phone: (____) _____ License or certificate #: _____

Witnesses: *(Attach additional pages if necessary.)*

Name: _____ Relationship / Title: _____

Phone: (____) _____

Name: _____ Relationship / Title: _____

Phone: (____) _____

Name: _____ Relationship / Title: _____

Phone: (____) _____

Continued on next page

Appendix B

(Attach additional pages to answer the questions below, if necessary.)

Describe the incident and any injury or adverse effect to the resident(s):

What immediate measures were taken to protect the resident(s)?

Has this happened before to the same resident(s) or others? Yes No If yes, describe:

Who else was contacted (such as law enforcement, ombudsman, licensing board, etc.)?

Name of person completing this report: _____ **Date:** _____

Facility name: _____ **Date of incident:** _____

APS OFFICE USE ONLY

Branch office: _____

Date rec'd: _____ **Time rec'd:** _____ **Rec'd by:** _____ **Log #:** _____

Disposition: Local unit investigation? Yes No **Investigator's name:** _____

Response priority: 2-hour Next day Other: _____

Referred to: CCMU: Yes No **and/or** Other: _____

Date referred: _____