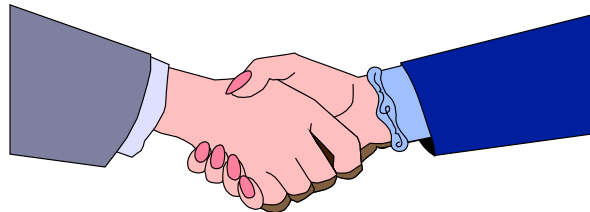


# Nursing Home Guidelines

- ◆ INCIDENT IDENTIFICATION
  - ◆ INVESTIGATION
  - ◆ REPORTING

**PARTNERS  
IN PREVENTION**



March 2006<sup>\*\*</sup>

Fourth Edition

<sup>\*\*</sup> (INCLUDING UPDATED REGULATORY REFERENCES COMPLETED DECEMBER 2008)

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# CHAPTER I

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## INTRODUCTION

This document contains guidelines for investigating, determining, and reporting incidents of resident abuse, neglect and mistreatment, injuries of unknown source, exploitation, or misappropriation of resident property in nursing homes. It also contains portions of and references to:

- [Chapter 74.34 Revised Code of Washington \(RCW\), Abuse of Vulnerable Adults;](#)
- [Code of Federal Regulations \(CFR\) Part 483 – Requirements for State and Long-Term Care Facilities;](#)
- [CFR Part 488 – Survey, Certification, and Enforcement Procedures;](#) and
- [Chapter 388-97 Washington Administrative Code \(WAC\) – Nursing Homes.](#)

*(UPDATED REGULATORY REFERENCES COMPLETED DECEMBER 2008)*

A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm. Assault is a crime and requires intent to cause harm. As used in these guidelines, an assault is always abuse, but some abusive actions may not amount to an assault.

These guidelines are intended to assist facilities in developing and implementing principles and procedures to help prevent resident abuse, neglect, mistreatment, exploitation, and misappropriation of resident property by any person. The principles and procedures developed should promote resident protection and prevent abuse, neglect and other mistreatment by providing facility staff with the necessary direction and information.

These guidelines also contain general information to help the facility in determining if abuse, neglect, negligent treatment, mistreatment, exploitation, a reportable injury of unknown source, or misappropriation of resident property is likely to have occurred. The guidelines may be useful for staff training.

Principles and procedures must also be established and implemented for the employment of new staff members, for the use of volunteers, and students. It is the responsibility of the nursing home to:

- Check the OBRA Nurse Aide Registry to ensure OBRA certification, prior to the employment of a nursing assistant;
- Conduct criminal history background checks on all staff, volunteers, and students who have unsupervised access to vulnerable adults, within 72 hours of conditional employment;
- Ensure all staff including agency-contracted personnel, are free of any disqualifying criminal history.

Questions about the guidelines may be sent to the attention of the Complaint Resolution Unit, Aging and Disability Services Administration, PO Box 45600, Olympia, Washington 98504-5600, or by calling the appropriate RCS Field Manager.

**NOTE: None of these guidelines are intended to replace federal and state law regarding abuse and neglect.**

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## CHAPTER II

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### REGULATIONS RELEVANT TO RESIDENT PROTECTION

The facility must become familiar with all of the federal and state rules, including any successor laws and rules, which apply to resident protection. The federal regulations are found at [42 CFR 483.13](#) and include a number of requirements and specific guidance around the regulatory expectations.

State law in chapter [74.34 RCW](#) includes definitions and provisions for reporting possible abuse and neglect. The nursing home rules at [WAC 388-97-0640](#), Prevention of abuse, also provide the facility with direction and information about resident protection. Some links to these laws and rules will be found at the end of this chapter.

Be aware that this book includes only some portions of applicable laws and rules. It is the responsibility of the facility to access the relevant laws and rules, become familiar with all of the provisions, and maintain compliance with the requirements.

#### [42 CFR §483.13:](#)

(b) The resident has the right to be free from verbal, sexual, physical and mental abuse. **INTENT:** 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.

(c) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. **INTENT:** Each resident has the right to be free from mistreatment, neglect, and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing other residents, and the development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis.

(c)(1)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(c)(1)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(c)(1)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

**RCW 74.34.035:**

(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:

- (a) Mandated reporters shall immediately report to the department; and
- (b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.

(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

- (a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
- (b) There is a fracture;
- (c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or
- (d) There is an attempt to choke a vulnerable adult.

## CHAPTER III

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### PURPOSE

The incident identification, investigation and reporting guidelines in this booklet are designed to assist nursing homes in complying with the requirements of the state Vulnerable Adult Act, [Chapter 74.34 RCW](#), and the federal Omnibus Budget Reconciliation Act (OBRA), 1987, found at [42 CFR 483.13](#).

The guidelines are intended for use primarily by:

- Nursing homes and nursing home employees;
- Department of Social and Health Services (DSHS) employees; and
- Health professionals.

Other individuals or agencies who may want to utilize these guidelines include:

- Residents and families;
- Law enforcement agencies;
- Community agencies and concerned citizens; and
- Long-Term Care Ombudsman staff and volunteers.

The guidelines provide:

- General information to be applied in determining whether abuse, neglect, abandonment, exploitation, or misappropriation of resident property has occurred;
- The nursing home's responsibility in reporting, investigating, and taking appropriate corrective and preventative measures; and
- The rights and responsibilities of persons reporting to DSHS Complaint Resolution Unit.

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# CHAPTER IV

## DEFINITIONS

This chapter contains the definitions of the most frequently used words in the process of nursing home abuse/neglect identification, reporting, and investigation. Also included are various guidelines and comments. Examples correlating to the definitions are provided. These examples should not be considered all-inclusive, nor are they mutually exclusive. This chapter also contains both legal references and state and federal guidelines.

Definitions	Guidelines & Comments	Examples
<p>“<b>ABANDONMENT</b>” as defined in RCW <a href="#">74.34.020(1)</a> means an action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.</p>		
<p>“<b>ABUSE</b>” as defined in <a href="#">42 CFR 488.301</a>, means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish.</p> <p>The federal interpretative guidelines for <a href="#">42 CFR 483.13(b) and (c)</a> in the State Operations Manual also include in the definition of abuse, the willful deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being.</p> <p><b>**See also <a href="#">Appendix A</a> for Abuse Definition Diagram</b></p> <p>“<b>ABUSE</b>” as defined in <a href="#">RCW 74.34.020(2)</a> means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable</p>	<p>The obligation of nursing homes is to protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves.</p> <p>In general, it must be presumed that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident.</p> <p><u>This means that instances of abuse of any resident, (whether comatose, cognizant or not), cause physical harm, pain, or mental anguish.</u></p> <p>The term “<i>willful</i>” describes the non-accidental action or inaction that resulted in the abuse of the resident. The term does not mean that an</p>	<p><b>EXAMPLES OF ABUSE</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ <b>Verbal abuse:</b> Any use of</li> </ul>

Definitions	Guidelines & Comments	Examples
<p>adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:</p> <ul style="list-style-type: none"> <li>▪ <b>Sexual abuse</b> means any form of non-consensual contact, including but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under <a href="#">chapter 71A.12 RCW</a>, and a vulnerable adult living in that facility or receiving services from a program authorized</li> </ul>	<p>individual intended to cause harm, pain, anguish, or injury. Instead, it means that the individual intended the action or inaction itself that he/she knew or should have known could cause harm, anguish, pain, or injury.</p> <p>Willful inaction includes, but is not limited to, a refusal to provide the necessary “care” and required services, &amp; intentional deprivation.</p> <p>Physical contact with a resident for the purpose of retaliating against that resident, even in response to a physical attack or verbal abuse from a resident, is never justifiable and constitutes abuse.</p> <p>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 to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs. Refer also to the federal interpretative guidelines <a href="#">for 42 CFR 483.13(b) and (c)</a> in the State Operations Manual for further guidelines related to involuntary seclusion.</p>	<p>oral, written or gestured language that willfully includes threats and/or disparaging &amp; derogatory terms to or about residents or their families, within hearing distance of any resident regardless of their age, ability to comprehend, or disability; threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.</p> <ul style="list-style-type: none"> <li>▪ <b>Involuntary Seclusion:</b> isolating a resident against the resident’s will or will of legal representative by leaving him/her in their room or other isolated location.</li> <li>▪ <b>Willful deprivation by inaction:</b> refusal of staff to intervene, such as when a resident who is taking a bath has been left there for quite a while, is getting cold and upset, needs assistance getting out of the tub, sees the caretaker and asks for help. The caretaker refuses, walks away and does not tell anyone.</li> <li>▪ <b>Sexual Abuse:</b> Inappropriate touching, sexual harassment, sexual coercion, or sexual assault.</li> </ul>

Definitions	Guidelines & Comments	Examples
<p>under <a href="#">chapter 71A.12 RCW</a>, whether or not it is consensual</p> <ul style="list-style-type: none"> <li>▪ <b>Mental abuse</b> means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.</li> <li>▪ <b>Physical abuse</b> means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.</li> <li>▪ <b>Exploitation</b> means “an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another”.</li> </ul> <p><b>**See also the definition of “Misappropriation of Resident Property” (pg 13) and “Financial Exploitation” (pg 9). In some situations these terms may be used interchangeably.</b></p>	<p>In addition to theft or outright taking of resident property, exploitation may involve tricking the resident into signing a document or giving consent regarding matters involving property or finances, through the use of manipulation, deception, or keeping the vulnerable adult ignorant of important facts about their money, property, or other resources. Compromised mental or physical capacity may make a resident more susceptible to deception, undue influence or pressure.</p>	<ul style="list-style-type: none"> <li>▪ <b>Mental Abuse:</b> humiliation, harassment, threats of punishment or deprivation, purposely withholding cigarettes or some form of entertainment, or something that is rightfully the resident’s, or placing any unreasonable restrictions on the resident’s mobility or ability to communicate with other persons either verbally or in writing.</li> <li>▪ <b>Physical Abuse:</b> Hitting, slapping, prodding, poking, or sticking a resident with a sharp object, pushing, shoving, spitting, twisting, squeezing, pinching, and kicking. It also includes controlling behavior through corporal punishment, such as purposely withholding food and medications.</li> </ul> <p><b>Exploitation:</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Any individual who sells the resident’s property, house, or other valuables for their own personal gain or profit;</li> <li>▪ Surrogate decision maker or payee who has been given fiduciary responsibility by the resident to pay the nursing home bill, is refusing to meet the resident’s needs by using the resident’s money or asset for his or her personal profit or gain;</li> <li>▪ Any individual who for personal profit or advantage <u>coerces</u> the resident to sign a</li> </ul>

Definitions	Guidelines & Comments	Examples
	<p><b>A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm. Assault is a crime and requires intent to cause harm. As used in these guidelines, an assault is always abuse, but some abusive actions may not amount to an assault.</b></p>	<p>document, contract, legal form, or any other form designating authority over the resident's finances and property;</p> <ul style="list-style-type: none"> <li>▪ Any individual who uses the resident's name or credit status to obtain personal credit;</li> <li>▪ Surrogate decision maker or payee does not pay into the resident's trust fund account and does not provide for the resident's personal needs, but uses the money to buy their own items or pay personal bills.</li> </ul>
<p><b>"ACCIDENT"</b> as defined in <a href="#">42 CFR 483.25(h)</a>, in the State Operations Manual is an <b>"unexpected, unintended event that can cause a resident bodily injury."</b></p>	<p>Foreseeable incidents are not accidents.</p> <p><a href="#">42 CFR 483.10(b)(11)</a> and <a href="#">WAC 388-97-0320(1)</a> require that nursing homes immediately inform the resident; consult with the resident's physician; and if known, notify the resident's surrogate decision maker when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.</p> <p><a href="#">42 CFR 483.25(h)</a> states that the facility must ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Accidents do include equipment or mechanical failures that were not known prior to the use of the equipment. Routine preventative maintenance is important to prevent accidents.</p>	<p><b>Examples of accidents</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ A self-propelling resident catches a finger in wheelchair spoke and fractures the finger.</li> <li>▪ An independent resident who becomes dizzy fails to use call light for help and falls while getting out of bed.</li> <li>▪ Resident pinches hand in doorjamb and sustains a skin tear.</li> <li>▪ Resident hits arm on the head of the bed and sustains a bruise on forearm.</li> </ul> <p>Any of the above examples <u>may</u> become examples of neglect if repeated without facility intervention, or if the prior risk of such an event was identified and no action was taken to prevent the occurrence.</p>
<p><b>"BODILY HARM"</b> as defined in <a href="#">RCW 9A.04.110(4)</a> means physical pain or injury, illness or an impairment of physical condition.</p>		

Definitions	Guidelines & Comments	Examples
<p><b><u>“FINANCIAL EXPLOITATION”</u></b> as defined in <a href="#">RCW 74.34.020(6)</a> means the “illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person’s profit or advantage”.</p> <p><b>**See also the definition of <a href="#">“Misappropriation of Resident Property”</a> (pg 13) and <a href="#">“Abuse - Exploitation”</a> (pg 9). In some situations these terms may be used interchangeably.</b></p>		
<p><b>“INCIDENT”</b> For the purposes of these guidelines, an incident means:</p> <ul style="list-style-type: none"> <li>▪ An occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or exploitation are alleged or suspected; or</li> <li>▪ A substantial injury of unknown source, or cause, or circumstance</li> </ul>	<p>All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury results from abuse or neglect. <u>It may not always be possible to determine the cause of the incident.</u></p> <p>The purpose of adding the definition of “<i>incident</i>” to these guidelines is to assist in identifying when a facility must do a thorough investigation. Not all occurrences that happen to residents are incidents that require an investigation. For example, superficial injuries of unknown source and some falls when <b>abuse or neglect is not alleged or suspected</b>, do not require a thorough investigation, but do require assessment to assist in preventing reoccurrence.</p> <p>An <b>allegation</b> is a statement or a gesture made by someone (regardless of capacity or decision-making ability) that indicates that abuse, neglect, exploitation, or misappropriation</p>	<p><b>EXAMPLES OF INCIDENTS</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Any occurrence that is not consistent with standards of care and practice;</li> <li>▪ Substantial injury of unknown source;</li> <li>▪ Any allegation of mistreatment, neglect or abuse; <i>and</i></li> <li>▪ Any misappropriation of resident property or exploitation of a resident.</li> </ul>

Definitions	Guidelines & Comments	Examples
	<p>of resident property may have occurred and requires a thorough investigation. To <b>suspect</b> means to have reason to believe without conclusive proof that someone may have abused, neglected, exploited a resident, or misappropriated a resident's property.</p> <p>Documentation of the investigation for all incidents and the determination of "reasonably related" must be kept and readily available for state review, internal risk management, and federal authorities.</p>	
<p><b>"INJURIES OF UNKNOWN SOURCE"</b> means any injury sustained by a resident where the source of the injury was:</p> <ul style="list-style-type: none"> <li>▪ Not observed directly by a staff person; or</li> <li>▪ Not identified through the process of assessment for a superficial injury; or</li> <li>▪ Not identified through the process of a thorough investigation for a substantial injury; or</li> <li>▪ Determined not to be reasonably related to the resident's condition, diagnosis, known and predictable interaction with surroundings or related to a known sequence of prior events.</li> </ul> <p>Injuries of unknown source may be either <u>superficial</u> or <u>substantial</u> in nature.</p> <p><b>Types of injuries of unknown source:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Superficial injury</b> of unknown source include injuries limited to the surface layers of the skin, easily treated with first</li> </ul>	<p>It is not always possible to determine the cause of the injury.</p> <p>Superficial injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to</p>	<p><b>Examples of superficial injury</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Small abrasions,</li> </ul>

Definitions	Guidelines & Comments	Examples
<p>aid/not requiring physician's orders for treatment (such as sutures or diagnostic x-rays); <b>and</b> located in areas generally vulnerable to trauma.</p> <ul style="list-style-type: none"> <li>▪ <b>Substantial injury</b> of unknown source include injuries that are more than superficial. Substantial injuries require more than first aid and may require close assessment and monitoring by nursing or medical staff. They also include injuries occurring in areas not generally vulnerable to trauma.</li> </ul>	<p>determine the cause and appropriate corrective action must be taken. Documentation of the assessment must be in the resident's clinical record.</p> <p>All substantial injuries of unknown source must be thoroughly investigated. All injuries (regardless of the extent) occurring in non-vulnerable areas will be considered substantial injuries.</p>	<p>lacerations, or bruises limited to the surface layers of the skin, occurring in areas generally vulnerable to trauma, such as hands, forearms, and shins;</p> <p><b>Examples of substantial injury</b> may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>▪ Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;</li> <li>▪ All fractures</li> </ul>
<p><b>“MANDATED REPORTER”</b> as defined in <a href="#">RCW 74.34.020(10)</a> is an employee of the department; law enforcement; social worker; professional school personnel; individual provider; <b>an employee of a facility; an operator of a facility;</b> an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to <a href="#">Chapter 18.130 RCW</a></p>		
<p><b>“MISAPPROPRIATION OF RESIDENT PROPERTY”</b> as defined in <a href="#">42 CFR 488.301</a> means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p><b>**See also the definition of</b></p>	<p>Refer also to <a href="#">42 CFR 483.13(c)</a> in the <b>State Operations Manual for further guidelines.</b></p> <p>Residents with cognitive impairments that are known to misplace/take other resident's belongings as part of their regular behavior are not considered to be</p>	<p><b>Examples of misappropriation of resident property</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Facility staff or others take resident money or property without permission of the resident;</li> <li>▪ Facility staff or others</li> </ul>

Definitions	Guidelines & Comments	Examples
<p><b><u>“Abuse – Exploitation”</u> (pg 9) and <u>“Financial Exploitation”</u> (pg 11). In some situations these terms may be used interchangeably.</b></p>	<p>misappropriating other resident's items.</p>	<p>“borrow” clothing or other property of one resident to lend to another resident (this behavior could range from improper use of resident clothing to lending a resident's TV or wheelchair to another resident);</p> <ul style="list-style-type: none"> <li>▪ Facility staff use disposable briefs, disposable gloves, and other expendable items which were purchased by, or charged to a resident for another resident's use.</li> </ul>
<p>“<b>NEGLECT</b>” as defined in <a href="#">42 CFR 488.301</a> means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>“<b>NEGLECT,</b>” as defined in <a href="#">RCW 74.34.020(11)</a>, means:</p> <p>(a) a pattern of conduct or inaction by a person or entity with a duty of care to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that avoids or prevents physical or mental harm or pain to a vulnerable adult; or</p> <p>(b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.</p> <p><b>See also <a href="#">Appendix B for Neglect Definition Diagram (p. 37)</a> and <a href="#">Appendix C for Medication Error Decision Tree (p. 39)</a></b></p>	<p>In the definition of neglect, the words “<b>necessary to avoid physical harm, mental anguish, or mental illness</b>” mean that it is more probable than not that harm could happen to the resident because the goods or service were not provided.</p> <p>Neglect may be determined even if no apparent negative outcome has occurred. According to HCFA (now CMS) comments in the <a href="#">Federal Register (November 10, 1994, Vol. 59, No. 217)</a> neglect may include instances where no apparent negative outcome has occurred, but the likelihood for deterioration of the resident's physical, mental, or emotional condition exists.</p> <p>The likelihood for negative outcome must be considered. For example, a staff member who fails to administer a resident's afternoon nourishment has failed to</p>	<p><b>Examples of neglect</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Failure to carry out orders for treatment, therapy, diagnostic testing, administration of medications, absent refusal by resident;</li> <li>▪ Failure to carry out the resident's plan of care;</li> <li>▪ Failure to answer a resident's call light or bell in a reasonable time frame;</li> <li>▪ Being left to sit or lie in urine or feces;</li> <li>▪ Failure to adequately supervise the whereabouts and/or activities of a resident;</li> <li>▪ Failure to protect a resident from another resident whose harmful action may not be willful due to cognitive impairment;</li> <li>▪ Failure to feed or assist a dependent resident who requires help with eating.</li> <li>▪ Failure to withhold resident's digoxin when resident clearly displayed signs and symptoms</li> </ul>

Definitions	Guidelines & Comments	Examples
	<p>provide goods. However, one would need to consider the resident's condition before a determination could be made if this one time omission would "likely" result in harm to the resident.</p> <p>Neglect does not include failure to provide treatment or service that a resident has, with consent, refused. In addition, the definition of "neglect" does not include the element of intent to do harm by a provider or caregiver.</p> <p>In general, neglect occurs with the failure of the facility or an individual to follow accepted standards of practice in accordance with the facility's or staff person's relevant knowledge base or training, which leads to harm or is known to cause harm to the resident. Serious disregard of consequence means that the facility or individual actually had knowledge, or should have known (based on training or educational background), that the act committed or omitted was a clear and present danger to the resident's health, welfare, or safety; or that the act was committed or omitted with reckless disregard of its clearly dangerous consequences.</p>	<p>of digoxin toxicity &amp; the resident's digoxin blood level indicated a toxic level;</p> <ul style="list-style-type: none"> <li>▪ Passing medications "by memory";</li> <li>▪ Failure to report a resident's chest pain and shortness of breath to supervising staff;</li> <li>▪ Failure of dietary staff to refrigerate meat and resident(s) acquire(s) "food poisoning";</li> <li>▪ Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water, and structural hazards;</li> <li>▪ Failure to transfer a resident in need of emergency help out of the facility when the resident's condition clearly warrants the transfer and the resident's health, safety or welfare is dependent upon emergency intervention;</li> <li>▪ Failure to consult with a resident's attending physician when resident's condition requires medical intervention;</li> <li>▪ Failure to assess and evaluate a resident's status or failure to institute nursing interventions as required by the resident's condition which results in harm to the resident or demonstrates a clear and present danger for harm;</li> <li>▪ Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals which can or does result in weight loss patterns or other parameters of poor nutritional status that are not the result of a medical condition.</li> </ul>

Definitions	Guidelines & Comments	Examples
<p><b>“PERMISSIVE REPORTER”</b> as defined in <a href="#">RCW 74.34.020(12)</a> means any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.</p>		
<p><b>“REASONABLE CAUSE TO BELIEVE”</b> means a mandated reporter thinks it is probable that an incident of abuse, abandonment, neglect, or financial exploitation happened. Probable means that based on information or evidence readily obtained from various sources, it is likely the incident occurred. Sources of information may include:</p> <ul style="list-style-type: none"> <li>▪ Personal observation of the incident;</li> <li>▪ The resident who is subject of incident;</li> <li>▪ Incident logs, medical records, etc.</li> <li>▪ Other persons who may have relevant information;</li> <li>▪ Resident behavior;</li> <li>▪ Other relevant information. A reporter may rely upon one or more of the above sources.</li> </ul>	<p><a href="#">RCW 74.34.035</a> requires a mandated reporter to: <b>Report immediately to the department when there is:</b></p> <ul style="list-style-type: none"> <li>• A reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred.</li> </ul> <p>Federal law requires the facility to report all allegations of abuse or neglect. This would include taking seriously any allegation from residents or others with a history of making allegations.</p>	<p><b>Examples of reasonable cause to believe</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Finger or slap marks on a resident;</li> <li>▪ A resident without a history of making allegations of abuse states that a staff member has abused her or treated her poorly;</li> <li>▪ Any physical evidence of rape such bruising in the perineal area, vaginal tears, abnormal redness or bleeding in the vaginal area, etc.;</li> <li>▪ A resident demonstrates fear in the presence of a particular caregiver or other people.</li> </ul>
<p><b>“REASON TO SUSPECT”</b> as defined in <a href="#">RCW 74.34.035</a> means a mandated reporter thinks, based on information readily obtained from various sources, it is possible that an incident of sexual or physical assault could have happened. Sources of information may include:</p> <ul style="list-style-type: none"> <li>▪ Personal observation of the incident;</li> <li>▪ The resident who is subject of incident;</li> </ul>	<p><a href="#">RCW 74.34.035</a> requires a mandated reporter to: <b>Report immediately to the department when there is:</b></p> <ul style="list-style-type: none"> <li>• A reason to suspect that sexual assault has occurred.</li> <li>• A reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:</li> </ul>	

Definitions	Guidelines & Comments	Examples
<ul style="list-style-type: none"> <li>▪ Incident logs, medical records, etc.</li> <li>▪ Other persons who may have relevant information;</li> <li>▪ Resident behavior;</li> <li>▪ Other relevant information.</li> </ul> <p>A reporter may rely upon one or more of the above sources.</p>	<p><b>Report immediately to the appropriate law enforcement agency when there is:</b></p> <ul style="list-style-type: none"> <li>• A reason to suspect that sexual assault has occurred.</li> <li>• A reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm.</li> <li>• An incident of physical assault between vulnerable adults that causes more than minor bodily injury and requires more than basic first aid, the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.</li> <li>• An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.</li> </ul>	
<p><b>“REASONABLY RELATED”</b> means a prudent person acting with professional knowledge, guided by community and professional standards, and with knowledge of facts and circumstances as established during a thorough</p>	<p>Facts and circumstances surrounding the resident may include, but are not limited to the following: their diagnosis; medication regimen; expected or known results of a medical or diagnostic procedure; their functional abilities; and the resident’s normal interaction</p>	<p><b>Examples of ‘reasonably related’</b> may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>▪ Normal bruising that results from venipuncture or other parenterally invasive procedures;</li> <li>▪ Skin tears related to fragile</li> </ul>

Definitions	Guidelines & Comments	Examples
<p>investigation, (or by assessment of superficial injuries of unknown source which are not incidents of suspected or alleged abuse or neglect), has good reason to believe that the source of the injury is reasonably connected to the facts and circumstances surrounding the resident.</p>	<p>with their environment.</p>	<p>skin;</p> <ul style="list-style-type: none"> <li>▪ Bruising in generally vulnerable areas related to certain drug usage such as anti-coagulants or prolonged steroid usage, or bruising associated with other medical conditions such as leukemia.</li> </ul>
<p>“<b>VULNERABLE ADULT</b>” as defined in <a href="#">RCW 74.34.020(15)</a> includes a person:</p> <ul style="list-style-type: none"> <li>▪ Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or</li> <li>▪ Found incapacitated under <a href="#">Chapter 11.88 RCW</a>; or</li> <li>▪ Who has a developmental disability as defined under <a href="#">RCW 71A.10.020(3)</a>; or</li> <li>▪ Admitted to any facility, or;</li> <li>▪ Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under <a href="#">Chapter 70.127 RCW</a>;</li> <li>or</li> <li>▪ Receiving services from an individual provider. <a href="#">RCW 74.34.020</a></li> </ul>		

# CHAPTER V

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## FACILITY REPORTING REQUIREMENTS

### 24 hour Hot Line 1-800-562-6078

The facility is required, by federal and state law, to protect residents, and to investigate and report certain events. The guidelines that follow do not exempt the facility from using good judgment in determining the best course of action to be taken in order to protect vulnerable adults.

The prioritization that follows is just a reminder of what the facility must do and the order in which it should be done. (Reporting and investigation may be undertaken simultaneously.) Remember to protect, and investigate and report.

**FIRST PRIORITY:** Protect the victim(s)/resident(s) from further harm.

**SECOND PRIORITY:** Perform a thorough investigation, and report to the department and law enforcement as required.

**NOTE: The facility must designate a person or persons to do the facility reporting required by federal and state law. Facility staff must know who that person is.**

Facilities are required to report to:

1. The department's 24 hour Hot Line:

- The department's hotline number is 1-800-562-6078. The number is available 24 hours a day, seven days a week and the time and date of messages are recorded.

2. Law enforcement:

- In an emergency, call 911 or the emergency services number.
- For other situations use the local number specified by your local law enforcement authorities.

3. Department of Health:

- If the incident involves an inappropriate action by a licensed professional, the facility must also report to professional licensing in the Department of Health, within 24 hours.

## Methods of reporting:

- By telephone; and
- By the “Reporting Log.”
  - The facility must maintain a state “Reporting Log” (see [Appendix E](#), page 45). The log must be retained in the facility and readily accessible at all times to state licensing and certification staff, and others according to their authority. Minimally, the log must contain the information indicated on the model form seen at Appendix E, using the prescribed format and codes. Other information may be added if desired by the facility. Log entries must be retained and preserved by the facility for a period of no less than three years.

## When to report:

- **Immediate** telephone reporting is required for allegations of abuse, neglect, exploitation and misappropriation.
- Substantial injuries of unknown source must be reported **within 24 hours**.
- On the reporting log within **5 days** of discovery.

## Where to report by telephone:

- Call the department’s hotline number 1-800-562-6078, unless directed otherwise. The number is available 24 hours a day, seven days a week and the time and date of the messages are recorded.
- Call local law enforcement or 911.

## What to report to the department by telephone “and” on the Reporting Log:

- All alleged violations involving abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property.
- Substantial injuries of unknown source (not related to suspected abuse or neglect).
- When there is reasonable cause to believe a crime, other than those listed above, has occurred.

## What to report to law enforcement:

- When there is a reason to suspect an incident is sexual assault.
- When there is reason to suspect an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.
- An incident of physical assault between vulnerable adults that causes more than minor bodily injury and requires more than basic first aid, the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.
- An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.
- When there is reasonable cause to believe a crime, other than assault, has occurred.

What to report on the “Reporting Log” only - within 5 days of discovery:

- Substantial injuries of unknown source determined through the process of investigation to be reasonably related to the resident’s condition, diagnoses, known and predictable interactions with surroundings, or a known sequence of prior events.

**Remember that you have to report substantial injuries of unknown source within 24 hours. However, if during your investigation, before the 24 hour period is up, you determine that the injury is reasonably related to the resident’s condition as defined in Chapter IV, you may report by log entry.**

- Superficial injuries of unknown source (not incidents of suspected abuse or neglect).
- Superficial injuries determined by assessment to be reasonably related to the resident’s condition, diagnoses, known and predictable interactions with surroundings, or known sequence of prior events.

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# CHAPTER VI

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## THE INVESTIGATION PROCESS

*Quality not quantity is the most important feature of any investigation*

All alleged incidents of abandonment, abuse, neglect, or mistreatment, including injuries of unknown source and misappropriation of resident property must be thoroughly investigated. The investigation is done to determine, as far as possible:

- What occurred; and
- To make necessary changes to the provision of care and services to prevent reoccurrence.

A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abandonment, abuse, neglect or misappropriation of resident property occurred, and how to prevent further occurrences.

Critical components of any investigation include:

- The objectivity of the investigator.
- The timeliness of the initiation of the investigation; and
- The thoroughness of the investigation.

The facility must develop and implement written principles and procedures to help organize the investigative process so that it can start as soon as possible and continues in an organized manner. The principles and procedures must include the responsibilities of staff who conduct investigations. The facility must train staff on the applicable federal and state regulations, the facility principles and procedures regarding abuse and neglect including investigations, and on the skills required to perform a thorough investigation.

Staff must protect residents from harm, immediately report incidents as required by federal and state law, and begin investigations as soon as possible. The nursing home and their staff must also immediately:

- Protect resident(s) from reoccurrence; and
- Take any action necessary to treat the ill effect(s) experienced by the resident(s) as a result of the alleged incident(s).

### Objectivity of the Investigator

The investigator of any incident must be objective and neutral during the course of the investigation. Investigators must:

- **Begin** with a “ruling out” of the fact that abandonment, abuse, neglect, mistreatment, exploitation, or misappropriation of resident property could have occurred; and

- **Not Begin** with a presumption of guilt or innocence of an individual(s).

The investigator must look at the incident fairly and without bias, and collect as much accurate data as needed to be able to reach a reasonable conclusion.

## The Timeliness of the Investigation

The facility must begin the investigation in order to collect accurate data related to the incident. Any delay in starting the investigation can cause valuable information to be either lost or altered.

## Thoroughness of the Investigation

Federal law requires the nursing home to do a thorough investigation of the incident. In order for the facility to provide evidence of the thoroughness of the investigation the information must be recorded.

A thorough investigation may require two phases of fact gathering:

- The first phase must be completed within 24 hours of knowledge of the incident, and begun, if possible, as soon as the incident is identified and the alleged victim protected.
- If the first phase is not successful in determining a reasonable cause, an extended or second phase must follow.

The investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened, including the probable or reasonable cause. It should also allow the nursing home to determine if the allegations were true or not. The amount of time and resources necessary for an investigation will vary depending upon the nature of the allegation or incident.

Each phase of a thorough investigation includes two steps:

- Data collection; and
- Data analysis.

**Data Collection:** The following questions should be reviewed to determine which apply to the particular incident. These examples are not all inclusive and only those that relate to a particular incident should be selected. You may need to add other questions that relate to the situation.

WHO:

- Who witnessed the incident?
- Who is (are) the alleged suspect(s) or who may have contributed to the occurrence of the incident?
- Who is (are) the alleged victim(s)?
- Who spoke to the alleged victim(s) regarding the incident?
- Who else may have information related to the incident?

#### WHAT:

- What is the incident?
- What is the chronological order of action leading up to the alleged incident?
- What are the injuries?
- What information does the alleged victim have regarding the incident?
- What did the discovering person or witness see, hear or smell?
- What did these people do in relation to first discovering the incident?
- What information do other staff members have of the incident or factor(s) leading up to the incident?
- What was the functional, mental and cognitive status of the alleged victim before and after the incident?
- What is known about the alleged suspect(s) or person(s) who may have contributed to the occurrence of the incident?
- What did the physical environment, where the incident occurred, look like? Were there any spills or tripping hazards? Were any medical devices being used?
- What were the victim and alleged perpetrator doing at the time of the incident?
- What was happening to the alleged victim just prior to the incident?
- What precipitating factors were identified?

#### WHEN:

- When was the incident discovered? By whom?
- When did the incident occur? (be as specific as possible related to time of day or night)

#### WHERE:

- Where did the incident occur? (exact location if known)

#### **Data Analysis: Should answer the HOW/WHY of the incident.**

Summarize and analyze the facts gathered to either establish reasonable cause for the incident, or establish the need for further investigation.

- How did the incident occur?
- How was this incident avoidable? (Were there factors that made this incident unavoidable?)
- Why did the injury or incident occur?

An analysis of the data gathered should establish a reasonable cause. If not, more information may be needed or there may be a need for further investigation.

## PHASE ONE: INITIAL INVESTIGATION

**NOTE:** When abuse or neglect is not suspected and the injury is of unknown cause, some injuries may be determined, during the course of the investigation, to be reasonably related to the medical and/or functional condition of the resident. In such cases it would not be necessary to complete other investigative elements.

**NOTE:** If during any phase of the investigation the investigator has a reason to suspect abuse or neglect, it must be immediately reported to the department.

For this investigative phase only the elements on the following list, that are appropriate to the circumstances surrounding the incident, should be considered. This list is not all inclusive

- Interview the alleged resident victim.
- Interview witnesses, including but not necessarily limited to:
  - Assigned caregiver;
  - Caregivers in immediate area;
  - Caregivers from the shifts prior to the incident discovery;
  - Remote or potential witnesses, such as visitors, family, roommates; and
  - Alleged perpetrator.
- Review the resident victim's medical condition.
- Review the resident victim's normal interaction with the environment.
- Observe environment where incident was likely to have occurred.
- Assess current cognitive status of victim.
- Physical exam.
- Diagnostic work, if needed.
- Comprehensive record review of the resident victim and others as appropriate, this may include but is not necessarily limited to the following elements depending on the nature of the incident:
  - Progress notes;
  - Flow sheets and care plans;
  - Physician orders;
  - Laboratory results;
  - Assessments: MDS, RAPs, and other assessments;
  - Social and psychological history;
  - Diagnosis/problem list; and
  - Injury trends, similar incidents and injuries, related quality assurance system documents (for facility investigator).
- See also: ["Preservation of Evidence"](#) on Page 28.

The first phase of the investigation should:

- Answer "who, what, when, where, why, and how";
- Enable the investigator to record the "who, what, when, where, why, and how" information; and
- Establish a reasonable cause or known source of the incident or injury within 24 hours of the incident or injury.

If the investigator is unable to establish a reasonable cause or known source, further investigation is required.

## **PHASE TWO: EXTENDED INVESTIGATION (After the first 24 hours)**

Further investigation is required if the first phase of the facility investigation did not establish reasonable cause or source of allegation or injury within 24 hours. The following elements may need to be included and considered:

- Interviews of expanded sample of witnesses, historians;
- Expand the time frame surrounding the incident for collecting data;
- Follow up on new information;
- Obtain related professional expertise; and
- If the suspected perpetrator is staff, interview the other residents the staff person was assigned to.
- See also: [“Preservation of Evidence”](#) on page 28.

Additional information obtained in Phase Two of the investigation should allow the investigator to answer “who, what, when where, why and how” and lead to the establishment of a reasonable cause or a known source of the allegation or injury, if possible. If the cause or reasonable cause cannot be established in either investigative phase, the cause should be reported as unknown.

Extended investigation findings must be entered into the Reporting Log and be available within five days of the discovery of the incident or injury. The entry may require updating as the investigation moves forward. See Pages 19-21 for facility reporting requirements. Refer also to [Appendix A](#) page 35 and [Appendix B](#) page 37 (Algorithms for Abuse and Neglect).

### **CORRECTIVE ACTION REQUIRED FOLLOWING THE INVESTIGATION:**

After the investigative phase(s) is completed, the nursing home is required to take action based upon the findings in order to correct the known and reasonable causes as well as to prevent further reoccurrence of the alleged incident(s).

### **EVIDENCE OF INVESTIGATION; FIRST PHASE AND EXTENDED:**

The resident’s record must include enough information about the incident to enable staff to identify, plan for and meet the resident’s needs. Documentation of incidents resulting in injury must provide enough information to identify the nature of the injury, and the facts that relate the injury to the condition of the resident. This will allow staff to appropriately plan for and meet the resident’s needs.

Evidence of investigation must be readily available to state licensing and certification staff and others according to their authority. This documentation may be in the format and location selected by the facility and must contain information and facts that address “who, what, when, where, how and why” of the incident.

All documentation of evidence of investigation of incidents must be retained by the nursing home for the period of three years. However, documentation in the resident’s clinical record must be retained for a period of eight years. [\[RCW 18.51.300\]](#)

## **PRESERVATION OF EVIDENCE:**

Relevant evidence identified during the course of the investigation must be preserved. Preservation of evidence is especially important when dealing with serious and/or criminal incidents. The date and time of collection must be included for all evidence gathered. If possible write the date and time on the article of evidence, such as on the side or back of a picture.

Evidence collected during the investigation may include the following:

1. A statement of evidence, based upon individual knowledge;
2. Documentary evidence;
3. Physical evidence; and/or
4. Demonstrative evidence.

Statements should be written, signed, and dated by the individual providing the statement. This evidence should be collected on a one-to-one basis, and as soon as possible after an incident, to avoid contamination of the evidence. The person receiving the statement should also sign and date the document. Blank areas on the paper should be crossed out and initialed.

Documentary evidence (such as laboratory results, progress notes, flow charts, etc.) should be copied and attached to the investigative report. Any direct evidence such as resident clothing, linen, or the scene in which the incident occurred should be preserved until the evidence has been thoroughly analyzed, photographed, or provided to law enforcement.

Demonstrative evidence, such as pictures of bruising or a drawn diagram of the room, should also be attached to the investigative report.

## CHAPTER VII

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### INDIVIDUAL MANDATED REPORTING REQUIREMENTS

#### 24 hour Hot Line 1-800-562-6078

State law at chapter [74.34 RCW](#) contains the individual mandated reporter requirements.

Mandated reporter, according to [RCW 74.34.035](#), includes but is not limited to an employee of the department; a law enforcement officer, an employee of a facility; and an operator of a facility.

For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual abuse and physical abuse:

The person mandated to report is:

- **Any nursing home employee who observes the incident or hears the victim state it happened.**
- **Any nursing home employee who hears about an incident from a permissive reporter who has direct knowledge of the incident.**

**NOTE:** *The person who does not have to report is an employee who hears about the incident from a mandated reporter and who believes that the report has been made.*

**NOTE:** This individual mandated reporting does not take the place of the facility reporting required in [Chapter V](#).

#### **Where to report:**

The department:

- The department's hotline number at 1-800-562-6078. The number is available 24 hours a day, seven days a week and the time and date of messages are recorded.

Law enforcement:

- In an emergency, call 911 or the emergency services number.
- For other situations use the number specified by your local law enforcement authorities.

#### **What to report to the department:**

Individual mandated reporters must immediately report to the department's hot line:

- When there is a *reasonable cause to believe* an incident is abuse, abandonment, neglect, or financial exploitation.

- o *Reasonable cause to believe* has also been defined as “a belief that the incident probably happened” based upon personal observation of the victim, records, other people and various other sources of relevant information. (See the definition of “reasonable cause to believe” in Chapter V, Definitions.)
- When there is a *reason to suspect* an incident is sexual or physical assault.
  - o *Reason to suspect* has also been defined as “a belief that the incident could have happened” based upon observations and other sources of information. (See the definition of “reasons to suspect” in Chapter V, Definitions.)
  - o Sexual assault includes but is not limited to unwanted inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, and sexual relations between a resident and a staff member.
  - o Physical assault includes the attempt to injure another person, unlawfully touching another person or action that causes fear of harm in another person. (An incidental push or gentle contact may not be an abuse unless the person intended to do harm or create fear.)
- When there is *reasonable cause to believe* a crime, other than assault, has occurred.

**What to report to law enforcement:**

Individual mandated reporters must immediately report to law enforcement:

- When there is a *reason to suspect* an incident is sexual assault.
- When there is *reason to suspect* an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.
- An incident of physical assault between vulnerable adults that causes more than minor bodily injury and requires more than basic first aid, the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.
- An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.
- When there is *reasonable cause to believe* a crime, other than assault, has occurred.

**When to make a report:**

- When an individual mandated reporter has reason to suspect an incident is sexual or physical abuse, he/she must report as soon as the resident(s)/victim(s) is protected from further harm.
- When a mandated reporter has reasonable cause to believe an incident is abandonment, abuse, neglect or financial exploitation, the report must be made immediately.

## **What should be reported for incidents involving Resident To Resident:**

- **Report to the department:** Requirements for reporting to the department incidents involving resident to resident were not set apart from other incidents in the law. See the reporting requirements under “What to report to the department” on the previous page.
- **Report to law enforcement:**
  - o Sexual assault;
  - o An incident of physical assault between vulnerable adults that causes more than minor bodily injury and requires more than basic first aid, the injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area; there is a fracture; there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult; and
  - o An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.

## **Information to be included in a mandated reporter’s report:**

The law states that each report, oral or written, must contain as much as possible of the following information:

- The name and address of the person making the report;
- The name and address of the vulnerable adult and the name of the facility providing care;
- The name and address of the legal guardian or alternate decision maker;
- The nature and extent of the abandonment, abuse, financial exploitation, neglect or self-neglect;
- Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect;
- The identity of the alleged perpetrator, if known, and;

Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult.

[RCW 74.34.035\(7\)\(a\) through \(g\)](#)

## **Mandated reporter identity confidentiality:**

- The identity of the person is kept confidential unless that person consents or there is a judicial proceeding. [RCW 74.34.095 \(1\) through \(3\)](#)

## **Termination, suspension or discipline of a mandated reporter:**

- A mandated reporter cannot be terminated, suspended or disciplined by the employer as long as the mandated report is made in good faith. The mandated reporter may, however, be terminated, suspended, or disciplined by the employer for other lawful purposes. [RCW 74.34.180\(3\)](#).

**Resident discharge when a resident (or others unassociated with the facility) makes a complaint on behalf of another resident or on behalf of him or herself:**

- As long as the department has substantiated the complaint, neither the resident making the complaint, nor the resident who is the subject of the complaint, may be discharged from the facility. An action, by the facility, to discharge a resident who makes a complaint or who was the subject of a complaint, substantiated by the department within one year from the date a complaint was made, is presumed to be a retaliatory discharge and prohibited by law. The presumption that the discharge was motivated by the complaint may be disproved, and a discharge may therefore be permitted, by showing that the increased needs of the resident cannot be met by the reasonable accommodation of the facility or that the discharge action was begun prior to the complaint having been filed. [\[RCW 74.34.180\(1\)&\(2\)\]](#)
- In addition to the mandated reporter requirements related to resident transfer or discharge, nursing facilities must continue to meet the federal and/or state law related to resident discharge and not discharge a resident unless those requirements are met. [\[42 CFR 483.12\]](#) and [\[RCW 74.42.450\]](#)

**Non-reporting:**

- “A person who is required to make a report under this chapter and who knowingly fails to make the report is guilty of a gross misdemeanor.” [\[RCW 74.34.053\(1\)\]](#)
- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- The penalties of a gross misdemeanor include fines of up to \$5000 and/or one year imprisonment in jail.
- Licensing action may be taken by the appropriate professional licensing authority based upon non-reporting, by those professionals, of incidents of suspected abuse or neglect.

**False reporting:**

- A person who intentionally makes a false report is guilty of a misdemeanor punishable by a fine of up to \$1000 and up to 90 days in jail. [\[RCW 74.34.053\(2\)\]](#)

**Reporting the incident to the supervisor:**

- Remember that for the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual abuse and physical abuse the person mandated to report to the department is:
  - **Any nursing home employee who observes the incident or hears the victim state it happened.**
  - **Any nursing home employee who hears about an incident from a permissive reporter who has direct knowledge of the incident.**
- Your reporting obligation under the law is not met if you only report to your supervisor. The law states that each employee is a mandated reporter; therefore, you must make the reporting call when you have reasonable cause to believe or reason to suspect the incident is reportable. To protect the victim from

further harm, a facility should have principles and procedures in place that direct staff to notify the responsible person in the facility. Procedures should tell you what you are to do if the person responsible for the incident is the person to whom you usually report.

### **Reporting to the supervisor prior to making the required reporting call:**

- A facility cannot have a procedure that interferes with mandated reporting; therefore a mandated reporter must be allowed to report as required before reporting to the supervisor. However, the individual may need to consult with the supervisor to assist in making the determination if there is a reasonable cause to believe or a reason to suspect the incident is reportable. [[RCW 74.34.035\(3\)and\(6\)](#)]

### **Protecting the resident from further harm:**

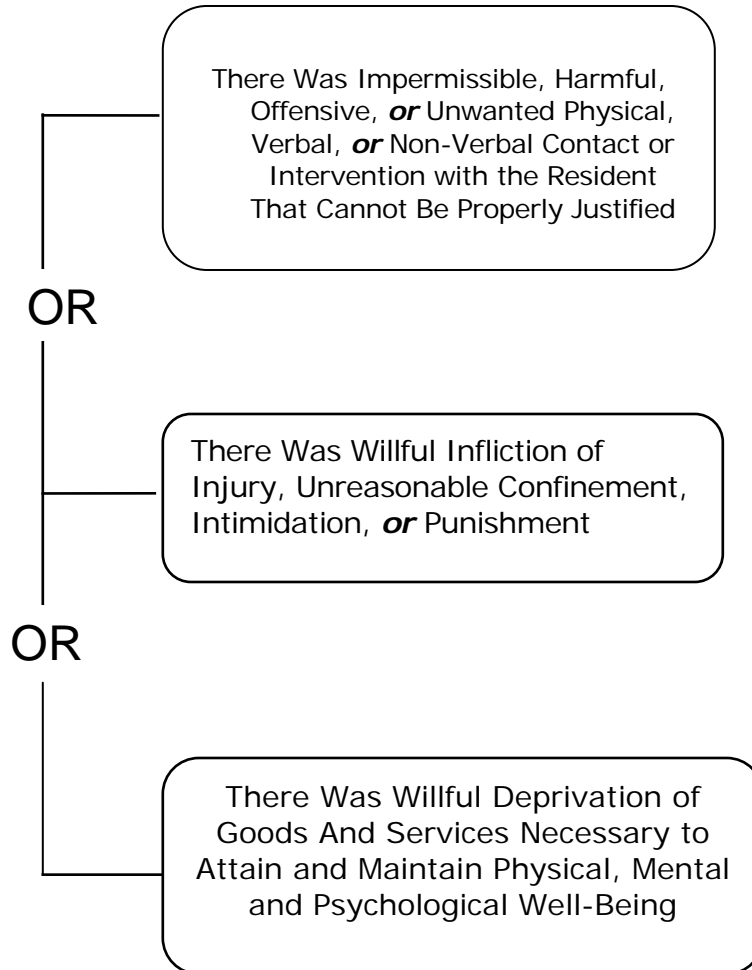
- Preventing the resident from further harm means keeping the resident safe. Each situation will be different. Here are some examples of actions that might be implemented:
  - Assuring that the alleged perpetrator is kept away from the resident or other residents;
  - Having a trusted person stay with the resident;
  - Allowing the resident to stay in an area he/she feels is safe (wellness center, nurses station); or
  - Safeguarding the resident's property.

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# APPENDIX A

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## DEFINITION DIAGRAM – ABUSE

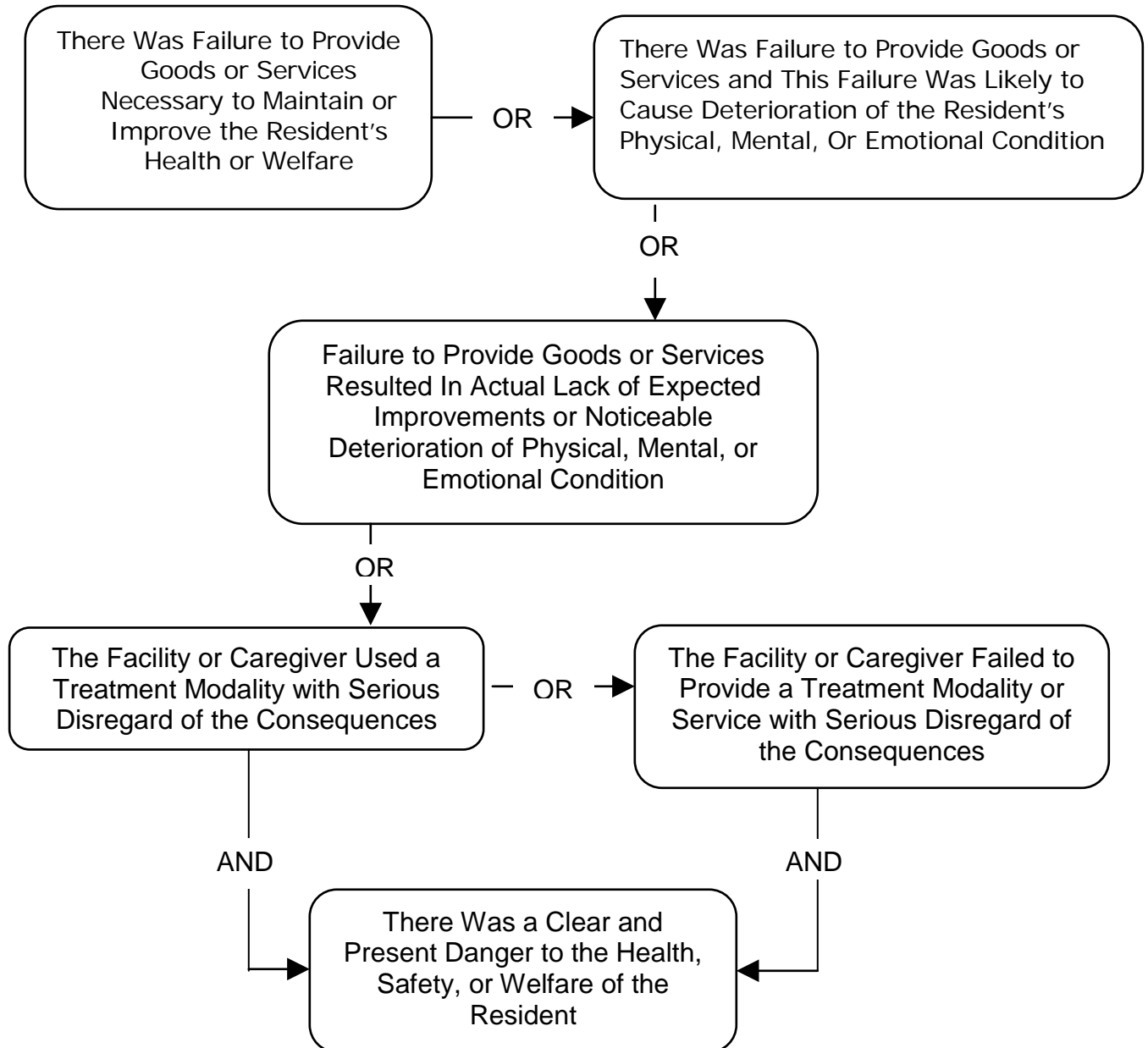


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## APPENDIX B

### DEFINITION DIAGRAM - NEGLECT

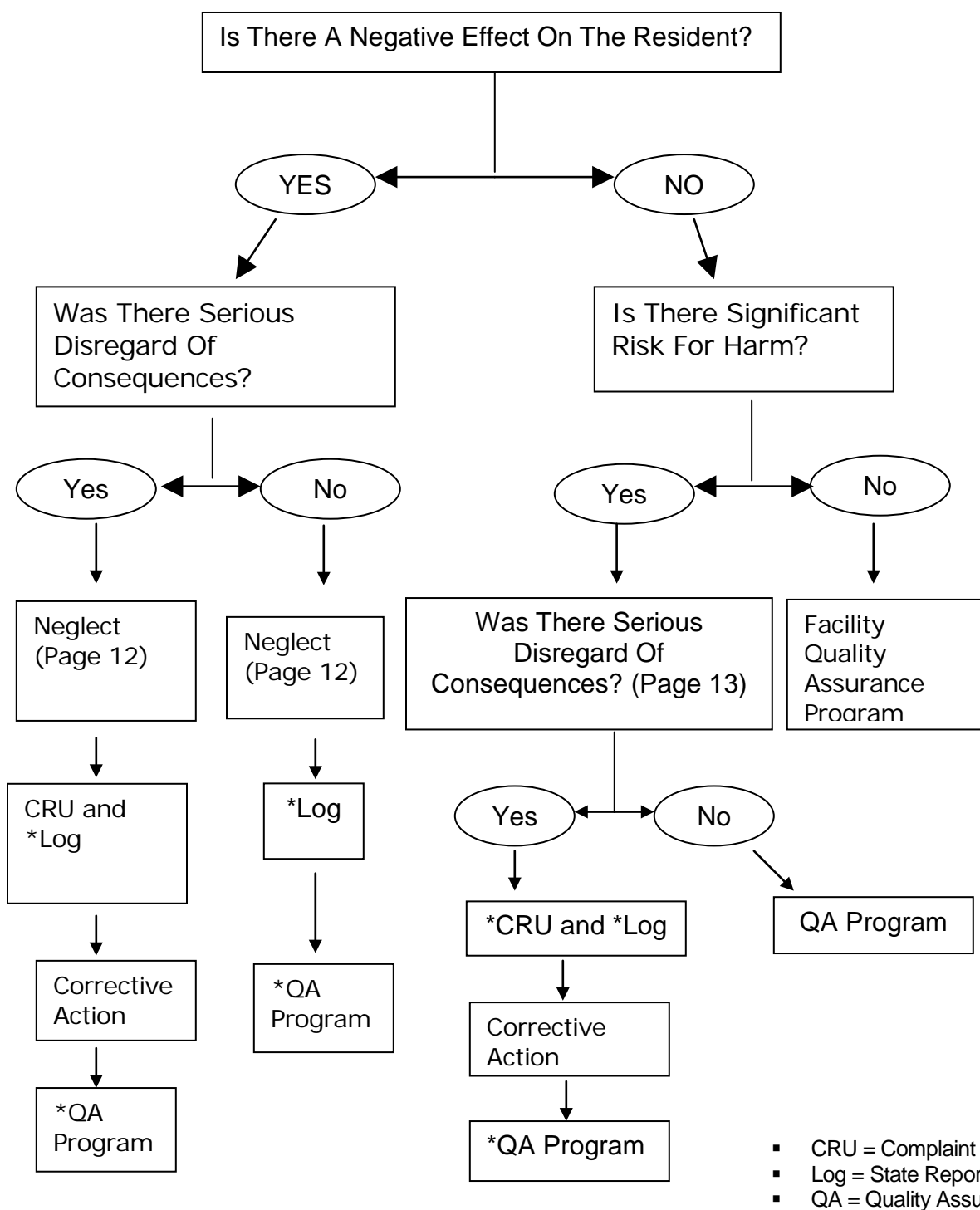
***Neglect may result from a pattern of conduct or inaction by a person or entity/facility.***



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## APPENDIX C

### MEDICATION ERROR DECISION TREE



**It has been the long-standing practice of facilities to have a system for the review of medication errors. It is not the intent of the department to change this system. Facilities should continue to monitor medication errors using their own internal quality assurance program. However, medication errors that are abuse, neglect, or negligent treatment must be reported to the department.**

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## APPENDIX D

### REPORTING GUIDELINES FOR NURSING HOMES

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police	Coroner	Local Health Dept.	DOH	Fire Marshall
<b><u>STAFF TO RESIDENT</u></b> Abuse, neglect, mistreatment, or negligent treatment (except for medication errors – see decision tree) Sexual or physical abuse/assault with bodily harm	X	X	X			Xb	
<b><u>MISAPPROPRIATION/ EXPLOITATION</u></b>	X	X	X			Xb	
<b><u>INJURIES OF UNKNOWN SOURCE***:</u></b> (Not incidents of abuse or neglect) <ul style="list-style-type: none"> <li>▪ Substantial</li> <li>▪ Substantial reasonably related</li> <li>▪ Superficial, Unknown</li> </ul>	X	X  X  Xc					
<b><u>NON-STAFF TO RESIDENT</u></b> <ul style="list-style-type: none"> <li>▪ Abuse/Assault, Neglect</li> <li>▪ Misappropriation/Exploitation</li> </ul>	Xa  Xa	X  X	X  X				
<b><u>RESIDENT TO RESIDENT</u></b> <ul style="list-style-type: none"> <li>▪ Mental abuse with psychological harm</li> <li>▪ <b>**Mental abuse without psychological harm</b></li> <li>▪ Physical abuse/assault with bodily harm</li> <li>▪ Physical abuse with psychological harm</li> <li>▪ <b>**Physical abuse without bodily or psychological harm</b></li> <li>▪ Sexual abuse/assault</li> <li>▪ Misappropriation/Exploitation</li> </ul>	X  X  X  X  X	X  X  X  X  X	X  X  X  X  *				

- a** = The call to the DSHS Hotline will meet the requirement for reporting to Adult Protective Services (APS), but the facility still may want to contact local APS office.
- b** = Report to the DOH when allegations about licensed/certified health care worker(s) have been substantiated.
- c** = Only those that are unknown after assessment.
- \*** = May need to be reported to police.
- \*\*** = In general there is a presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant or not) cause physical harm, pain, or mental anguish.
- \*\*\*** = Repeated injuries, even when related to condition, may become abuse or neglect if preventative measures are not taken.

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## APPENDIX D

### REPORTING GUIDELINES FOR NURSING HOMES (continued)

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police	Coroner	Local Health Dept.	DOH	Fire Marshall
<b><u>UNEXPECTED DEATH</u></b>							
▪ Possible R/T abuse or neglect	X	X	X	X			
▪ Suicide	X	X	X	X			
▪ Not related to abuse/neglect but suspicious	X	X		X			

### OTHER REPORTING REQUIREMENTS FOR NURSING HOMES

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	DSHS Log Within 5 days	Police	Coroner	Local Health Dept.	DOH	Fire Marshall
<b>Evacuation</b>	X	X					
<b>Discontinuance of Services</b> (such as no food, water, or care supplies)	X	X					
<b>Transfer/Discharge Notice</b>	Other*						
<b>Communicable Disease Outbreak</b>	X	X			X		
<b>Fire</b>	X	X					X
<b>Explosion</b>	X	X					X
<b>Missing Resident</b>	X	X	X				

\* Send a copy of notice to Field Manager

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## APPENDIX E

REPORTING LOG FORM									
*NATURE OF OCCURRENCE (Record as many as apply)			*TYPE OF INJURY (Record as many as apply)		*FINDINGS (Record as many as apply)			*ACTION TAKEN (Record as many as apply)	
01 Fall 05 Medication error 10 Missing Person/Elopement 15 Equipment related or involved 20 Restraint related 25 Dietary related 30 Disaster/major outbreak 31 Evacuation 32 Unexpected death/suicide 35 Resident-to-resident altercation 40 Adverse reaction to medication/treatment 45 Self-inflicted injury + 50 Limb caught in bed, chair, side rail, etc. 55 Injury during handling 60 N/G tube related 65 Property (dentures, etc.) 66 Missing property 70 Other (describe)			<u>Substantial</u> S1 Fractures S5 Burns S10 Deep laceration S15 Bruises of deep color, depth S20 Area not generally vulnerable to trauma such as face, neck, back, chest, breasts, groin and inner thigh S25 Other (describe)  <u>Superficial</u> S30 Surface layers of skin S35 Abrasions S40 Lacerations S45 Small bruises occurring in places generally vulnerable to trauma such as arms, forearms, and shins S50 Other (describe)  S80 Psychological Harm		75 Unknown origin ++  80 Origin established 81 Reasonably related to condition 85 Abuse 90 Neglect 95 Not preventable 100 Misappropriation/Exploitation 105 Abandonment		100 Staff training/counseling 101 Staff employment termination 105 Care plan revision 110 Adaptive equipment 115 First aid 120 Medical treatment 125 Physical plant modification 130 Procedure revision 135 No further action 140 Other (Indicate location of documentation)		
DATE LOGGED	RESIDENT NAME	DATE/TIME OF INCIDENT	*NATURE OF OCCURRENCE	INCIDENT LOCATION	*TYPE OF INJURY	*FINDINGS	*ACTION	HOTLINE NOTIFIED YES/NO	BY WHOM

APPENDIX E

**\*Complete categories with corresponding category number(s) as listed above.**

+ *Self-inflicted* means the resident was the sole cause of his/her injury.

++ *Unknown origin* -The cause of the incident was not established

+++ *Origin established* – The cause of the incident was established. In establishing the source, the investigator is trying to determine the cause of the incident, not just the injury. For example, observation may establish that lacerations were caused by a fall, but what caused the fall?

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# APPENDIX F – NURSING HOMES

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## STATE HOTLINE QUESTIONS (1-800-562-6078)

To make an official facility report, listen to the main message and then press “2”. If you wish to bypass the next menu, press the number that represents the type of incident you will be reporting.

#	TYPE OF INCIDENT
1	Follow-up Call
2	Resident-to-Resident Incident
3	Staff-to-Resident Incident
4	Injury of Unknown Source
5	Resident Fall
6	Exploitation/Misappropriation of Resident Property
7	Other Types of Resident Incidents
8	Medication Error

**The following standard information is required by facilities making reports to the state hotline:**

### **ALL TYPES OF INCIDENTS:**

1. Caller’s first and last name;
2. Name of the facility followed by phone number;
3. The name of the resident(s) who is/are involved in the incident;
4. Identify if the doctor and responsible parties were notified of the incident
5. The resident’s diagnosis
6. The resident’s mental status
7. The resident’s ambulatory and transfer status, or if wheelchair bound, identify if the resident self-propels and if he/she was using an assistance device
8. The date and time of the allegation, incident, or injury, **or** the date and time when the allegation, incident or injury was first discovered.
9. Identify if the care plan has changed.

***In addition* to the above questions,  
be prepared to provide the following information when calling to report:**

### **FOLLOW-UP CALL – Select 1:**

1. Identify the date of the initial report;
2. Identify the conclusion of the investigation;
3. Identify measures put in place to prevent a reoccurrence.

### **A RESIDENT-TO-RESIDENT INCIDENT – Select 2:**

1. Describe the incident and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.
4. Identify if there was evidence of psychological harm.
5. Identify if the incident is isolated or a pattern;
6. Describe the plan to prevent further incidents.

### **ALLEGATION OF STAFF TO RESIDENT ABUSE OR NEGLECT – Select 3:**

1. Describe the alleged incident, and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom.

4. Identify if there was evidence of psychological harm.
5. Identify the correct spelling and name of the employee(s) including their middle initial;
6. Identify the employee's title and if a nursing assistant, if he or she is certified;
7. Identify the employee's date of hire and date of birth;
8. Identify the employee's social security number;
9. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
10. Identify if the employee has had previous warnings or incidents at your facility;
11. Describe the measures taken to protect the resident during the investigation;
12. Describe measures taken to prevent reoccurrences of the incident.

**AN INJURY OF UNKNOWN SOURCE – Select 4:**

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.

**RESIDENT FALL – Select 5:**

1. Describe other falls within the last 12 months;
2. Identify witnesses;
3. If staff involved, state their name and explain the circumstances.
4. Identify if the care plan was followed at the time of the fall;
5. Identify the action taken to prevent reoccurrences.

**EXPLOITATION OR MISAPPROPRIATION OF RESIDENT PROPERTY – Select 6:**

1. Describe the details of the exploitation or misappropriation of property including the dollar amount;
2. Identify if local law enforcement has been notified, if so, identify the case number;
3. Identify the alleged perpetrator and identify the person's title or relationship to the resident;
4. If an employee is involved, identify their name including the middle initial, title, date of hire, date of birth and social security number;
5. Identify the action taken to prevent reoccurrences.

**OTHER TYPES OF RESIDENT INCIDENTS – Select 7:**

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.
4. Identify witnesses.
5. Identify the action taken to prevent reoccurrences.

**MEDICATION ERROR – Select 8:**

1. Identify the correct spelling and name of employee(s) involved including their middle initial;
2. Identify the employee's title and if a nursing assistant, if he or she is certified;
3. Identify the employee's date of hire and date of birth;
4. Identify the employee's social security number;
5. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
6. Identify if the employee has had previous medication error incidents at your facility;
7. Describe the medication error. Include the time and date of the medication error, the name and dosages of the medication and when it was discovered.

If you believe there is further information relevant to the incident that is not addressed in the questions outlined, please feel free to leave that information at the end of your call.

## APPENDIX G

### RESPONSIBILITY TABLE

This table serves as a tool to help providers in understanding responsibilities to protect, investigate, report, and prevent abuse, neglect, exploitation, and misappropriation of resident property.

	<b>NURSING HOME RESPONSIBILITIES</b>	<b>*STATUTORY REQUIREMENTS</b>
Protection	<ul style="list-style-type: none"> <li>▶ Safeguard resident(s) from further incident reoccurrence</li> <li>▶ Treat all consequent ill effects experienced by resident(s)</li> <li>▶ Provide first aide or emergency medical attention to address any sustained injuries and/or medical/mental problems</li> <li>▶ Implement facility administrative decisions (e.g. suspension or reassignment of staff during investigation, if necessary)</li> </ul>	<ul style="list-style-type: none"> <li>▶ <a href="#">Chapter 74.34 RCW Vulnerable Adult Act</a>,</li> <li>▶ OBRA, F223, F224, F225, F226 (CFR 483.13)</li> <li>▶ WAC 388-97-076(7)(b)</li> </ul>
Investigation	<ul style="list-style-type: none"> <li>▶ Conduct Phase I investigation within 24 hours</li> <li>▶ Follow up with Phase II investigation if cause and/or reasonable cause undetermined</li> </ul>	<ul style="list-style-type: none"> <li>▶ <a href="#">Chapter 74.34 RCW Vulnerable Adult Act</a>,</li> <li>▶ OBRA, F225 (CFR 483.13 (c))</li> <li>▶ <a href="#">WAC 388-97-0640(7)(a)</a></li> </ul>
Reporting	<ul style="list-style-type: none"> <li>▶ *Log in state reporting log abuse, neglect, superficial/substantial injuries of unknown source, misappropriated property</li> <li>▶ Notify State Hotline of allegations within 24 hours</li> <li>▶ Notify Administrator immediately of allegations</li> <li>▶ **Notify police of suspect criminal activity</li> </ul>	<ul style="list-style-type: none"> <li>▶ <a href="#">Chapter 74.34 RCW Vulnerable Adult Act</a>,</li> <li>▶ OBRA, F225, (CFR 483.13 (c)). 488.335</li> <li>▶ <a href="#">WAC 388-97-0640(6)(a)(b)</a></li> </ul>
Prevention and Corrective Action	<ul style="list-style-type: none"> <li>▶ Resolve cause</li> <li>▶ Prevent re-occurrence of incident (e.g. revise plan of care, disciplinary action, education, training, revision of principle/procedure)</li> <li>▶ Engage facility administrative decisions</li> <li>▶ Report all suspect incidents of abuse, neglect, exploitation, or misappropriated property</li> </ul>	<ul style="list-style-type: none"> <li>▶ <a href="#">Chapter 74.34 RCW Vulnerable Adult Act</a>,</li> <li>▶ OBRA, F225, and other applicable F-tags relative to area of failed practice (CFR 483.13)</li> <li>▶ CFR 488.335</li> <li>▶ <a href="#">WAC 388-97-0640(7)(b)</a></li> </ul>

The intent of the federal and state regulations is to ensure that each resident is free from incidents of abuse, neglect, and injuries of unknown source are prevented. If such incidents occur residents must be protected, and the incident must be identified, investigated and further incidents prevented as early as possible.

\*Reporting log must be kept in facility.

\*\*The decision to call the law enforcement agency depends upon whether criminal activity is suspected and immediate action needs to be taken by the law enforcement agency. Death due to abuse, neglect, or negligent treatment is a crime. Deaths of indeterminate cause with suspected abuse, neglect, or negligence must be reported immediately to the police.

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# APPENDIX H

## Problem Solving Procedures for Facilities Upon Discovery of An Incident/Allegation

**PROTECT \* INVESTIGATE \* REPORT \* CORRECT \* PREVENT**

In general, there is presumption that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident (whether comatose, cognizant or not) causes physical harm, pain, or mental anguish.

1. Immediately treat ill effects to resident
2. Protect resident against further occurrences
3. Institute other interventions as needed

### PHASE I

1. Begin investigation upon discovery of the incident
2. Gather facts to answer who, what, when, where, how, and why
3. Analyze information to rule out or establish the likelihood that abuse, neglect, exploitation, or misappropriation has occurred, or may have contributed to the incident

**NOTE:** Report suspected abuse/neglect/exploitation/misappropriation within 24 hours  
Record: **(1)** The details of the incident in the residents medical record(s); and **(2)** The details of the investigation according to the requirements and facility protocol

Cause identified: Go back to **Phase I**

**d.** The cause/circumstance of the incident cannot be determined in Phase I investigation

### PHASE II

1. Gather additional facts
2. Analyze for likelihood of abuse / neglect / exploitation, or misappropriation of resident property

**e.** Cause of incident still undetermined after Phase II investigation

**c.** Incident is suspected to be abuse, neglect, exploitation, or misappropriation

**a.** Substantial injury seems reasonably related to: resident's condition, known & predictable interactions with surroundings, diagnoses, etc. OR a known sequence of prior events

**b.** There was an unexpected, unusual, unintended event (AN ACCIDENT) & could have been predicted, given prevailing circumstances

**RESIDENT TO RESIDENT**  
Record details of the incident.  
**Report to the department all incidents:**  
Of sexual abuse  
That result in psychological harm to the victim  
Of physical abuse that results in bodily harm to the victim;  
That may show neglect on the part of the facility due to the recurrent resident-to-resident incidents.  
**Report to law enforcement incidents of:**  
Sexual abuse  
Physical abuse with bodily harm  
**Reporting log within 5 days:**  
All incidents

**FAMILY/VISITOR TO RESIDENT**  
Record details of the incident.  
**Report to the department:**  
All incidents  
**Report to law enforcement:**  
Sexual abuse  
Physical abuse with bodily harm  
Misappropriation/financial exploitation  
**Reporting log within 5 days:**  
All incidents

**STAFF TO RESIDENT**  
Record details of the incident.  
**Report to the department:**  
All incidents.  
**Report to law enforcement:** Sexual abuse; Physical abuse with bodily harm;  
Misappropriation/financial exploitation  
**Reporting log within 5 days:**  
All incidents

1. Record details of investigation
2. For a Substantial injury: Call Hotline and Log within 5 days
3. For a Superficial injury: Log within 5 days

1. Record findings that validate this conclusion
2. For substantial injuries, Log within 5 days

1. Record findings that validate this conclusion
2. No reporting in Log or to Hotline is necessary

1. Act to prevent recurrence of incident and protect resident(s), even if exact cause of incident has not been identified
2. If related to abuse/neglect/negligent treatment/misappropriation, refer to appropriate protective services
3. Do needed re-assessment, care revision, staff training and equipment modification to assure resident's safety







It is the policy of the Department of Social and Health Services that no person shall be subjected to discrimination in this agency or its contractors because of race, color, national origin, sex, age, religion, creed, marital status, disabled or Vietnam Era veteran status, or the presence of any physical, mental, or sensory handicap.