Reporting Decision Tool: *When Do I Report to State Agency and Law Enforcement?*

Problem solving flowchart upon discovery of an incident/allegation

1. Immediately treat ill effects to resident.
2. Determine if a report should be made…if yes you MUST report ***immediately*** to the State Agency (see below).
3. Protect resident against further occurrences.
4. Institute other interventions as needed.
5. Begin investigation upon discovery of the incident.
6. Gather facts to answer who, what, when, where, how, and why.
7. Analyze information to rule out or establish the likelihood that abuse, neglect, financial exploitation has occurred, or may have contributed to the incident. ***NOTE:*** Report suspected abuse, neglect, or financial exploitation immediately (***MUST BE*** reported within two hours of suspicion to local law enforcement). Record: *(1)* The details of the incident in the resident's medical record(s); and *(2)* The details of the investigation according to the requirements and facility protocol.

A and **B**: Two different incident types that will not need to be reported to the State Agency (hotline) or Law Enforcement. You know what happened, the incident is directly related to diagnosis and predictable, the resident is able to explain what happened, an ACCIDENT occurred. If in doubt, call your regional office.
C: The incident is suspected abuse, neglect, exploitation, or misappropriation. You need to immediately take action. This must be reported to the Abuse Hotline immediately and to Local Law Enforcement within ***TWO HOURS of SUSPICION***. For example, (1) a resident tells you another resident hit them or sexually abused them; (2) a family member or visitor hit them or sexually abused them; or (3) a staff member hit them or sexually abused them; or that someone is taking advantage of them financially or you discover that money has been stolen or misappropriated. In addition, an injury of unknown origin that is suspicious in nature i.e., excessive or large bruising, skin tear(s), or broken bones would require ***immediate*** reporting to the State Agency (hotline) ***and*** Local Law Enforcement.
D: You are unable to determine how the incident occurred. ***Report Immediately!***
E: You will continue with your investigation and analyze the facts for abuse/neglect/misappropriation.
F: Cause cannot be determined. For substantial injury, REPORT incident to State Agency (hotline). If you are *SUSPICIOUS* a crime has occurred you ***must*** *also* report within ***TWO HOURS of Suspicion*** to Local Law Enforcement.

Regulatory references: Look for compliance with F689 Accidents and Supervision, F600-F608 Abuse/Exploitation/Staff/Policies, F609 Reporting, F610 Response, F656 Comprehensive Care Plans, F658 Meet Professional Standards, and F684 Quality of Care. A copy of S&C 11-30-NH is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf Please note, these are not all inclusive and for reference only. For State Specific Reference refer to 19 CSR 30-88.010 (22), (23), (24), (25), http://health.mo.gov/safety/abuse/, and http://www.nursinghomehelp.org/qftf/QFTF_Abuse_0415.pdf.

*It is important to note that if you are ever in doubt if an incident is reportable to call and discuss it with your Regional State Agency Office or the Abuse and Neglect Hotline. A map of the Department of Health and Senior Services (DHSS) Division of Regulation and Licensure, Section for Long-Term Care Regulation Regional Office locations is available at http://health.mo.gov/seniors/nursinghomes/pdf/LongTermCareRegions.pdf.

Reporting Decision Tool: *When Do I Report to State Agency and Law Enforcement?*

Problem solving flowchart upon discovery of an incident/allegation

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)*** which ***could not*** have been predicted, given prevailing circumstances

C. YOU HAVE A REASONABLE CAUSE TO SUSPECT THAT THE INCIDENT IS ABUSE, NEGLECT, EXPLOITATION, OR MISAPPROPRIATION OF PROPERTY, INJURY OF UNKNOWN ORIGIN ***OR*** SUCH AN INCIDENT WAS REPORTED TO YOU- ***REPORT IMMEDIATELY!***

D. ***THE CAUSE OF THE INCIDENT CANNOT BE DETERMINED IMMEDIATE REPORTING***

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

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2. No reporting to Hotline is necessary

1. RESIDENT TO RESIDENT
Record details of the incident.
Report to the Department all incidents:
i. Of sexual abuse
ii. Of physical abuse
iii. That may show neglect on the part of the facility due to the recurrent resident-to-resident incidents.
iv. Injury of Unknown Origin
Report to law enforcement incidents of:
Sexual abuse
Physical abuse

2. FAMILY/VISITOR TO RESIDENT
Record details of the incident.
Report to the Department:
All incidents
Report to law enforcement:
Sexual abuse
Physical abuse
Misappropriation/ financial exploitation

3. STAFF TO RESIDENT
Record details of the incident.
Report to the Department:
All incidents
Report to law enforcement:
Sexual abuse;
Physical abuse
Misappropriation/ financial exploitation

E. Gather additional facts and analyze for likelihood of abuse / neglect /financial exploitation

F. Cause of incident still undetermined after investigation

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. Things to do: Re-assessment, care plan revision, staff training and equipment modification to assure resident's safety.

Timeline for reporting abuse:
Abuse should be reported ***immediately*** to the State Agency. For Missouri call the Hotline number at 1-800-392-0210.

1. Record details of investigation.
2. To self report: ***Call Hotline 1-800-392-0210 immediately.***
3.* Contact police** (local law enforcement agency) ***if crime is suspected within **TWO HOURS** of suspicion**.**

Adapted from Nursing Home Guidelines AKA "The Purple Book" Fifth Edition, Partner's In Protection, February 2012, Appendix H: Problem Solving Procedures for Facilities Upon Discovery of an Incident/Allegation
https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/purplebook.pdf

Updated 10/18

Coaching for Nursing Home Administrators

Guidelines for Facility Self-Reporting
Effective November 28, 2016

Certified Facilities

F225 – The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but **not later than 2 hours** after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or **not later than 24 hours** if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures.

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse, neglect or exploitation or mistreatment while the investigation is in progress.

The facility must report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The requirement is to report and investigate all alleged violations. This is more stringent that the state requirements which include the language "reasonable cause to believe".

Policies and Procedures:

Policies and procedures must cover the following areas:

Screening
Training
Prevention
Identification
Investigation
Protection
Reporting/Response

Policies and procedures should be consistent with regulatory requirements, including reporting requirements – ensure policies and procedures **do NOT** include "reasonable cause to believe" language.

Facilities must also meet the additional reporting requirements included under the affordable healthcare act for suspected crimes. These additional reporting requirements must be included in the policies and procedures.

Facilities must ensure policies and procedures contain specific reporting timeframes.

Facilities must ensure policies and procedures include prohibitions from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).

State-Licensed Only Facilities

Section 198.070.1, RSMo, requires long-term care (LTC) administrators or employees who have "***reasonable cause to believe*** that a resident of a facility has been abused or neglected… shall immediately report or cause a report to be made to the department."
The LTC employee should have ***reasonable cause to believe*** that the abuse or neglect occurred and the facility must ensure that all employees report allegations of abuse or neglect to the facility administrator. This allows an administrator or director of nursing a short amount of time to conduct an internal investigation to determine if there is reasonable likelihood that the alleged abuse or neglect actually occurred; and, in the case of "neglect," that the allegation actually rises to the level of "neglect." Once a determination is made that there is ***reasonable cause to believe*** the abuse or neglect occurred, the LTC employee is mandated to immediately report, or cause such a report to be made, to the department.

Misappropriation of RESIDENT property does not fall under a STATE mandated reporting category in state licensed only facilities, however, it should be reported if the alleged perpetrator is a facility employee for the purpose of a potential employee disqualification list (EDL) investigation.

How to File a Facility Self-Report

During normal business hours (Monday – Friday between 8:00 a.m. and 5:00 p.m.) facilities are encouraged to call their regional office directly to report incidents that may require a self-report to be generated. Regional office staff will then determine whether the information meets the self-reporting criteria. Regional office staff will verify whether the caller is making the report on behalf of the facility.

Region 1 (Springfield) - (417) 895-6435; Fax (417) 895-6290
Region 2 (Poplar Bluff) – (573) 840-9580; Fax (573) 840-9586
Region 3 (Kansas City) – (816) 889-2818; Fax (816) 889-2888
Region 4 (Cameron) – (816) 632-6541; Fax (816) 632-1810
Region 5 (Macon) – (660) 385-5763; Fax (660) 385-4706
Region 6 (Jefferson City) – (573) 751-2270; Fax (573) 526-1269
Region 7 (St. Louis) – (314) 340-7360; Fax (314) 340-3414

After hours and on weekends facilities must call the Elder Abuse & Neglect Hotline (1-800-392-0210) to report an incident that meets the self-reporting criteria in lieu of calling the regional office. **During times when the hotline or regional office is closed a report may be faxed to the regional office in order to meet mandatory reporting timeframes. Please note: If a report is faxed to the regional office, the facility must follow-up with a call to the hotline (weekends/holidays) or the regional office (weekdays) as soon as possible, i.e., as soon as the hotline or regional office is available to take the report.** Faxed reports must clearly indicate the facility and reporter name and shall include a specific description of the incident, the resident(s) affected, the name staff person(s) involved, and any action taken by the facility as a result of the allegation.

Facility Investigative Documentation

1. Specific description of the incident (persons involved, date, time, and location of the incident).

2. Relevant information/documentation from the resident's medical record (i.e., face sheet, nurse's notes, MDS, care plans, physician notes, discharge information).

3. A description of the resident's injury and photographs, if possible.

4. Names, addresses, home telephone numbers, dates of birth, social security numbers, and positions for staff involved in the incident.

5. Written statements by all persons with knowledge of the incident. Statements must be signed and dated and give specific details.

6. Documentation of interviews with other residents who might have been affected or that the involved staff person worked with to determine if there are additional concerns.

7. Documentation of any interviews conducted with persons who might have some knowledge of the incident.

8. Copy of disciplinary action taken including the date, if any action was taken.

9. Summary of investigation, including corrective actions/monitoring the facility implemented to prevent the incident from reoccurring.

10. Police report and contact information, if completed and when available.

11. Any other relevant information that would helpful to show what happened for the specific incident and actions taken by the facility not included in the above dot points.