



COMMISSIONER
Jon Weizenbaum

August 19, 2014

To: All Nursing Facilities

Subject: **Provider Letter 14-13 – Abuse, Neglect, Exploitation and Other Incidents that Must Be Reported (Replaces PL 06-43)**

The purpose of this letter is to update the Health and Safety Code (HSC) and Texas Administrative Code (TAC) references in Provider Letter 06-43, dated January 3, 2007. This letter provides guidance for reporting incidents to the Department of Aging and Disability Services (DADS).

Health and Safety Code §[260A.002](#) and Texas Administrative Code, Title 40, Part 1, Chapter 19, §[19.602](#)(a) require any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation. Facilities are required at 40 TAC §[19.601](#)(c)(2) to ensure that all alleged violations involving mistreatment, neglect or abuse, including suspicious injuries of unknown source and misappropriation of resident property, are reported immediately to DADS.

Facilities are also required to report certain other incidents, which may or may not constitute abuse, neglect or exploitation. Certified facilities are required by 42 Code of Federal Regulations (CFR) §483.13(c)(2) and (4) (F226) to report alleged violations involving mistreatment, neglect or abuse, including suspicious injuries of unknown source and misappropriation of resident property, and the results of the investigation conducted by the facility to the state survey and certification agency.

REPORTING ABUSE, NEGLECT, EXPLOITATION AND OTHER INCIDENTS

1. ABUSE [as defined in [40 TAC §19.101](#)(1)]

“Abuse--negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or emotional harm or pain to a resident; or sexual abuse, including involuntary or nonconsensual sexual conduct that would constitute an offense under Penal Code §21.08 (indecent exposure) or Penal Code Chapter 22 (assaultive offenses), sexual harassment, sexual coercion, or sexual assault.”

- Allegations or incidents of resident-to-resident behavior may or may not meet the definition of abuse. To determine whether such incidents are reportable, refer to Attachment 2.

- A facility owner or employee who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person must report the abuse, neglect or exploitation.

For certified facilities, abuse is also defined at 42 CFR §488.301 and prohibited at §483.13(b) (F223, the right to be free from abuse) and §483.13 (c) (F224, the right to be free from mistreatment, neglect and misappropriation of property).

2. **NEGLECT** [as defined in [40 TAC §19.101\(81\)](#)]

“The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness.”

The facility must determine if an injury, harm to or death of a resident was due to a facility failure to provide services, treatment or care to a resident. The following are examples of reportable neglect.

- A resident with a doctor's order for close supervision due to unsteady gait is left unsupervised or inadequately supervised. As a result, the resident falls and fractures his hip.
- A resident, according to his care plan, requires a two-person transfer from bed to chair. Only one staff person assists the resident in transferring him from a bed to a chair and the resident falls, resulting in extensive bruising to his thigh.
- A resident with a known history of physical abuse (that has not been addressed by the facility) punches another resident in the eye, causing a black eye. Note: This is a reportable incident of neglect because staff inaction resulted in injury to a resident.
- A resident slips in urine left on the floor in the hallway and breaks his arm. Staff was aware that the urine was on the floor but failed to remove it or take precautions to prevent a person from slipping in it. The injury was accidental but due to neglect because staff inaction (failure to clean the urine from the floor) resulted in the injury. (If there was urine on the floor but staff immediately cleaned it up or placed barriers around it to prevent anyone from slipping in it until it could be cleaned up, the situation would be an accident hazard and not an injury due to neglect.)

For certified facilities, neglect is also defined at 42 CFR §488.301 and prohibited at §483.13(c) (F224).

3. **EXPLOITATION** [as defined in [40 TAC §19.101\(38\)](#)]

“The illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with a resident using the resources of the resident for monetary or personal benefit, profit, or gain without the informed consent of the resident.”

4. DEATH

If the death of a resident involves unusual circumstances that raise a doubt about whether the death was from natural causes, the death must be reported. Examples include:

- a death due to a medication overdose, an administration of a wrong medication, or a failure to administer a medication;
- an accidental death caused by exposure to weather, being struck by a motor vehicle, drowning, strangulation (by ligature or aspiration), burns (fire or water), electrical shock or fall;
- a suicide; or
- a death following a resident-to-resident altercation.

5. MISSING RESIDENT

If a resident is not located during a search of the facility, facility grounds and immediate vicinity, and circumstances place the resident's health, safety or welfare at risk, the report must be made as soon as the facility becomes aware that the resident is missing and cannot be located. Examples include, but are not limited to:

- a resident requires medications that, if not taken as scheduled, place the resident at risk of serious illness or death or both;
- extreme weather conditions expose the resident to potential freezing, heat prostration or drowning from flooding;
- the resident is confused or otherwise incapable of assessing potential danger; or
- the facility suspects foul play.

Regardless of the circumstances, any resident missing for eight hours and not yet located must be reported at that time. In addition, the facility must contact the DADS Consumer Rights and Services Section every day until the resident is found.

6. MISAPPROPRIATION [as defined in [40 TAC §19.101](#)(80)]

Misappropriation of resident property is “the taking, retention, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real, or personal, or anything of value belonging to or under the legal control of a resident, without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.”

For certified facilities, misappropriation of resident property, as defined in 42 CFR [§488.301](#), is “...the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.”

7. DRUG DIVERSIONS

Facility staff must make a report to DADS if the facility has reason to believe that drugs were stolen. Staff must also notify the local police department.

8. SUSPICIOUS INJURIES OF UNKNOWN SOURCE [injuries of unknown source are defined in CMS [Survey & Certification \(S&C\) 05-09](#)]

“An injury should be classified as an ‘injury of unknown source’ when both of the following conditions are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and,
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.”

9. FIRES

Fires of any nature, including those requiring notification of the local fire department, are to be reported to DADS as incidents according to 40 TAC §[19.1914\(f\)\(1\)\(A\)\(B\)](#). The facility must report all fires on the “Fire Report for Long Term Care Facilities,” Form 3707, within 15 days after the fire. The form can be viewed at:

<http://www.dads.state.tx.us/forms/3707/3707.pdf>.

The completed form must be mailed to the Consumer Rights and Services Section, Complaint Intake Unit, Mail Code E-249, with the completed Provider Investigation Report.

Additionally, the facility must immediately notify DADS by phone of an emergency situation that caused death or serious injury, and submit a completed DADS form entitled “DADS Provider Investigation Report” within five working days after making the phone report [40 [TAC §19.1914\(f\)\(2\)\(A\)\(B\)](#)].

10. CONDITIONS THAT POSE A THREAT TO RESIDENT HEALTH AND SAFETY

Any situation that poses a threat to residents, staff or the public must be reported, including situations for which the police or the local fire authority must be notified or summoned in order to maintain safety. Examples include the following situations:

- Bomb threat
- Tornado that hits the building
- Flood
- Generator or emergency power failure
- Failure of the sprinkler system
- Failure of the fire alarm system
- Environmental conditions that compromise the facility’s structure

- Air conditioning failure when outdoor temperature is or will be 90 degrees Fahrenheit or above
- Heating failure when outdoor temperature is or will be 65 degrees Fahrenheit or below
- Firearms in the building

PROCEDURES FOR THE INITIAL TELEPHONE REPORT OF ABUSE AND NEGLECT

Facility staff must report abuse, neglect, exploitation and other incidents to:

- DADS Consumer Rights and Services Section at (800) 458-9858 **immediately** (within 24 hours) upon learning of the incident; and
- send a written investigation report to the Consumer Rights and Services Section **within 5 working days after the telephone report.**

The report must include the following information:

- facility name;
- vendor/ID number;
- resident name(s);
- time and date of incident;
- what occurred;
- condition of resident(s), person(s) involved (other than resident); and
- action taken by facility authority to date.

If you leave the information on the voicemail reporting system:

- leave a phone number where you can be reached during hours other than regular business hours; or
- leave detailed instructions for the intake specialist regarding who to speak to in the facility about the incident during other than normal business hours.

PROCEDURES FOR THE FACILITY INVESTIGATION

The facility must conduct an investigation of the reported act(s) and must send a written report of the investigation to DADS no later than the fifth working day after the oral report according to [40 TAC §19.602\(b\)\(1\)\(2\)](#).

The Provider Investigation Report form can be found at <http://www.dads.state.tx.us/forms/3613-A/3613-A.pdf>.

Instructions for completing the forms are accessible at <http://www.dads.state.tx.us/handbooks/instr/3000/F3613-A/>.

The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. If the alleged violation is substantiated, appropriate corrective action must be taken.

PROCEDURES FOR SUBMITTING THE FOLLOW-UP WRITTEN INVESTIGATION

Within five working days of making the telephone report, send the written investigation report with statements and other relevant documentation to DADS. Always include your Medicaid or DADS-assigned vendor number on the report. If the Provider Investigation Report form with statements and other relevant documentation does not exceed 15 pages, you may fax them toll-free to DADS at (877) 438-5827. Otherwise, mail the report and attachments to:

Department of Aging and Disability Services
Consumer Rights and Services Section, E-249
ATTN: Intake Coordinator
P.O. Box 149030
Austin, TX 78714-9030

DO NOT REPORT THE FOLLOWING INCIDENTS

- Burglary of nursing facility property – notify the local police department.
- Theft of any property not belonging to a resident – notify the local police department.

If you have questions about these guidelines, please contact a nursing facility program specialist with the Policy, Rules and Curriculum Development unit at (512) 438-3161.

Sincerely,

[signature on file]

Mary T. Henderson
Assistant Commissioner
Regulatory Services

MTH:cg

Attachments:

Attachment 1, Provider Investigation Report Form Instructions

<http://www.dads.state.tx.us/handbooks/instr/3000/F3613-A/>

Provider Investigation Report Form

<http://www.dads.state.tx.us/forms/3613-A/3613-A.pdf>

Attachment 2, Resident-to-Resident Incidents

Attachment 3, Flowchart

Attachment 2 Resident-to-Resident Incidents

The purpose of this attachment is to provide guidance to facilities concerning appropriate nursing facility practice regarding reporting resident-to-resident alleged abuse.

Abuse versus Inappropriate Behavior

DADS has developed a flowchart (Attachment 3) to assist facilities in determining when to report resident-to-resident incidents.

The flowchart makes the same distinction as the Centers for Medicare & Medicaid Services Regional Survey and Certification Letter No: 00-03 regarding abusive behaviors by residents who have dementia. The letter states, "a determination of abuse requires that the incident under investigation must have been willful and/or deliberate." Similarly, the flowchart's first decision box asks whether the resident has the capacity to act willfully, knowingly or recklessly. If the answer is "no," then abuse has not occurred.

Although abuse has not occurred, further assessment is required to determine if neglect occurred. Did the facility exercise reasonable judgment in managing the resident and minimizing the threat to the resident or other residents? Does the facility have appropriate policies and procedures in place to address the behaviors, as well as to protect the resident and others? If the answer to these or other similar questions is "no," neglect may have occurred and must be reported to DADS.

Instances of resident-to-resident inappropriate behavior that do not constitute either abuse or neglect may not need to be reported; however, such behavior must still be addressed (see Facility Responsibility). Additionally, please note, as detailed in the flowchart, that some incidents must be reported, regardless of whether they constitute abuse or neglect.

Reportable incidents are those that result in:

- physical injury requiring medical attention for evaluation or treatment, excluding minor skin tears;
- a threat to health or safety;
- resident psychological distress (related to the incident) that does not resolve within eight hours; and
- a change in condition related to the incident.

Reporting Incidents and Abuse

When either a reportable incident or actual abuse occurs, the facility must:

- report the incident or abuse;
- conduct and document a thorough investigation of each incident;
- complete an appropriate assessment of the residents involved; and
- implement a plan of action designed to prevent recurrence.

Facility Investigation

Facility actions when conducting an investigation must be documented and include:

- observations, interviews and record reviews of all residents involved;
- interviews of all witnesses, including residents, staff and family members;
- notification of the physicians and, where appropriate, the families or responsible parties of the involved residents; and
- recording of all relevant physical findings.

Deficient Practice

A deficiency is defined as failure to meet a requirement. DADS may identify a deficient practice when a facility fails to:

- report all reportable incidents and allegations of abuse;
- thoroughly investigate and document all incidents and allegations of abuse;
- properly assess residents upon initial and annual assessments, as well as after a significant change in condition; or
- implement a plan of action to prevent recurrence of incidents or abuse.

The occurrence of problem behaviors or reportable incidents does not in itself constitute evidence of deficient practice. However, the facility's failure to address important early warning signs (see Attention to Early Warning Signs) may constitute a deficient practice, even in incidents that otherwise appear to be unprecedented.

Attention to Early Warning Signs

If a resident begins to exhibit inappropriate behavior, the facility must assess the resident and promptly intervene, taking appropriate action to protect other residents, even if no allegation of abuse is made. Failure to do so is a deficient practice that may constitute neglect. Appropriate actions include steps such as additional supervision for aggressive residents and appropriate medical/psychiatric evaluation and treatment.

Inappropriate behavior may first be directed toward staff or may be minor in nature. It is important that facilities assess and intervene at this point, rather than after inappropriate behavior is directed toward other residents or the inappropriate behavior escalates.

Facility Responsibility

When any resident's behavior constitutes a threat to the health and safety of other residents, the facility must report the behavior and must protect other residents from that threat. Minimum evidence of protection must include both assessment and prompt intervention. The facility must reassess the inappropriate behavior and adjust the care plan accordingly. The facility must take specific steps to control the inappropriate behavior and to protect other residents. The facility's plan of action may include steps such as:

- specific psychiatric or medical therapy for the resident with aggressive behavior;
- additional supervision of residents;
- adjustment of facility practices to minimize the risk of occurrences;
- activities and other interventions that redirect the energies of the resident with aggressive behavior; and
- care plan changes to minimize the risk of recurrent incidents.

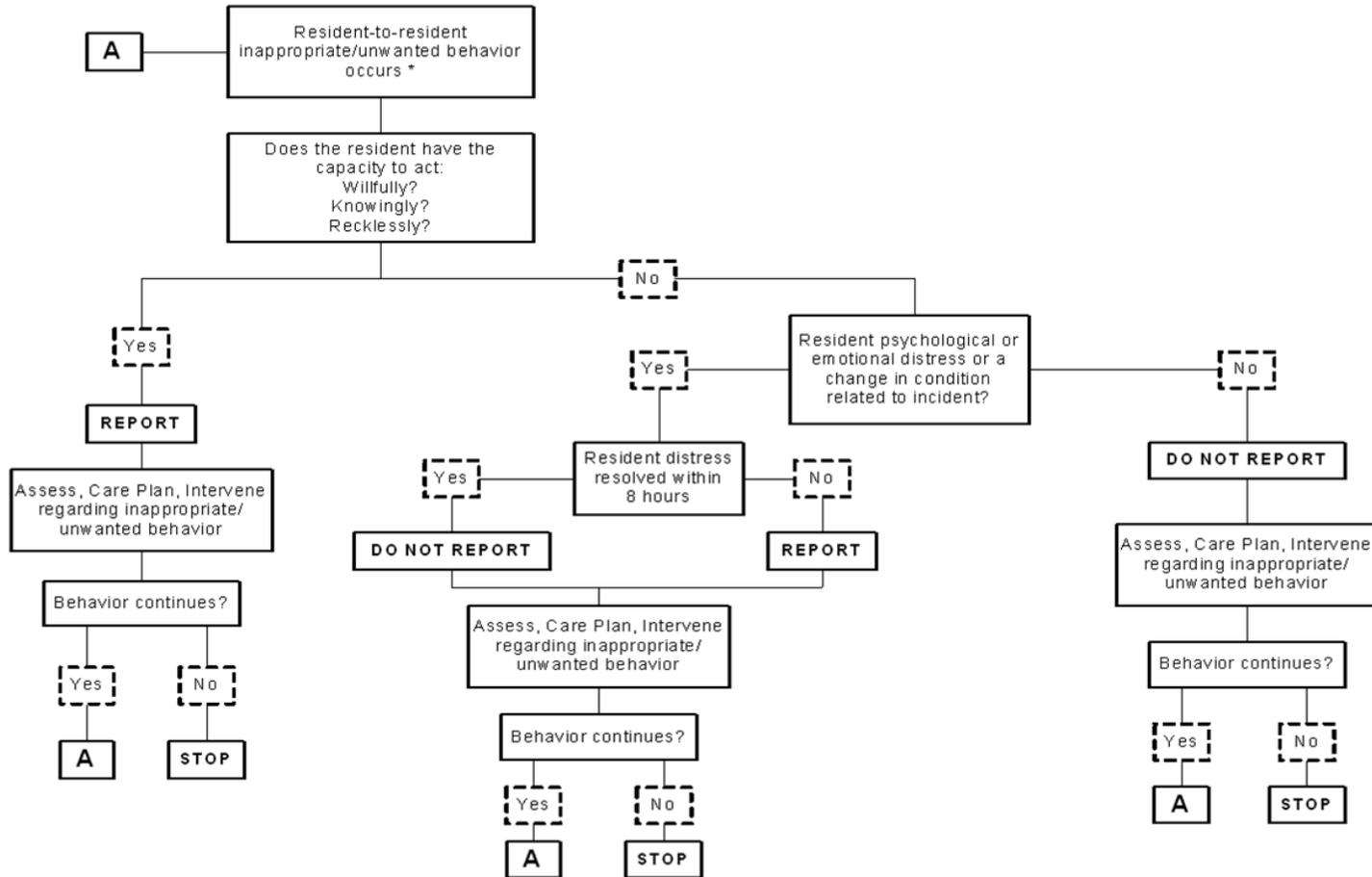
Sexual Activity

When a third party (other than the participants) makes an allegation of sexual abuse, it is necessary to determine whether the sexual activity was consensual. In the case of a resident who has been adjudicated incompetent, the guardian must have provided consent. A resident may have decision-making capacity over sexual matters, even though he or she lacks the ability to handle the entirety of his or her life affairs. In all other cases, consent must come from the resident.

In the absence of allegations of abuse, consensual sexual activity between residents having specific decision-making capacity over sexual matters is not a reportable incident. Sexual activity involving a resident without specific decision-making capacity over sexual matters is a reportable incident and must be addressed.

Inappropriate sexual behavior not directed toward a particular individual that does not result in an allegation and does not constitute cause to believe sexual abuse has occurred does not need to be reported but must be addressed. The facility must document the behavior, conduct a resident assessment, as necessary, and incorporate in the care plan procedures to address the behavior and protect other residents from the inappropriate behavior.

Attachment 3 Flowchart



*Persistent behaviors must be documented