I. INTRODUCTION

The facility will investigate and document all incidents and accidents involving residents. Certain incidents and accidents involving residents must also be reported to the appropriate state agencies. Reportable incidents and accidents are those involving allegations or suspicion of resident abuse, neglect, exploitation, or misappropriation of resident property. Certain unusual occurrences may also be reportable. Certain incidents and accidents that cause minor injuries where there is no reasonable cause to believe that abuse or neglect was involved may not have to be reported. Both reportable and non-reportable incidents and accidents must be investigated and documented in the manner set forth in this policy.

The investigation protocol for incidents and accidents is set forth in Section VIII of this policy.

The facility's policy strictly prohibits the abuse, neglect, exploitation, misappropriation of resident property and involuntary seclusion of residents. This policy against abuse, neglect, exploitation and misappropriation of resident property includes abuse by any other person, including, but not limited to:

1. Any member of the facility staff
2. Physicians
3. Podiatrists
4. Physician assistants
5. Certified Registered Nurse Practitioner
6. Dentists
7. Beauticians
8. Staff of governmental agencies
9. Family members of the resident
10. Visitors
11. The resident's legal guardian
12. Residents of the facility
13. Contract providers in the facility

The facility has established procedures to screen and educate employees to help prevent instances of abuse, neglect, exploitation, misappropriation of resident property, and involuntary seclusion, and to identify and investigate possible occurrences that violate the policy. The facility's policy requires that it report all instances of abuse, neglect,

exploitation, misappropriation of resident property, and suspicious injuries or unusual occurrences that might indicate abuse or neglect, as required by state and federal law.

II. DEFINITIONS

This policy addresses the acts and occurrences that constitute abuse, neglect, misappropriation of resident property, and unusual occurrences; when such acts and occurrences must be reported to agencies and officials outside of the facility; the proper reporting procedures to be used in such instances; training of employees regarding such acts and occurrences and reporting procedures; and the investigation of such acts and occurrences. The policy also addresses the proper investigation and documentation of incidents or accidents involving residents that are not caused by abuse, neglect, exploitation, misappropriation of resident property, and do not constitute reportable unusual occurrences.

For purposes of this policy, the following terms are defined below:

A. ABUSE

The definition of abuse encompasses a broad scope of behavior. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled though the use of technology. **Willful**, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury.

The following are definitions of specific types of abuse:

1. **Vulnerable Adult** is any and all residents of the facility.
2. **Verbal Abuse** is the use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their ages, abilities to comprehend, or the nature of their disabilities. Examples of verbal abuse include, but are not limited to, threats of harm and saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
3. **Sexual Abuse** is non-consensual sexual contact of any type with a resident. This includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
4. **Physical Abuse** includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.
5. **Mental Abuse** includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

6. **Involuntary Seclusion** is the separation of a resident from other residents, from his/her room, or confinement to his/her room (with or without roommates) against the resident's will or the will of the resident's legal representative. In certain circumstances, involuntary seclusion may not qualify as abuse. Emergency or short-term monitored separation from other residents will not be considered abuse 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.
7. **Exploitation** is taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
8. **Misappropriation of Resident Property** is the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Acts that constitute the misappropriation of resident property include, but are not limited to, the theft or attempted theft of a resident's money or personal property, theft of a resident's medication, or the inappropriate use of a resident's funds or property.
9. **Mistreatment** is inappropriate treatment or exploitation of a resident.

B. NEGLECT

Neglect is a failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

C. UNUSUAL OCCURRENCES

Reportable unusual occurrences are unusual events that threaten the welfare, safety or health of residents, personnel, or visitors. Examples of unusual occurrences include, but are not limited to, catastrophes, life threatening burns, fires, and deaths under unusual circumstances.

D. SUSPICIOUS INJURIES AND INJURIES OF UNKNOWN SOURCE

Suspicious injuries and injuries of unknown source must be reported if there is any cause to believe or suspect that these injuries have been abusively inflicted upon a resident or that the injuries are the result of a failure to provide necessary goods and services by a nurse aide or by another individual. Examples of these types of injuries include, but are not limited to:

1. Black eyes
2. Extensive bruising around the neck and/or other body parts
3. Cigarette burns
4. Repetitive injuries

F. NON-REPORTABLE INJURIES

Some injuries of unknown source may not be reportable. If there is no reasonable cause to believe or suspect that the injury is the result of abuse or neglect, then the facility does not have to report the occurrence to the Alabama Department of Public Health, Division of Health Care Facilities (ADPH) The facility will follow the policies and procedures outlined in this policy to determine whether the injury is reportable and will document its rationale for its determination as to whether the incident is reportable.

In the event the facility determines that the incident is not reportable, it will follow the policies and procedures set forth in this policy regarding the investigation and documentation of non-reportable incidents or accidents. The following are examples of non-reportable types of injuries:

1. A fall, whether witnessed or not, including a fall requiring medical intervention such as an x-ray, if there is no reason to suspect that the injury was caused by abuse or neglect
2. An injury of unknown origin such as a skin tear or bruise, if there is no reason to suspect that the injury was caused by abuse or neglect
3. Broken bones that are determined not to be the result of abuse or neglect and
4. Injuries that occur when a resident is out of the facility on a pass if there is no reason to suspect that the injury was caused by abuse or neglect.

III. SCREENING OF EMPLOYEES

A. The facility will not knowingly employ any individual who has been found guilty by a court of law of abusing, neglecting, exploiting, or mistreating residents. In addition, the facility will not knowingly employ any individual who has had a finding entered into the State Nurse Aide Registry concerning abuse, exploitation, neglect, mistreatment of residents, or misappropriation of resident property. The facility will report any knowledge it has of actions by a court of law against an employee that would indicate unfitness for service as a Nurse Aide or other facility staff to the State Nurse Aide Registry licensing authorities.

B. To ensure that the facility does not knowingly hire such an individual, it has established the following procedures:

1. All potential employees must state on their employment application whether they have been found guilty of any crime that constitutes abuse, neglect, exploitation, mistreatment, or misappropriation of resident's property.
2. The facility will search the appropriate registries and will conduct a background investigation to determine whether a finding of abuse, neglect, exploitation, mistreatment, or misappropriation has been entered against a

potential employee. As a part of this background check, potential employees will be required to disclose the names of previous healthcare employers who will be contacted to determine whether the potential employee has a history of resident abuse or neglect or exploitation or misappropriation of resident property. At its discretion, the facility may conduct additional background investigations on any employee.

3. Prior to employment, the facility will screen potential employees for drug abuse. The facility may re-screen an employee when an employee files a worker's compensation claim, upon reasonable suspicion of resident abuse, or on a random basis.

IV. TRAINING OF EMPLOYEES

A. The facility will educate all employees so that every employee understands this policy. Employees will receive training on abuse prevention and identification at the following times:
   1. The employees will receive training upon beginning their employment with the facility.
   2. The facility will conduct in-service sessions at regular intervals which will occur on at least an annual basis to supplement its employees' initial training and
   3. The facility will conduct an in-service session if the administration believes that its employees are not following this policy, if the facility believes its employees' understanding of the policy is deficient, or in response to an incident at the facility.

B. As a part of these training sessions, the facility will train all employees on appropriate interventions to deal with aggressive and catastrophic reactions of residents. Further, the facility will explain that all employees may report alleged abuse, neglect, exploitation, or misappropriation of resident property without fear of reprisal. The facility will educate all employees, including those who are not direct caregivers, regarding the types of prohibited behavior, the employees' duty to report certain incidents, and the proper procedures for doing so. At the training sessions, the facility will address issues related to staff burnout.

   The facility will also educate its employees as to revisions of its policies and procedures or changes to the applicable state and federal regulations. The goal of this training is to keep employees mindful of the conduct that constitutes abuse, neglect, exploitation, or misappropriation of resident property and of the facility's reporting procedures.

V. PREVENTION POLICIES AND PROCEDURES

A. The facility's goal in establishing this policy is to prevent instances of abuse, neglect, exploitation or misappropriation of resident property and to educate employees on the facility's reporting procedures. As previously discussed, the facility screens potential employees to identify those who have histories of

abusing or neglecting residents or exploiting residents or misappropriating resident property. Identifying such applicants serves as one of the facility's measures to help prevent abuse. In addition, the facility's training of employees educates employees as to the types of behavior that this policy prohibits and the types of occurrences that the facility must report.

B. To help prevent abuse inflicted upon a resident by a non-employee, the facility will monitor residents and visitors for inappropriate behavior. In addition to monitoring residents who act inappropriately toward other residents, the facility will implement a plan of care to address the resident's behavior. If an instance of resident-on-resident or visitor-on-resident abuse occurs, the facility will take reasonable measures to help prevent a reoccurrence. The facility's Quality Assurance Process Improvement Committee is responsible for problem identification and for making certain that the facility takes appropriate corrective action. Steps taken to help prevent a reoccurrence may include, but are not limited to:

    1. Have a staff member monitor the visits with a visitor who has behaved inappropriately on prior visits.
    2. Obtain a resident's consent before permitting visits by a visitor who has behaved inappropriately on prior visits and
    3. Separate residents who become agitated when they are in close proximity of each other.

C. The facility wishes to prevent all instances of abuse, but in cases where such an instance occurs, the facility will use the event as an opportunity to develop new interventions in an attempt to prevent a reoccurrence. Further, the facility welcomes the suggestions of residents, their family members, and their visitors as to additional measures that will prevent instances of abuse, neglect, or misappropriation of resident property.

D. The facility will also review staffing patterns and the acuity level of residents to help prevent abuse, neglect, exploitation and misappropriation of resident property. The facility will maintain a sufficient number of staff on each shift to meet the needs of residents and to make certain that the staff members assigned to each resident know the resident's individual care needs.

E. The facility staff will be supervised and trained to identify inappropriate behaviors. Examples of inappropriate behaviors include, but are not limited to, the following: use of derogatory language, rough handling, ignoring residents while giving care, and directing residents who need toileting assistance to urinate or defecate in their beds.

VI. IDENTIFICATION OF RESIDENT INCIDENTS AND ACCIDENTS

The facility's employees, its residents, and the residents' families and visitors may become aware of resident incidents or accidents. The facility will investigate all such

incidents or allegations regardless of how the facility became aware of the incident or the source of the allegation.

Upon the resident's admission and at least annually, the facility will inform the resident and his/her responsible party of the facility's policy against abuse, neglect, exploitation, and misappropriation of resident property and the resident's right to be free of such treatment. The facility will also inform the resident of the ways in which the resident can report such incidents without fearing retaliation from the offending party. One possible way for the resident to make such complaint is through the facility's grievance procedure. If a complaint received through this procedure reveals a possible incident of abuse, neglect or misappropriation of resident property, the facility will follow the procedures outlined below. Finally, the facility will place notices throughout the facility to inform visitors of how they can make complaints concerning a resident's treatment.

Each employee has an obligation to report any incident that could constitute an instance of abuse or neglect, exploitation, an unusual occurrence, an injury of unknown source, or misappropriation of resident property to the Administrator, the Director of Nursing (DON), or the department supervisor. If the report is made to the DON or a department supervisor, that individual will notify the Administrator.

To further screen for incidents of possible abuse and neglect, the facility will immediately review the medical record of any resident who expires within forty-eight (48) hours or less following admission to the facility and any event that is potentially reportable to the Board of Nursing that involves the death of a resident.

VII. PROTECTION OF RESIDENTS DURING THE INVESTIGATION

A. The facility will take all reasonable measures to protect a resident during an investigation of abuse, neglect, or misappropriation of the resident's property. Such measures may include separating the resident from the person(s) who is/are suspected of abusing the resident or misappropriating the resident's property. If the facility receives an allegation or suspects that an employee may have committed an act of abuse, neglect, or misappropriation of resident property, the facility may suspend the employee while the investigation is in progress.

B. The facility recognizes the resident's right to make complaints against the facility, and the facility will not tolerate any retaliatory behavior against a resident who has reported an incident of abuse, neglect, or misappropriation of resident property. In addition, the facility will not tolerate the threatening of residents or their visitors in an attempt to discourage them from exercising their rights under this policy.

C. The facility's goal is to create an environment where residents and their visitors may report concerns regarding possible incidents of abuse, neglect, or misappropriation of resident property without fear of reprisal. To create this environment, the facility will:

    1. Encourage resident attendance at Resident Council meetings and

2. Inform room-bound residents of their right to make complaints and how they may do so.

VIII. INVESTIGATIONS AND FACILITY RESPONSE TO INCIDENTS AND ACCIDENTS

The facility will report all instances of alleged or suspected abuse, including verbal and mental abuse, exploitation, neglect, misappropriation of resident property, unusual occurrences, and injuries of unknown origin in the following manner:

A. **INVESTIGATION AND REPORTING STEPS**

1. Immediately notify the Administrator of any unusual situation in the facility, whether reportable or not.
2. Immediately consider and initiate interventions to protect the resident(s) involved and other facility residents.
3. The Administrator and/or the Director of Nursing will notify the resident's physician and sponsor if the event involves an allegation or possibility of abuse or neglect, or a suspicious injury of unknown origin.
4. The Administrator and/or the Director of Nursing is responsible for conducting a thorough investigation and obtaining witness statements if the event involves an allegation or possibility of abuse or neglect, or a suspicious injury of unknown origin.
5. A complete and thorough investigation must be conducted on all incidents, including injuries of unknown origin, whether reportable or not, within five (5) working days to determine the cause of the injury or incident. The outcome of the investigation must also determine whether or not the incident was abusive or neglectful in nature. All investigations must be documented in a written report and be made available upon request to ADPH.
6. The Administrator will report his or her findings from the investigation to the attending physician, the resident and/or resident sponsor on all reportable events.
7. If there is reasonable cause to believe or suspect that an injury has been neglectfully or abusively inflicted upon a resident, the facility is required to report it to ADPH. The Administrator will determine whether the incident is reportable to ADPH and law enforcement.
8. If reportable to ADPH, the facility will report the alleged event immediately not to exceed 2 hours 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. The final investigation report is due within 5 working days. The report will be in writing and will contain:
   a. Number and names of residents involved
   b. Date of the incident

c. Time of the incident
d. Name of witnesses
e. Date of examination by any facility representative of the resident involved.
f. Time of resident examination
g. The seriousness of the injury
h. How the injury occurred
i. What the facility did to immediately correct the problem
j. Actions taken by the facility following the investigation
k. Agency notification information – name of agency, date of notification, time of notification, method of notification, person notifying the agency, and the name of the facility representative responsible for directing the investigation
l. Whether the incident was reported to law enforcement
m. Any other details contained in the investigation file

9. Alleged violations that would constitute violations of criminal statutes, such as murders, rapes, and assaults, must also be reported to the appropriate local law enforcement agency.

B. DETERMINING WHETHER AN EVENT IS REPORTABLE TO ADPH AND LAW ENFORCEMENT

1. **RESIDENT-ON-RESIDENT ABUSE**
   If a resident is injured by another resident, the facility will report the incident to ADPH and to the Chief of Police or County Sheriff. **All alleged instances of sexual or mental abuse of a resident by another resident shall be reported, even if no physician intervention is required. For example, if at any time a resident touches another in a manner that could be construed as having sexual overtones; the touching must be reported unless the involved residents are known to be capable of consenting to the touching and to have actually consented to it.**

2. **VISITOR-ON-RESIDENT ABUSE**
   The facility will report alleged incidents of abuse by a facility visitor to ADPH and the Chief of Police or County Sheriff.

3. **EXPLOITATION OF A RESIDENT**
   The facility will report all alleged incidents that involve taking advantage of a resident for personal gain through intimidation, threats, manipulation or coercion to ADPH and local law enforcement if there is a reasonable suspicion that a crime has occurred.

4. **UNUSUAL OCCURENCES**
   Occurrences such as catastrophes and unusual occurrences that threaten the welfare, safety or health of residents, personnel, or visitors shall be documented

within twenty-four (24) hours of the incident or occurrence. This documentation shall be retained in the facility for at least two (2) years. All records retained by this subsection shall be, upon request, made immediately available to surveyors employed by the ADPH. Copies of such records shall be forwarded to ADPH promptly upon request.

5. **SUSPICIOUS INJURIES OF UNKNOWN SOURCE**
   A suspicious injury of unknown source is regarded in the same light as mistreatment, neglect, and abuse and must be reported to ADPH if there is any cause to believe or suspect that the injury has been abusively inflicted upon a resident or that the injury is the result of a failure to provide necessary goods and services by a Nurse Aide or another individual. Local law enforcement agencies will be notified of suspicious injuries of unknown source if there is a reasonable suspicion that a crime has occurred. Examples of suspicious injuries of unknown source include, but are not limited to, black eyes, extensive bruising around the neck and/or other body parts, bruising on or near male or female private body parts, and fractures that are unusual in nature (for example, bed-bound residents with fractures or dislocations). Suspicious injuries of unknown source must be reported to ADPH in accordance with the procedures set forth in this policy.

6. **NON-SUSPICIOUS INJURIES OF UNKNOWN SOURCE**
   Non-suspicious injuries of unknown source must be investigated within five (5) working days to determine the cause of the injury or incident. A non-suspicious injury of unknown source does not have to be reported to ADPH if there is no cause to believe or suspect that the injury has been abusively inflicted upon a resident or that the injury is the result of a failure to provide necessary goods and services by a Nurse Aide or by another individual. Although this type of injury does not have to be reported to ADPH, the facility must document its investigation in writing and make the document available upon request from ADPH.

7. **WHAT SHOULD NOT BE REPORTED TO ADPH**
   a. Witnessed injuries/accidents/incidents that do not involve abuse or neglect
   b. Unwitnessed injuries/accidents/incidents that do not involve abuse or neglect
   c. Injuries/accidents/incidents requiring medical intervention such as an x-ray when abuse or neglect is not suspected
   d. Injuries of unknown origin such as skin tears or bruises when abuse or neglect is not suspected
   e. Broken bones that are determined not to be a result of abuse or neglect
   f. Injuries that occur when the resident is out of the facility on pass that are not a result of abuse or neglect

8. **WHAT SHOULD BE REPORTED TO LOCAL LAW ENFORCEMENT**
   a. Any reasonable suspicion of a crime against a resident must be reported to ADPH and to one or more law enforcement entities for the political subdivision in which the facility is located such as but not limited to police, sheriffs, detectives, medical examiners, investigators and coroners. All reasonable suspicions of a crime against a resident that results in serious

bodily injury must be reported immediately but not later than 2 hours after forming the suspicion. All reasonable suspicions of a crime against a resident without involvement of a serious bodily injury must be reported no later than 24 hours after forming the suspicion.

C. RESPONSE TO INVESTIGATIONS

After reporting suspected abuse, neglect, or a suspicious injury of unknown source, the facility will prepare a Quality Assurance Process Improvement (QAPI) Report for its internal use. This report will be in writing and will contain the following:

1. Names of witnesses to the incident
2. Name of the facility representative receiving the report
3. Date of the incident
4. Time of the incident
5. Brief statement of the person witnessing the incident
6. Signature of the person witnessing the incident and a subscribing witness
7. Date reviewed by the QAPI Committee
8. Corrective actions recommended by the QAPI Committee
9. Signature of the QAPI Committee representative
10. Corrective actions implemented by the facility and
11. Signature of a facility representative and date

Note: Do NOT send copies of incident reports or other QAPI documents.

D. TRENDS

As part of its quality assurance process, the facility will analyze incidents and occurrences to identify trends. In doing so, the facility will determine whether its policies or procedures need to be changed to help prevent further occurrences. If so, the QAPI Committee will follow up to make certain that any needed changes are implemented in a timely and effective manner.

IX. HOW TO REPORT TO ADPH

The Alabama Department of Public Health (ADPH) has developed an online incident reporting system which allows facilities to electronically transmit the initial report and upload the final report of abuse, exploitation, and neglect allegations, misappropriation of resident property, suspicious injuries of unknown origin and fires.

To access this system, visit the following website: https://ph.state.al.us/IncidentReporting or by going to the ADPH website, www.adph.org.

On the ADPH home page go to the Contents A-Z and select the Health Care Facilities link. On the Health Care Facilities page, click on Reporting Forms. On the Reporting Forms page, the facility can access the online incident reporting system by clicking on the link Nursing Home On-Line Reporting. The facility will need their Facility ID and PIN# provided by ADPH to log in to the system.

ADDENDUM A:

SUGGESTIONS FOR CONDUCTING A COMPELETE AND THOROUGH FIVE-DAY INVESTIGATION OF ABUSE INCIDENTS

This section was created by the Alabama Department of Public Health, Division of Health Care Facilities, Bureau of Health Provider Standards

This is not an exhaustive list. Each situation presents unique circumstances. This is intended to be an aid to facilities in developing investigative plans. A facility that conducts a thorough investigation into an incident and sends the Department strong documentation of its investigation greatly reduces the chance that the incident will result in an on-site survey. In addition, if a facility finds that an employee abused a resident and terminates the employee, a thorough, well-documented investigative file will increase the chances that the abusive employee will be added to the abuse registry.

Each series of questions covers an aspect of the investigation that should be considered by the facility. A thorough investigative file will document for each series of question, that either the suggested intervention was accomplished, or that the intervention was considered but not undertaken, and the reason the intervention was not undertaken will be documented.

1. Don't Overlook the Victim

Was the victim resident interviewed? Failure to do so is a very common problem with facility investigations. A facility should not assume that a resident who has a diagnosis of dementia is non-interviewable, or that his or her statements are inherently unreliable. If the resident can understand questions and can speak or otherwise answer questions, his or her perceptions about the incident may be a valuable source of information. Does the resident believe himself or herself to have been physically injured? Is the resident experiencing any physical pain? Is the resident distressed by the incident? If the resident is non-interviewable, the specific reason should be documented, for example, the resident has died, the resident has expressive aphasia, and is non-responsive to questions, or the resident has been moved from the facility. Any observed changes or lack of observed changes in the resident's mood or behaviors since the incident should be documented. The investigative file should contain the resident's most recent assessment, CAAS, care plan and any documentation related to the incident, including nurses' notes, social services notes, incident logs, ADL sheets and for physical or sexual abuse, documents such as body audits or assessments and bath sheets. Don't overlook physical evidence such as soiled or torn clothing, bed sheets, or bodily fluids. If the incident is an allegation by the resident of otherwise unwitnessed abuse, has the resident made any other allegations of abuse in the past? If so, what were these allegations, were they substantiated and how did the facility determine whether or not abuse occurred?

2. Law Enforcement Involvement

(For physical or sexual abuse or misappropriation of property) Was the incident reported to the police? If so, obtain a copy of the police report and include it in the submission of your investigative file. If the police were notified, please make sure to include in your file the name of law enforcement agency that was contacted, the case number assigned to the incident by the law enforcement agency and the name of the investigator or responding officer.

3. Medical Intervention

(For physical or sexual abuse) Was the victim resident sent to the local emergency department for an evaluation? For sexual abuse, if penetration was witnessed, alleged, or suspected, was a rape kit ordered? Was the victim resident given any kind of evaluation or examination at the facility by a physician or by anyone else? The results of all examinations should be documented in the investigative file. This should include a description of any injuries or apparent injuries, however minor.

4. Other Residents

Any resident who was a witness, or who was or may have been in a position to observe the incident should be interviewed. Likewise, any resident who may have had contact with the alleged perpetrator should be interviewed. Have any of these residents been the subject of abusive behavior by the alleged perpetrator in the past? Have any of them witnessed abusive behavior in the past by the alleged perpetrator or anyone else?

5. Family Members

Of course, the victim resident's sponsor should be notified of any know, suspected, or alleged abuse. Family members should be asked if the resident reported anything to them, if they themselves witnessed anything, and whether they have noticed a change in the resident's physical condition, behaviors, or mood.

6. Facility Staff Members

Anyone who witnessed the incident or who was in a position to witness the incident should be interviewed, especially those staff members assigned to the wing or hall where the incident occurred or was alleged to have occurred during the shift in question. Co-workers of the alleged perpetrator should be asked whether they have ever witnessed the accused individual do anything abusive to the resident, or ever behave in an unprofessional manner.

7. Visitors or Anyone Else Who May Have Knowledge of the Incident

Facilities should attempt to find out if any visitors to the facility or outside workers such as maintenance and repair workers were witnesses to the incident. Such disinterested individuals can be important and very credible witnesses.

8. The Alleged Perpetrator

Always give the alleged perpetrator the opportunity to tell his or her side of the story and carefully document this account. The perpetrator should be interviewed near the end of the investigative process. Alternatively, depending on the circumstances, it may be preferable to interview the perpetrator soon after the incident is reported and again after all other witnesses have been interviewed. In either case, the perpetrator should be confronted with any discrepancies between the perpetrator's account and the accounts of other witnesses and asked to explain those discrepancies.

9. Conducting and Documenting Interviews

When interviewing staff members, it is helpful, if possible for the individual conducting the interview to be someone the staff member recognizes as having supervisory or management authority within the facility. Generally, those conducting interviews should avoid questions using legally conclusive terms such as, "abuse", in other words, try not to ask, "Have you ever seen CNA Jones abuse anyone?" It would be preferable to phrase the question, "Have you every seen CNA Jones do anything that made you think she should not have done", or to phrase the question in some other way that will allow the witness to characterize the nature of what happened rather than adopt your characterization. If the witness denies having seen the perpetrator engage in misconduct after having been asked a generally worded statement it would be appropriate to follow up with more specific questions. Ask the witness if he or she saw what was alleged to have occurred. Establish where the witness was at the time of the alleged incident and what he or she was doing when the incident occurred, would the witness have been in a position to see the incident? In all cases, allow the witness to the tell the story of what happened in his or her own words. Ask follow-up questions as necessary to fill in any gaps. Write down the questions asked and the answers given by the witness. At the end of the interview, the individual conducting the interview should review the questions asked and the answers given with the witness.

The witness should be asked to verify that the questions and answers are accurately recorded. If the witness is a staff member, the staff member may be asked to sign the interview document. For any interview not signed, whether it is an interview or a staff member or someone else, the individual conducting the interview should document that he or she reviewed the questions and answers with the witness and that the witnessed agreed that the written documentation of the interview is accurate. Always include in the investigative file contact information for each witness interviewed, including the alleged perpetrator. This includes witness names, addresses, telephone numbers (home and cell) and for the alleged perpetrator, a social security number and date of birth.

10. Concluding the Investigation

It is the facility's responsibility to reach a conclusion about whether abuse occurred. The investigative file submitted to ADPH should document the conclusion reached, describe the reason the conclusion was reached, and describe and document any corrective action taken to

reduce future risk of abuse. A facility seeking additional guidance in conducting its five day investigation may contact ADPH during normal business hours at (334) 206-5163.

ADDENDUM B:

GUIDELINES FOR INVESTIGATING POSSIBLE ABUSE, NEGLECT, EXPLOITATION, MISAPPROPRIATION OF RESIDENT PROPERTY, AND UNUSAUAL OCCURRENCES

A. First Things First

1. **Respond to and assess the resident**
   a. Provide protection if warranted
   b. Provide medical treatment or nursing interventions as needed.

2. **Protect the resident(s) involved in the incident.**
   a. It does not matter whether or not an allegation seems credible; make sure the resident is protected.
   b. If something about the situation does not seem right, protect the resident .
   c. If something tells you that something is not right, protect the resident.

3. **All suspicions and allegations must be investigated. Review the circumstances around the incident.**
   a. Interview the resident if possible
   b. Interview any direct care staff or other witnesses to the incident as soon as possible, so that they do not forget details of the incident.
   c. Interview all individuals who may have knowledge about what happened.
   d. Monitor the residents condition.

4. **Investigate until the entire story of what happened is known.**
   a. The evidence should lead to a conclusion. *Go where the evidence leads, not what is thought to have happened.* Focus on what else can be learned.
   b. Do not speculate; get the facts.
   c. If there is evidence about the event that has not been examined, the investigation is not complete.
   d. Investigate until what happened is known or until there is no more information that can be obtained.

5. **The Administrator will determine whether the event is reportable to the ADPH.**
   a. If the Administrator is unsure, he/she will engage additional help to make the determination.
   b. Regardless of whether the event is reportable, investigate it.

B. Gathering Information

1. **Assess the resident(s)**
   a. If the event involves potential injuries, immediately assess the resident.

b. The assessment protects the resident(s) and preserves the evidence of the event.

2. **Conduct interviews**

a. Start by interviewing all eye witnesses (staff, other residents, sponsors, visitors, anyone present or in close proximity) to the event. Ask them the following key questions:
   1) What did you see?
   2) What did you hear?
   3) What did you do?
   4) Who else was there?
   5) Who else do you think might know something about the event?
   6) Have you told me everything you know about the event?

b. Then interview everyone who came to the scene immediately after the event and ask the same questions above.

c. Then interview everyone who has been named as possibly knowing something about the event. Ask the same questions.

d. Listen carefully to the witness's answers, and ask follow-up questions.

e. Watch for clues that a witness may know something that merits a follow-up question. For example:
   1) Voice inflection—"Well, *she* didn't do that"
   2) Body language, such as:
      i. Looking away during an answer
      ii. Rolling eyes
      iii. Crossing arms
      iv. Fidgeting
   3) Limited answers- "That's all I saw *that* day"

f. Get all the facts prior to writing the written statement. This will help to obtain a focused and relevant written statement.

3. **Obtain the written statements:**

a. Written statements should obtain facts, not speculation
b. Written statements should be documented by the interviewer
c. The interviewer should review the written statement with the interviewee to determine if the facts are accurately documented. Ask the interviewee to sign as acknowledgement they have reviewed the statement and it is accurate. If the interviewee refuses to sign the statement, the interviewer should document if the statement was reviewed with the interviewee and the interviewee's response.

4. If a resident who was present during an incident is not capable of giving an interview, make a record that an attempt was made to interview the resident.

5. **Review documents.** Consider reviewing documents, including, but not limited to, the following, when relevant:
   a. Medical Records
   b. Pharmacy Records
   c. Prior Incident Records
   d. Grievance Logs
   e. Personnel Records
   f. Equipment Maintenance Records
   g. Any other records relevant to the investigation.

C. Compile the Investigation

The investigation should contain the investigation report, witness statements, other supporting documents, and the conclusion. If the incident was reportable, the file should contain the initial report and investigation's conclusion.

ADDENDUM C

On October 4, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final rules regarding the requirements of participation for skilled nursing facilities. One of the most significant changes to the regulations, is the new abuse reporting requirements. Pursuant to 42 CFR 483.12, skilled nursing facilities must report any allegation of abuse within two hours of the allegation. Additionally, any neglect, mistreatment, exploitation or injuries of unknown source that results in serious bodily injury must also be reported within two hours to ADPH. Although serious bodily injury is not defined by the new rules, this term was used in the Elder Justice Act and was defined as "an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation." All other allegations of neglect, mistreatment, exploitation or misappropriation of resident property must be reported within 24 hours. There was no change to the submission of the results of the investigation within five working days.

Type of Allegation	**2 Hour Reporting**	**24 Hour Reporting**
Abuse without serious bodily injury	X	
Abuse with serious bodily injury	X	
Neglect without serious bodily injury		X
Neglect with serious bodily injury	X	
Mistreatment without serious bodily injury		X
Mistreatment with serious bodily injury	X	
Exploitation without serious bodily injury		X
Exploitation with serious bodily injury	X	
Injuries of unknown source without serious bodily injury		X
Injuries of unknown source with serious bodily injury	X	
Misaproppriation of resident property		X