Assisted Living Facility Guidebook

Partners in Protection

Prevention and Protection • Incident Identification • Investigation • Reporting

February 2018

Washington State
Department of Social
& Health Services
Transforming lives

Note

This document provides guidance, but it is not law. State law regarding reporting and investigating vulnerable adult abuse and neglect has precedence over this document's text and guidelines. Federal requirements that are a necessary condition to receipt of federal funds by Washington State also have precedence over any unintended conflict in this document's text and guidelines.

This document is not big enough to include everything. Because of this, you must consider other possible examples, questions, and triggers. The assisted living facility is responsible for the identification, protection, investigation, reporting, and prevention of abuse/neglect.

Selected Resources

For access to your city, county police, sheriff or other law enforcement agencies, use your local phone directory or visit:

http://www.the911site.com/911pd/washington.shtml

Emergency situations – DIAL 9-1-1 or your county's emergency services number
Non-emergency situations – use local numbers for Police/Sheriff/State Patrol

For access to contact information and the phone number of your county's Coroner or Medical Examiner, visit:

http://www.dahp.wa.gov/sites/default/files/WA%20State%20Medical%20Examiners-Coroners.pdf

For access to the Department's letters and other basic information and links to other resources for Assisted Living Facility (ALF) professionals, residents and families, advocates, interested parties, and the general public, visit:

https://www.dshs.wa.gov/altsa/residential-care-services/information-assisted-living-facility-professionals

For access to the Department of Social and Health Services Disqualifying List of Crimes and Negative Actions that may be amended or updated at any time, visit:

http://app.leg.wa.gov/wac/default.aspx?cite=388-113

For access to the Department's brochure, Partners in Protection: A Guide for Reporting Vulnerable Adult Abuse (DSHS 22-810X), written and available in English and seven other languages to help protect residents from abandonment, abuse, neglect and personal and/or financial exploitation, visit:

https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/22-810.pdf

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Introduction

This document contains guidelines for the protection of assisted living facilities residents along with guidelines for preventing, investigating, determining, and reporting incidents of resident abuse, neglect, abandonment, injuries of unknown source, or personal and/or financial exploitation, in assisted living facilities, including reporting reasonable suspicion of a crime in a Long-Term Care (LTC) facility.

The word "resident" or "client" as used throughout is equivalent to the term "vulnerable adult" as defined in state law.

These guidelines also contain portions of and references to:

- Chapter 74.34 Revised Code of Washington (RCW), Abuse of Vulnerable Adults;
- Chapter 388-78A WAC: ASSISTED LIVING FACILITY LICENSING RULES; and
- The Elder Justice Act of 2009, Section 1150B of the Social Security Act – Reporting possible crimes to law enforcement.

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 policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. The policies 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, abandonment, or personal and/or financial exploitation is likely to have occurred. They also contain information about reporting requirements that apply to facilities and reporting requirements that apply to individuals, including facility owners, operators and employees.

Effective March 23, 2011, there are federal requirements that require certain individuals in federally funded long-term care facilities to report any reasonable suspicion of a crime committed against a resident of that facility. There are specific facility-related responsibilities under Section 1150B of the Social Security Act including the following:

A Medicare or Medicaid-participating LTC facility must:

- Notify covered individuals annually of their reporting requirements;
- Prevent retaliation if an employee makes a report;
- Post information about employee rights, including the right to file a complaint if a long term care facility retaliates against anyone who files a report.

Introduction (continued)

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

- Conduct criminal history background checks on all staff, volunteers, and students who have unsupervised access to vulnerable adults, within one business day of starting work;
- Ensure all staff, including agency-contracted personnel, are free of any disqualifying criminal history, per regulation Chapter 388-113 Disqualifying Crimes and Negative Actions

Contact your local Residential Care Services (RCS) Regional Administrator or RCS Field Manager if you have questions about this document or its guidelines.

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

Purpose

The incident identification, investigation and reporting guidelines in this document are designed to assist assisted living facilities in complying with the requirements of the state Vulnerable Adult Act, Chapter 74.34 RCW, and the Elder Justice Act of 2009, Section 1150B of the Social Security Act – Reporting possible crimes to law enforcement.

Some of the federal requirements became effective in 2011 and other requirements already existed under Washington state law. NOTE: If there is a difference between federal and state reporting requirements, you must follow whichever law is the most stringent.

These guidelines are intended for use primarily by:

- Assisted living facilities and assisted living facility 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 Ombuds staff and volunteers.

The guidelines provide:

- General information to be applied in determining whether abuse, neglect, injuries of unknown source, or personal and/or financial exploitation has occurred;
- General information to be applied in determining what and when to report any reasonable suspicion of a crime against a resident in a long term care facility, including assisted living facilities;
- The assisted living facility'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.

Chapter 1

Facility Reporting Requirements

Residential Care Service (RCS) 24 hour Hotline: 1-800-562-6078

Effective March 23, 2011, the federal Elder Justice Act of 2009 requires that a participating Long-Term Care (LTC) facility (Facility), including assisted living facilities that participate in the Medicare or Medicaid programs, **must**:

- **Notify Covered Individuals:** The Facility must notify covered individuals annually of their duty to report suspected crimes, as required in Section 1150(b) of the Social Security Act;
- **Post Conspicuous Notice:** The Facility must post a conspicuous sign in an appropriate location notifying covered individuals of their rights under this law. This sign must include a statement than an employee may file a complaint against a Facility that retaliates against an employee who complies with this law and must also provide information about the way to file a complaint; and
- **Refrain from Retaliation:** The Facility is prohibited from retaliating against anyone who files a complaint under this law. Retaliation includes discharge, demotion, suspension, harassment, denial of promotion, or the filing of a professional licensing complaint. Penalties could include a civil penalty of up to $200,000 and exclusion from federal contraction.

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.**

1ST PRIORITY: Protect the victim(s)/resident(s) from further harm.

2ND PRIORITY: Perform a thorough investigation, and report to the Department and law enforcement as required.

Facilities are required to report to:

1. The Department's 24 hour Hotline:
   - 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.
   - Online reporting is also an option for facilities through this link: https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services-online-incident-reporting.
   - If the information the facility provided to the Complaint Resolution Unit (CRU) in its initial report is substantially the same as the information the facility learned during its investigation, then the investigation results should be documented and placed in a facility file that will be available to licensors or complaint investigators when requested.
   - If, during its investigation, the facility learns additional information that is pertinent to the incident or that substantially changes the information contained in the initial CRU report, the facility must provide the results of the investigation (or the status of an ongoing investigation) to the CRU hotline (1-800-562-6078).

2. Law Enforcement:
   - In an **emergency**, call **9-1-1** or the emergency services number.
   - For **non-emergency** situations, use the local number specified by your local law enforcement authorities.
   - You can locate police, sheriff and other law enforcement agencies for the state, cities and counties in Washington at: www.the911site.com/911pd/washington.shtml or use your local phone directory.
3. Coroner/Medical Examiner:
   - The facility is required to call the county's Coroner or Medical Examiner to report any resident death in which there is reason to suspect the death of the vulnerable adult was caused by abuse, neglect, or abandonment by another person; as required in RCW 74.34.035 and RCW 68.50.010
   - Refer to WAC 388-78A-2630, Prevention of Abuse, for rules related to reporting requirements.
   - You can locate your county's Coroner or Medical Examiner contact information at: www.dahp.wa.gov/sites/default/files/WA%20State%20Medical%20Examiners-Coroners.pdf
4. State Department of Health:
   - In certain circumstances, the assisted living facility is required to report an employee who is a credentialed health care provider, usually a nurse or a certified or registered nursing assistant, to the appropriate disciplining authority at the State Department of Health (DOH), Health Professions Quality Assurance Division.
   - These reports must be submitted to the disciplining authority as soon as possible. Contact DOH Customer Service at 360-236-4700 or on the internet at hsqa.csc@doh.wa.gov.

Methods of Reporting:

- By telephone; or
- By fax; or
- Online

When to Report:

- **Immediate** telephone or online reporting is required.

Where to Report:

By Telephone or Online:

- Call the Department's hotline number 1-800-562-6078 or report online at https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services-online-incident-reporting. The number and online access are available 24 hours a day, seven days a week, and the time and date of the messages are recorded.
- Call local law enforcement or **9-1-1** in an emergency.

By Fax:

- If you prefer to fax your report, you can send all pertinent information to **360-725-2644**

What to Report:

To the Department:

- When there is reasonable cause to believe violations have occurred involving abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation;
- Any reasonable suspicion of a crime, including physical or sexual assault, has been committed against a resident;
- Any act, when there is reasonable cause to believe the act caused a fear of imminent harm;
- Substantial injuries of unknown source not related to suspected abuse or neglect (because under some circumstances the failure to take preventive measures may constitute abuse or neglect).

To Law Enforcement:

- When there is a reason to suspect that sexual assault or physical assault against a resident has occurred (***except*** under circumstances described below), or:
- When there is reasonable cause to believe that an act has caused fear of imminent harm.
- Limited Exception: An incident of physical assault between residents always has to be reported to the Department, but does not have to be reported to Law Enforcement, ***unless***

  (a) it caused more than minor bodily injury ***and***
    - required more than basic first aid, ***or***
    - if 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 residents or involving the same residents; or there is an attempt to choke a resident, ***or***

  (b) the injured resident or his or her legal representative or family member asks that a report be made.

What to Report to County Coroner or Medical Examiner:

- A facility must report the death of a resident living in an assisted living facility in which there may have been abuse or neglect (criminal mistreatment), or other reportable circumstances, even if the death otherwise appears to be due to natural causes. Once reported, and if jurisdiction is taken, your county's Coroner or Medical Examiner is responsible for investigating the cause and manner of death to decide the most appropriate death certification for that resident.

What to Report to the State Department of Health's Disciplining Authority for Credentialed Staff:

- The assisted living facility must report to the Department of Health, any employee/staff person who is a health care professional, including a licensed nurse, a registered or certified nursing assistant, or a certified home care aide, in certain circumstances where findings are made involving abuse, neglect, or personal and/or financial exploitation.
- The assisted living facility must report any information it has about an action taken by a court of law against an employee to the Department's hotline and to the appropriate Department of Health licensing authority, if that action would disqualify the individual from employment as described in RCW 43.43.842.

Chapter 2

The Investigation Process

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

All alleged incidents of abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation must be thoroughly investigated. The investigation is done to determine:

- 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 policies and procedures to help organize the investigative process so that it can start as soon as possible and continues in an organized manner. The policies 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 policies 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 assisted living facility and their staff must also *immediately*:

- Protect resident(s) from possible reoccurrence; and
- Take any action necessary to address potential negative 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 abuse, neglect, abandonment or personal and/or financial exploitation 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 as soon as possible after protecting the resident(s) 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

State law requires the assisted living facility 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 documented.

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 or ruling out potential abuse, neglect, or personal and/or financial exploitation, 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 assisted living facility to determine if the allegations were true or not true. 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 (Within the first 24 hours)

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 further investigation.

If during any phase of the investigation the facility 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 labs, 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 negotiated service agreements;
  - Physician orders;
  - Laboratory results;
  - 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".

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."

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 documented as unknown.

CORRECTIVE ACTION REQUIRED FOLLOWING THE INVESTIGATION

After the investigative phase(s) is completed, the assisted living facility is required to take any necessary action based upon the findings in order 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 assisted living facility for the entirety of the resident's stay and five years after the resident moves out. For a more detailed description of a facility's obligations to maintain resident records, refer to WAC 388-78A-2420.

Preservation of Evidence

The first step of proper evidence preservation is thorough documentation recorded as soon as possible. Identification, protection, preservation and security of relevant evidence identified during the course of the assisted living facility's investigation is essential and especially important when dealing with serious events or potential criminal incidents.

Documentation of the date and time of collection must be included for all evidence gathered. If possible, write the date, time and name of staff person collecting the evidence, such as on the back of a picture.

Evidence Collected During the Facility's Investigative Activities May Include the Following:

1. Witness statements: 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/event, in order to avoid the witness becoming confused by hearing other accounts of what occurred. These statements should describe in as much detail as possible what the witness observed. The facility staff person receiving such statements should also sign and date the document. Blank areas on the paper of such statements should be crossed out and initialed.
2. Other document evidence: Attached to the facility's investigative report. Examples of document evidence include but are not limited to: copies of laboratory test results, monitoring notes, comprehensive care plans, staff attendance records, names of emergency services responders to the scene and other such written evidence.
3. Physical evidence: Law enforcement should collect all physical evidence. Physical evidence should be left in place and the scene secured until law enforcement arrives and can process it. If law enforcement will not be arriving quickly or the scene cannot be preserved, ask the law enforcement agency how to best handle the scene and the physical evidence.

4. **Demonstrative evidence:** Photos of bruising, drawn diagrams of the location or room of the incident/event, audio or video tapes should also be attached to or kept with the facility's documentation of its investigative actions, findings, along with appropriate measures taken to prevent similar future situations if the alleged or suspected incident is substantiated.

Each assisted living facility must establish their own internal policies and procedures to guide their staff in how to do proper evidence collection, documentation and preservation. For example, a facility's investigation guidance could include, but would not need to be limited to:

- How to systematically identify possible sources of evidence to collect for the investigation of allegations/events of suspected incidents of abuse, personal exploitation, financial exploitation, neglect, or injuries of unknown source;
- How to secure the scene of a resident's location of serious injury or death for the arrival of law enforcement;
- How to keep an accurate inventory of an investigation's types of collected evidence;
- How to obtain consent from a resident or resident representative to allow for collection of photographic evidence;
- How to protect the integrity of physical evidence

Chapter 3

Individual Mandated Reporting Requirements

24 hour hotline: 1-800-562-6078

Under state law, the individual mandated reporter requirements are described in RCW 74.34.035-053. A mandated reporter includes but is not limited to an employee of the Department; a law enforcement officer, an employee of a facility; a social worker or health care provider and an operator of a facility.

For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, an assisted living employee (or other mandated reporter) is required to make a report if he or she has reasonable cause to believe the incident occurred. Examples of reasonable cause may include:

- The individual observes the incident or hears the victim state it happened; or
- The individual hears about an incident from a permissive reporter who has direct knowledge of the incident.

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

This individual mandated reporting does ***not*** take the place of the facility reporting outlined in Chapter I.

WHERE TO REPORT:

The Department:

- The Department's hotline number at **1-800-562-6078** or online at https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services-online-incident-reporting. The number and secure website are available 24 hours a day, seven days a week, and the time and date of messages are recorded.

Law Enforcement:

- In an emergency, call **9-1-1** or the emergency services number.
- For non-emergency 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 hotline:

- When there is a *reasonable cause to believe* an incident is abuse, neglect, substantial injuries of unknown source, or personal and/or financial exploitation.
  - ***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 Appendix J, Definitions.).

- When there is a *reason to suspect* that any crime, including sexual or physical assault, has been committed against a resident of the facility.
  - ***Reason to suspect*** has been defined as "a belief that the incident could ***possibly*** have happened" based upon observations and other sources of information. (See the definition of "reason to suspect" or "reasonable suspicion" in Appendix J, Definitions.)
  - Sexual assault includes but is not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, and sexual relations between a resident and a staff member.
  - 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 assault unless the person intended to do harm or create fear.)

To Law Enforcement:

Individual mandated reporters and covered individuals must report to law enforcement:

- When there is a reason to suspect that any crime, including sexual assault or physical assault, has been committed against a resident; or
- When there is reasonable cause to believe that an act has caused fear of imminent harm.
- Limited Exception: An incident of physical assault between residents always has to be reported to the Department, but does not have to be reported to law enforcement, ***unless***
  (a) it caused more than minor bodily injury ***and*** required more than basic first aid, ***or***
  (b) 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 residents or involving the same residents; ***or***
  (c) there is an attempt to choke a resident, ***or***
  (d) the injured resident or his or her legal representative or family member asks that a report be made.

WHEN TO MAKE A REPORT:

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

WHAT SHOULD BE REPORTED FOR INCIDENTS INVOLVING RESIDENT TO RESIDENT ALTERCATIONS?

To the Department:

- Requirements for reporting resident to resident assaults to the Department are the same as the reporting requirements for any incident of physical assault against a resident. See the reporting requirements under "*What to Report to the Department*".

To Law Enforcement:

- Sexual assault;
- An incident of physical assault between residents must be reported to law enforcement if it causes more than minor bodily injury and requires more than basic first aid; ***or if***
  - 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 residents or involving the same residents; ***or***
  - there is an attempt to choke a resident; ***or***
- *Any* incident of sexual or physical assault between residents must be reported if the injured resident or his or her legal representative or family member asks that a report be made.

Information to be Included in a Mandated Reporter's Report to Law Enforcement and the Department:

State law identifies 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, personal and/or financial exploitation, neglect or self-neglect;
- Any history of previous abandonment, abuse, personal and/or 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(8)(a)-(g)]

Mandated Reporter Identity Confidentiality:

- The identity of the person is kept confidential unless that person consents or there is a mandate by a court of law. [RCW 74.34.095]

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]

Non-Reporting:

- A person who is required to make a report under this chapter and who knowingly fails to make the report may be found guilty of a gross misdemeanor. [RCW 74.34.053(1)]
- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- 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.

- Under federal law, a covered individual who fails to report a reasonable suspicion of a crime will be subject to a civil money penalty. The individual could also be excluded from participating in any federally funded health care program, including a Medicare or Medicaid-funded program.

False Reporting:

- A person who intentionally makes a false report may be found guilty of a misdemeanor. [RCW 74.34.053(2)]

Reporting the Incident to the Supervisor:

- Remember that for the purposes of reporting abuse, abandonment, neglect, personal and/or financial exploitation, sexual abuse/assault and physical abuse/assault, the person mandated to report to the Department is any assisted living employee or other mandated reporter:
  - Who observes the incident or hears the victim state it happened.
  - Hears about an incident from a permissive reporter who has direct knowledge of the incident.
- A mandated reporter's obligation under the law is not met if he/she only reports to a supervisor. The law states that each employee is a mandated reporter; therefore, he/she must make the reporting call when they have reasonable cause to believe or reason to suspect the incident is reportable. To protect the victim from further harm, a facility should have policies and procedures in place that direct staff to notify the responsible person in the facility. Procedures should instruct a mandated reporter what 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 or policy that interferes with mandated reporting; therefore a mandated reporter must be allowed to report as required. The individual may choose 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]

Protecting the Resident(s) from Further Harm:

- Preventing the resident(s) from further harm means keeping the resident(s) 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(s);
  - Allowing the resident(s) to stay in an area they feel is safe (wellness center, nurses station); or
  - Safeguarding the resident's property.

Appendix A

Definition Diagram – Abuse

Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult.

Sexual abuse means any form of nonconsensual sexual conduct. Sexual abuse also includes any sexual conduct between a staff person of a facility and a vulnerable adult living in that facility whether or not it is consensual.

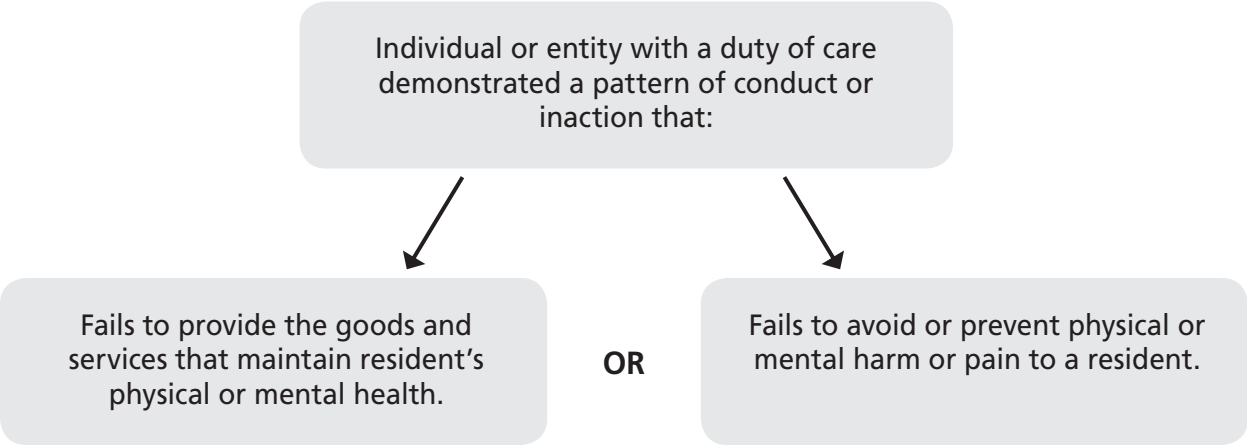
Physical abuse means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.

Appendix B

Definition Diagram – Neglect

Per state rules applicable to assisted living facilities, neglect has occurred if a or b below are present.

a. Neglect may result from a pattern of conduct or inaction by an individual or entity with a duty of care for assisted living facility residents. (*Pattern means more than one occurrence*) RCW 74.34.020



OR

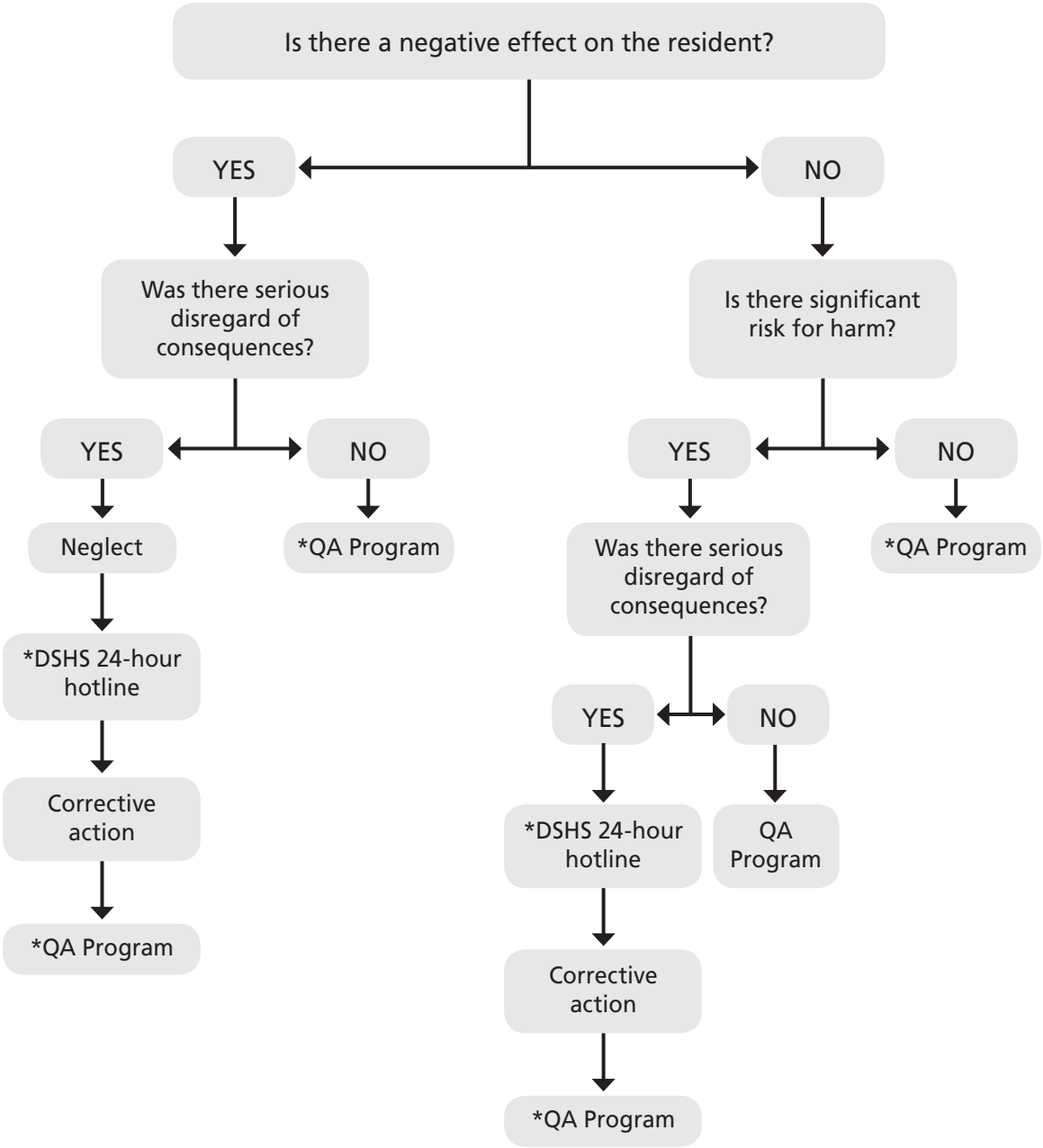
b. Neglect may result from a one-time act or omission by an individual or entity with a duty of care for assisted living facility residents. RCW 74.34.020

Individual or entity with a duty of care by an action or failure to act demonstrated a serious disregard of the consequences of such magnitude that:

There was a clear and present danger to the resident's health, welfare or safety.

Appendix C

Medication Error Decision Tree



QA = Quality Assurance

*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 program, including a QA program if the facility has one. However, medication errors that may be abuse or neglect must be reported to the Department.

Appendix D

Reporting Guidelines for Assisted Living Facilities

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	Police or 9-1-1	Coroner or Medical Examiner	Local Health Dept.	State DOH	State Fire Marshal
STAFF TO RESIDENT					X (a)	
Abuse, neglect, mistreatment, or negligent treatment (except for medication errors – see decision tree – Appendix C)	X	X			X (a)	
Sexual or physical abuse / assault with bodily harm	X	X			X (a)	
EXPLOITATION (Including financial exploitation)	X	X			X (a)	
ABANDONMENT	X	X				
INJURIES OF UNKNOWN SOURCE* (***Not*** incidents of abuse or neglect)						
• Substantial	X					
• Substantial reasonably related						
• Superficial, Unknown						
NON-STAFF TO RESIDENT						
• Abuse / Assault, Neglect	X (b)	X				
• Misappropriation / Exploitation	X (b)	X				
RESIDENT TO RESIDENT						
• Mental abuse with psychological harm	X					
• Mental abuse without psychological harm**						
• Physical abuse / assault with bodily harm	X	X				
• Physical abuse with psychological harm	X					
• Physical abuse without bodily or psychological harm**						
• Sexual abuse / assault	X	X				
• Exploitation	X	***				
UNEXPECTED DEATH						
• Possible R/T abuse or neglect	X	X	X			
• Suicide	X	X	X			
• Not realted to abuse / neglect but suspicious****	X	****	****			

a = Report to the DOH when there are allegations about licensed, certified, or registered health care worker(s).

b = 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.

* = Repeated injuries, even when determined by a process of evaluation/assessment to be reasonably related to the resident's condition, diagnoses, known environmental interactions or known sequence of prior events, may become abuse or neglect if preventative measures are not taken.

** = 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.

*** = May need to be reported to police.

**** = Certain suspicious circumstances (RCW 68.50.010) that require reporting to the coroner may also need to be reported to the police.

Appendix D (continued)

Other Reporting Requirements for Assisted Living Facilities

TYPE OF INCIDENT	DSHS Hotline 1-800-562-6078	Police or 9-1-1	Coroner or Medical Examiner	Local Health Dept.	State DOH	State Fire Marshal
EVACUATION	X					X
RISK OF DISCONTINUANCE OF SERVICES (such as no food, water, or care supplies)	X					
TRANSFER / DISCHARGE NOTICE	OTHER*					
COMMUNICABLE DISEASE OUTBREAK	X (c)			X		
FIRE	X					X (d)
EXPLOSION	X					X (d)
MISSING RESIDENT	X (e)	X				

c. Depending on the specific nature of a communicable disease outbreak, the ALF would be required to report per WAC 388-78A-2650(2)(3), if/as applicable.

d. If there is a need to do fire reporting per WAC 212-12-025, facility staff persons shall report such fire incidents within 24 hours to the DSHS hotline.

e. Depending on the circumstances of each individual event/incident, the ALF may be required to report any alleged, suspected or actual neglect of a resident.

* In order to reduce overpayments, the ALF must notify any agency responsible for paying for the resident's care and services as soon as possible whenever the resident is relocated to a hospital or other health care facility, or the resident dies. [WAC 388-78A-2640(2)] The ALF may report client readmissions to the Case Manager/Social Worker or by using the bed hold toll free number, 1-866-257-5066 (if the readmission occurs during the bed hold period).

Appendix E

Responsibility Table

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

	ASSISTED LIVING FACILITY RESPONSIBILTIES	STATUTORY REQUIREMENTS*
PROTECTION	• Safeguard residents from further incident/event occurrence • Treat all consequent ill effects experienced by residents • Provide first aid or emergency medical attention to address any sustained injuries and/or medical/mental problems • Implement facility policies and procedures to ensure that the suspected or accused staff person does not have unsupervised access to any resident • Take preventive actions per regulations	• Chapter 74.34 RCW Vulnerable Adult Act, • WAC 388-78A-2120 • WAC 388-78A-2450(1) • WAC 388-78A-2470 • WAC 388-78A-2600(2) • WAC 388-78A-2732
INVESTIGATION	• Protect the resident and other residents during the course of the investigation • Conduct Phase I investigation within 24 hours • Follow up with Phase II investigation if cause and/or reasonable cause undetermined • Document facts on event, incident or loss to resident, responsive steps taken by facility, and resident outcomes	• Chapter 74.34 RCW Vulnerable Adult Act, • WAC 388-78A-2450(2)(h)(iv) • WAC 388-78A-2450(3)(a)(b) • WAC388-78A-2460(7) • WAC 388-78A-2700(1) and (2)(c)
REPORTING	• Notify state Hotline of allegations immediately or as soon as the resident(s) is protected • Notify Administrator immediately of allegations • Notify police immediately of suspect criminal activity, i.e. deaths of indeterminate cause with suspected abuse, neglect or negligence. • Notify Coroner/Medical Examiner timely and accurately of resident death in certain circumstances • Notify state Department of Health's disciplining authority timely about employed licensed, certified, or registered staff persons in certain circumstances	• Chapter 74.34 RCW Vulnerable Adult Act, • Chapter 68.50 RCW – Human Remains • WAC 388-78A-2630 • WAC 388-78A-2640 • WAC 388-78A-2650
PREVENTION AND CORRECTIVE ACTION	• Resolve cause of event/incident, injury or loss • Prevent re-occurrence of substantiated event (e.g., revise negotiated service agreement, staff disciplinary action, education, training, revision of policy/procedure) • Achieve compliance with regulations relative to any other failed facility practices identified • Incorporate concepts learned into facility administrative decisions • Report all suspect incidents of abuse, neglect, or financial exploitation	• Chapter 74.34 RCW Vulnerable Adult Act, • WAC 388-78A-2450(2)(h) • WAC 388-78A-2470 • WAC 388-78A-2600(1) • WAC 388-78A-2700(2)(c)

Appendix F

Problem Solving Procedures for Facilities

Problem solving procedures for facilities upon discovery of an incident / allegation of abuse, neglect, exploitation, misappropriation

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(s) against further occurrences

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, financial exploitation has occurred, or may have contributed to the incident

NOTE: Report suspected abuse, neglect, financial exploitation *immediately*

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

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

e. Cause of incident still undetermined after Phase II investigation

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

1. Record findings that validate this conclusion

b. There was an unexpected, unusual, unintended event (AN ACCIDENT) which could *not* have been predicted, given prevailing circumstances

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

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

RESIDENT TO RESIDENT

Record details of the incident.

Report to the Department all incidents:

- Of sexual abuse
- Of physical abuse that result 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*

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
- Exploitation

STAFF TO RESIDENT

Record details of the incident.

Report to the Department all incidents:

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 (not reasonably related to condition):
   (a) Call Hotline immediately
   (b) Contact police if crime is suspected
1. For a Superficial injury: Log within 5 days

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, report to the department
3. Do needed re-assessment, care revision, staff training and equipment modification as necessary to assure resident's safety

* That caused more than minor bodily injury AND required more than basic first aid; or if 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 residents or involving the same residents; or there is an attempt to choke a resident, or the injured resident or his/her legal representative or family member asks that a report be made.

Appendix G

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 The Elder Justice Act of 2009 added requirements for the reporting of possible crimes to law enforcement. The requirements can be found in Section 1150B of the Social Security Act.

State law in chapter 74.34 RCW includes definitions and provisions for reporting possible abuse and neglect.

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

REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

Section 6703(b)(3) LONG-TERM CARE FACILITIES – Part A of title XI of the **Social Security Act** (42 U.S.C. 1301 et seq.), as amended by section 6005, is amended by inserting after section 1150A the following new section:
SEC. 1150B

(b) REPORTING REQUIREMENTS

(1) IN GENERAL – Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

(2) TIMING – If the events that cause the suspicion –

(A) result in serious bodily injury, the individual shall report the suspicion *immediately*, but not later than 2 hours after forming the suspicion; and

(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

(d) ADDITIONAL PENALTIES FOR RETALIATION

(1) IN GENERAL – A long-term care facility may not –

(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

RCW 74.34.035(1–7): Reports – Mandated and permissive

(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.

(5) When there is reason to suspect that the death of a vulnerable adult was caused by abuse, neglect, or abandonment by another person, mandated reporters shall, pursuant to RCW 68.50.020, report the death to the medical examiner or coroner having jurisdiction, as well as the Department and local law enforcement, in the most expeditious manner possible. A mandated reporter is not relieved from the reporting requirement provisions of this subsection by the existence of a previously signed death certificate. If abuse, neglect, or abandonment caused or contributed to the death of a vulnerable adult, the death is a death caused by unnatural or unlawful means, and the body shall be the jurisdiction of the coroner or medical examiner pursuant to RCW 68.50.010.

(6) Permissive reporters may report to the Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited, or neglected.

(7) No facility, as defined by this chapter, agency licensed or required to be licensed under chapter 70.127 RCW, or facility or agency under contract with the Department to provide care for vulnerable adults may develop policies or procedures that interfere with the reporting requirements of this chapter.

OTHER APPLICABLE ASSISTED LIVING FACILITY STATUTES/RULES

These guidelines may refer to portions of other regulatory requirements applicable to assisted living facilities to assist them in promoting the safety and well-being of their residents. Some applicable laws and rules are listed below.

THE ONLINE VERSION OF THESE GUIDELINES PROVIDES HYPERLINKS TO THESE SELECTED REGULATIONS:

- Chapter 18.20 RCW: ASSISTED LIVING FACILITIES (Formerly Boarding homes)
- Chapter 43.43 RCW – Washington State Patrol – Criminal Background Checks
- Chapter 68.50 RCW – Human Remains
- Chapter 70.129 RCW – Long-Term Care Resident Rights
- Chapter 74.34 RCW – Abuse of Vulnerable Adults
- Chapter 388-78A WAC: ASSISTED LIVING FACILITY LICENSING RULES

Appendix H

Definitions

This appendix 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. It also contains both legal references and state and federal guidelines.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"ABANDONMENT" as defined in RCW 74.34.020(1) 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.	RCW 74.34.205 Abandonment, abuse or neglect - Exceptions (1) Any vulnerable adult who relies upon and is being provided spiritual treatment in lieu of medical treatment in accordance with the tenets and practices of a well-recognized religious denomination may not for that reason alone be considered abandoned, abused, or neglected. (2) Any vulnerable adult may not be considered abandoned, abused, or neglected under this chapter by any health care provider, facility, facility employee, agency, agency employee, or individual provider who participates in good faith in the withholding or withdrawing of life-sustaining treatment from a vulnerable adult under chapter 70.122 RCW, or who acts in accordance with chapter 7.70 RCW or other state laws to withhold or withdraw treatment, goods, or services.	NOTE: Leaving a resident at a hospital emergency room (ER) is ***not*** considered an act of abandonment.
"ABUSE" as defined in RCW 74.34.020 means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable 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.	Assisted living facilities must protect the health and safety of every resident, including those that are incapable of perception or who are unable to express themselves. In general, you must presume that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive or unwanted contact with a resident.	

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"ABUSE" *(continued)* See also Appendix A for Abuse Definition Diagram. A variety of actions fall within the definitions of abuse. An action can be abusive even if there is no intent to cause harm.	"Willful" means that the individual intended the action or inaction itself that he/she knew or should have known could cause one or more negative outcomes to assisted living facility resident(s), including harm, anguish, pain or injury. Willful inaction includes, but is not limited to, an assisted living facility staff member's refusal to provide the necessary care and required services, or, intentional deprivation of a resident, or both. 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.	**EXAMPLES OF ABUSE** may include but are not limited to the following: • Involuntary Seclusion: Separation of a resident from other residents or from his/her room (with or without roommates) or in an isolated location against the resident's will, or will of the resident's legal representative. • Striking a resident
"ABUSE" includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings: • ABUSE – "PERSONAL EXPLOITATION" as defined in RCW 74.34.020(2)(d) 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. See also the definition of **"Financial Exploitation"**. In some situations, these terms may be used interchangeably.	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.	**Exploitation: Examples** may include, but are not limited to, the following: • Any individual who sells the resident's property, house, or other valuables for their own personal gain or profit; • 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; • Any individual who for personal profit or advantage coerces the resident to sign a document, contract, legal form, or any other form designating authority over the resident's finances and property; • **Review Appendix K** – Key Triggers/Possible Criminal Indicators for other examples of **Personal Exploitation / Financial Exploitation**.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
• **ABUSE – "MENTAL" as defined in** RCW 74.34.020(2)(c) a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing. **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.	**Mental Abuse:** humiliation, harassment, threats of punishment or deprivation. **Verbal Abuse:** Any use of oral, written or gestured language that willfully includes threats and/or disparaging & 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.	• **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Mental or Verbal Abuse.** • **Example:** 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. • Telling a resident that she will never be able to see her family again.
• **ABUSE – "PHYSICAL" as defined in** RCW 74.34.020(2)(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, or prodding.	Physical contact with a resident for the purpose of retaliating against that resident is never justifiable and constitutes abuse. 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.	• **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of Physical Abuse. • **Physical Abuse**: 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 such methods as purposely withholding food and medications.
• **ABUSE – "SEXUAL" as defined in** RCW 74.34.020(2)(a) means any form of non-consensual conduct, including but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving services from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.		• **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of Sexual Abuse. • **Sexual Abuse**: Inappropriate touching, sexual harassment, sexual coercion, or sexual assault. • **Sexual Contact**: May include interactions that do not involve touching including, but not limited to, sending sexually explicit messages, or cueing or encouraging a resident to perform sexual acts.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"ACCIDENT" As referenced in this Guidebook, an accident means an "unexpected, unintended event that can cause a resident bodily injury."	Foreseeable incidents are not accidents. Various licensing rules provide guidance to assisted living facility operators and staff persons for the actions expected to respond to any resident with bodily injury resulting from an accident, to prevent further injury while the circumstances of the event can be determined, and, to take actions to protect the resident and other residents from the risk for similar injury.	**EXAMPLES OF ACCIDENTS** may include, but are not limited to, the following: • A self-propelling resident catches a finger in her wheelchair spoke and fractures the finger. • A resident with no known history of dizziness who becomes dizzy, fails to use call light for help, and falls while getting out of bed. • Resident pinches hand in doorjamb; and sustains a skin tear. • Resident hits arm on the head of the bed and sustains a bruise on forearm. Any of the above examples may 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.
"COVERED INDIVIDUAL" is defined in section 1150B(a)(3) of the Social Security Act as anyone who is an owner, operator, employee, manager, agent or contractor of a Medicare or Medicaid certified nursing facility, ICF/ID, or hospice. For individuals and entities affiliated with nursing facilities, this term is similar to the definition of "mandated reporter," except that "covered individual" also includes facility owners. The facility reporting requirement stems from federal law, not RCW 74.34. WAC 388-78A, which was adopted to comply with federal law, also includes a facility reporting requirement.] See also the definition of "MANDATED REPORTER". In some situations these terms may be used interchangeably.	Section 1150B is a section of the Social Security Act that requires the reporting of any reasonable suspicion of a crime committed against a resident of, or an individual receiving care from, a long-term care facility. These reports must be submitted to at least one law enforcement agency of jurisdiction and the State Survey Agency (SA) per the provisions in section 6703 of the Affordable Care Act of 2010, part of the Elder Justice Act of 2009. Section 1150B (d) of the Act also prohibits a long-term care facility from retaliating against any "covered individual" who makes such a report. "**Covered Individuals**" who fail to report under Section 1150B (b) of the Act shall be subject to various penalties, including civil monetary penalties.	

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"CRIME" as referenced in Section 1150B (b)(1) of the Social Security Act provides that a "crime" is defined by law of the applicable political subdivision where a long-term care facility is located. See also the definitions of "BODILY HARM" related to certain criminal offenses.	Federal law requires nursing facilities to coordinate with their local law enforcement entities to determine what actions are considered crimes within their political subdivision. NOTE: RCW Title 9A is known as the Washington Criminal Code.	In certain cases, neglect may be the ***crime*** of Criminal Mistreatment per RCW 9A.42.020-037.
"FINANCIAL EXPLOITATION" as defined in RCW 74.34.020(7)(a)(b)(c) means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage. "Financial exploitation" includes, but is not limited to: (a) The use of deception, intimidation, or undue influence by a person or entity in a position of trust and confidence with a vulnerable adult to obtain or use the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; (b) The breach of a fiduciary duty, including, but not limited to, the misuse of a power of attorney, trust, or a guardianship appointment, that results in the unauthorized appropriation, sale, or transfer of the property, income, resources, or trust funds of the vulnerable adult for the benefit of a person or entity other than the vulnerable adult; or (c) Obtaining or using a vulnerable adult's property, income, resources, or trust funds without lawful authority, by a person or entity who knows or clearly should know that the vulnerable adult lacks the capacity to consent to the release or use of his or her property, income, resources, or trust funds. See also definitions of "MISAPPROPRIATION OF RESIDENT PROPERTY" and "ABUSE – EXPLOITATION". In some situations these terms may be used interchangeably.	Others may financially exploit a resident for personal gain or profit by breach of fiduciary duty, deception, and intimidation of undue influence. **Acts of financial exploitation** may include, but are not limited to, the following: • Identity theft (RCW 9.35.020); • Theft by taking, deception, embezzlement (RCW 9A.56 (030-050); • Forgery (RCW 9A.60(020-060); • Undue influence, coercion and fraud; • Abuse of Trust: powers of attorney or legal guardianships	• **Review Appendix K** – Key Triggers / Possible Criminal Indicators for other examples of **Exploitation / Financial Exploitation**. • Scams **EXAMPLES OF FINANCIAL EXPLOITATION** may include, but are not limited to, the following: • Facility staff or others take resident money or property without permission of the resident; • Facility staff or others "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); • Facility staff uses disposable briefs or gloves, or other expendable items by, or charged to a resident for another resident's use.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"INCIDENT" For the purposes of these guidelines, an incident means: An occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or financial exploitation are alleged or suspected; or A substantial injury of unknown source, or cause, or circumstance.	All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury or allegation of injury results from abuse or neglect. *It may not always be possible to determine the cause of the incident*. The purpose of adding the definition of *"incident"* 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. For example, superficial injuries of unknown source and some falls when ***abuse or neglect is not alleged or suspected***, do not require a thorough investigation, but do require assessment to assist in preventing reoccurrence. An allegation is a statement or a gesture made by someone (regardless of capacity or decision-making ability) that indicates that abuse, neglect, financial exploitation, or misappropriation of resident property may have occurred and requires a thorough investigation. To ***"suspect"*** means to have reason to believe without conclusive proof that someone may have abused, neglected, financially exploited a resident, or misappropriated a resident's property. Documentation of the investigation for all incidents and the determination of "reasonably related" must be kept readily available for state review, internal risk management, and federal authorities.	**EXAMPLES OF INCIDENTS** may include, but are not limited to, the following: Any occurrence that is not consistent with standards of care and practice; Substantial injury of unknown source; Any allegation of mistreatment, neglect or abuse; and/or Any misappropriation of resident property or financial exploitation of a resident.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"INJURIES OF UNKNOWN SOURCE" means any injury sustained by a resident where the source of the injury was: • Not observed directly by a staff person; or • Not identified through the process of assessment for a superficial injury; or • Not identified through the process of a thorough investigation for a substantial injury; or • 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; and • The resident is not able to report/inform how the injury occurred. Injuries of unknown source may be either **superficial** or **substantial** in nature.	It is not always possible to determine the cause of the injury. **Types of injuries of unknown source:** **SUPERFICIAL INJURIES** of unknown source include injuries limited to the surface layers of the skin, easily treated with first aid/not requiring physician's orders for treatment (such as sutures or diagnostic x-rays); **and** located in areas generally vulnerable to trauma. Superficial injuries of unknown source that are not incidents of suspected or alleged abuse or neglect must be assessed to determine the cause and appropriate corrective action must be taken. Documentation of the assessment must be in the resident's clinical record. **SUBSTANTIAL INJURIES** 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. These injuries are not determined by process of investigation to be reasonably related to resident's condition. Substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, **must** be reported to the Department; because the injuries may have resulted from the failure to take preventative measures. • ***ALL*** substantial injuries of unknown source must be thoroughly investigated. • ***ALL*** injuries (regardless of the extent) occurring in non-vulnerable areas of the body will be considered substantial injuries.	**EXAMPLES of SUPERFICIAL INJURIES** may include, but are not limited to, the following: • Small abrasions, lacerations, or bruises limited to the surface layers of the skin, occurring in areas generally vulnerable to trauma, such as hands, forearms, and shins. **EXAMPLES of SUBSTANTIAL INJURIES** may include, but are not limited to, the following: • 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; • All fractures

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"LAW ENFORCEMENT" could include the full range of potential responders to elder abuse, neglect, and exploitation including: police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.	Unless directed otherwise, in an **emergency**, call **9-1-1** or your county's emergency services number. For **non-emergency** situations, use the local number specified by your local law enforcement authorities. Nursing homes are advised to *pre-determine* the non-emergency phone numbers of city, county or state police, sheriff and other law enforcement agencies. Each nursing home is advised to *pre-determine* the phone number of your county's coroner or medical examiner so that notification of the death of a resident, coming under their potential/actual jurisdiction, as set forth in RCW 68.50.010, can be made as expeditiously as possible. In certain circumstances, the death of a nursing home resident needs to be reported to: 1) County Coroner or Medical Examiner, ***and*** 2) Local law enforcement, ***and*** 3) Department's Hotline at **1-800-562-6078**	
"MANDATED REPORTER" as defined in RCW 74.34.020(13) is an employee of the Department; law enforcement; social worker; professional school personnel; individual provider; **an employee of a facility**; **an operator of a facility**; 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 Chapter 18.130 RCW. **See also the definition of "COVERED INDIVIDUAL". In some situations these terms may be used interchangeably.**	For the purpose of the definition of **mandated reporter**: **"Facility"** includes, but is not limited to, any home, place or institution licensed or required to be licensed under RCW 18.20 – Assisted Living Facilities.	Therefore, any licensee, manager, employee, and contractor associated with a licensed nursing facility or a skilled facility in Washington state is an individual mandated to report abandonment, exploitation, mental/verbal abuse, physical abuse, sexual abuse, neglect, potential criminal mistreatment, financial exploitation, misappropriation of resident property, and injuries of unknown source.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"NEGLECT," as defined in RCW 74.34.020(15), means: (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 (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, including but not limited to conduct prohibited under RCW 9A.42.100. As referenced in RCW 74.34.020(15)(b), RCW 9A.42.100 explains the felony crime of Endangerment with a Controlled Substance (Methamphetamine). See also Appendix B for Neglect Definition Diagram and Appendix C for Medication Error Decision Tree.	In *certain* cases, neglect may be the ***crime*** of Criminal Mistreatment under RCW 9A.42.020-037. In the definition of neglect, the words **"necessary to avoid physical harm, mental anguish, or mental illness"** mean that it is more probable than not that harm could happen to the resident because the goods or service were not provided. Neglect may be determined even if no apparent negative outcome has occurred. Federal guidelines indicate that 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. 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 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. 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. 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. **NOTE:** Neglect can be an investigative action finding even if no apparent outcome has occurred, but the likelihood for deterioration of the resident's physical, emotional and psychosocial well-being exists.	• Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water, and structural hazards; • 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; • Failure to consult with a resident's attending physician when resident's condition requires medical intervention; • 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; • 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. • Review Appendix K – Key Triggers / Possible Criminal Indicators for other examples of Neglect.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"PERMISSIVE REPORTER" as defined in RCW 74.34.020(13) means any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults. A permissive reporter may report.	**PERMISSIVE REPORTERS** may include but are not limited to, the following: • Family members; • Visitors; • Bank Tellers; • Postal Employees; • Church ministers	A permissive reporter may report, but is not required to report, abandonment, exploitation, mental/verbal abuse, physical abuse, sexual abuse, neglect, potential criminal mistreatment, financial exploitation, misappropriation of resident property, and injuries of unknown source.
"REASONABLE CAUSE TO BELIEVE" 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: • Personal observation of the incident; • The resident who is subject of incident; • Incident logs, medical records, etc.; • Other persons who may have relevant information A reporter may rely upon one or more of the above sources.	RCW 74.34.035 requires a mandated reporter to: **Report *immediately* to the Department when there is:** A reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred. 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.	**EXAMPLES OF REASONABLE CAUSE TO BELIEVE** may include, but are not limited to, the following: • Finger or slap marks on a resident; • A resident demonstrates fear in the presence of a particular caregiver or other people.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"REASON TO SUSPECT" or "REASONABLE SUSPICION" means a mandated reporter or covered individual thinks, based on information readily obtained from various sources, it is ***possible*** that something happened. Sources of information may include: • Personal observation of the incident; • The resident who is subject of incident; • Incident logs, medical records, etc.; • Other persons who may have relevant information; • Resident behavior; • Other relevant information. A reporter may rely upon one or more of the above sources.	RCW 74.34.035 and/or federal law requires a mandated reporter or a covered individual to: **1. Report *immediately* to the Department when there is:** • A reason to suspect that sexual assault has occurred. • 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. • The requirement to report to the Department does *not* include an exception for resident to resident assault. **2. Report *immediately* to the appropriate law enforcement agency when there is:** • A reason to suspect that sexual assault has occurred. • A reason to suspect that physical assault has occurred (except when the law does not require reporting of resident to resident physical assault per RCW 74.34) • Reasonable cause to believe that an act has caused fear of imminent harm. **3. Report *immediately* an incident of physical assault between residents to the appropriate law enforcement agency under the following circumstances:** • When the incident 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 residents or involving the same residents; or there is an attempt to choke a resident. • When the injured resident or his or her legal representative or family member requests that the incident be reported.	**EXAMPLES OF REASON TO SUSPECT or REASONABLE SUSPICION** may include but are not limited to the following: • Large bruises of unknown origin located on the head (especially the face/ neck) and the trunk/ torso of body; • Resident self-reports of being slapped, choked, kicked, or burned by another resident; • Staff is witnessed taking sexually explicit photos of a nude resident with dementia; • Any physical evidence of rape such bruising in the perineal area, vaginal tears, and abnormal redness or bleeding in the vaginal area.

DEFINITIONS	GUIDELINES & COMMENTS	EXAMPLES
"REASONABLY RELATED" as referenced in RCW 74.34.035 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 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.	Facts and circumstances surrounding the resident may include, but are not limited to, the following: • Their diagnoses; • Their medication regimen; • Their expected or known results of a medical or diagnostic procedure; • Their functional abilities; and • Their normal interaction within and about the assisted living facility environment.	**EXAMPLES OF REASONABLY RELATED** may include, but are not limited to, the following: • Normal bruising that results from venipuncture or other parenterally invasive procedures; • Skin tears related to fragile skin; • 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.
"VULNERABLE ADULT" as defined in RCW 74.34.020(17)(a) through (g) includes a person: • Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or • Found incapacitated under RCW 11.88; or • Who has a developmental disability as defined under RCW 71A.10.020(3); or • Admitted to any facility, or • Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under RCW 70.127; or • Receiving services from an individual provider under RCW 74.39A; or • Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW		

Appendix I

Key Triggers / Possible Criminal Indicators

This appendix includes possible/actual indicators of various types of abuse or neglect of **residents** in assisted living facilities. The appendix is not all inclusive.

Mandated reporters and covered individuals must consider other possible indicators of all types of abuse, neglect, and personal and/or financial exploitation, and must report reasonable suspicion of a crime against any resident of that facility.

PERSONAL EXPLOITATION/FINANCIAL EXPLOITATION – "KEY TRIGGERS"

Possible/Actual Indicators of Personal Exploitation/Financial Exploitation: Personal exploitation is an act of forcing, compelling, or exerting undue influence over a resident causing the resident to act in a way that is inconsistent with relevant past behavior, or causing the resident to perform services for the benefit of another. Financial exploitation is the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult. Such fraudulent or otherwise illegal, unauthorized or improper acts can deprive a resident of rightful access to, or use of his or her benefits, resources, belongings, or assets.

A financial exploiter can be an individual, an institution, or someone who has power of attorney for the resident. It includes the improper use of legal guardianship arrangements or powers of attorney.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of financial exploitation or missing property
- Suspicion/evidence of possible "grooming behaviors" over a period of days, weeks, or months by a potential offender to see how the resident at risk for exploitation, or those close to the intended resident, will respond to a pattern of gifts, treats, extra attention or unrequested help in an effort to win their individual or collective trust
- Any individual who for personal profit or advantage coerces the resident to sign a document, contract, legal form, or any other form designating authority over the resident's finances and property
- Unexplained, sudden changes in bank accounts or banking practices, including disappearance of funds or withdrawal/s of large sums of money from checking, savings or investment accounts of a resident
- Missing bank checks or financial statements/records usually in resident's possession
- Adding additional unauthorized names on a resident's bank signature cards
- Unauthorized withdrawal of resident's funds by an unauthorized party using the resident's ATM card
- Abrupt changes in resident's will or other financial/legal documents without the resident having a full understanding of the consequences
- Abrupt changes in resident's legal or financial representatives without the resident having participated in, or having a full understanding of, these decisions
- Awareness that a resident with cognitive impairment is/was video-taped by family or outside persons, perhaps as a means to document that the resident agrees to decisions that may actually represent potential undue influence by parties known or unknown to the resident
- Personal health, financial or governmental information (health care insurance cards, credit cards, social security number) is taken and misused by any party with unsupervised access to resident or to the resident's confidential information
- Unexplained disappearance of valuable possessions/property from the resident's room without his/her knowledge or consent
- Bills not paid by resident's representative payee despite the money being available to pay bills

- Forged signature/s on financial transactions or on the transfer of titles of property (home in the community) or possessions (automobile) belonging to a resident
- Sudden appearance of previously uninvolved relatives claiming rights to a resident's possessions/resources
- Unexpected sudden transfer of a resident's assets to a family member or someone outside the family
- Providing services that are not necessary, or, denying services that are necessary per a resident's assessment and comprehensive plan of care
- Improper use of official guardianship or power of attorney responsibilities
- Surrogate decision maker or representative payee, who has been given fiduciary responsibility by the resident to pay the facility's bill, is refusing to pay legitimate bills and to meet the resident's needs by taking or using the resident's money or assets for his or her personal gain or profit
- Facility staff persons, caregivers or others "borrow" clothing or other property of one resident to give to another resident (for example, clothing, TV, wheelchair)
- Facility staff use disposable briefs, disposable gloves and other expendable items which were purchased by, or charged to one resident, for another resident's use
- The presence of emotional or psychological abuse can be a potential/actual indicator that financial exploitation may also be occurring
- Potential/actual theft, forgery, identify theft, false identity or pretending to be a legal representative of the resident, or improperly obtaining financial information are among, but are not the only, examples that need to be reported to local law enforcement

MENTAL ABUSE – "KEY TRIGGERS"

Possible/Actual Indicators of Mental Abuse: A willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. In instances of abuse of a resident 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.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of being verbally, emotionally or mentally mistreated
- Terrorizing and/or threatening harm or deprivation to a resident by use of oral, written or gestured language
- Unexplained withdrawal from and/or inappropriate isolation of a resident from family, friends, or from regular activities
- Ridiculing, yelling, insulting or swearing at a resident which results in mental pain and suffering, anguish or distress
- Denying food, personal property or privileges as a punishment or deprivation
- Inappropriate use of silence to control behavior of resident
- Sudden changes in behaviors that are not in the resident's usual nature, such as, agitation, change in alertness, increased ambivalence, low self-esteem, unusual depression, extreme passivity, reluctance to leave room for fear of certain persons or other residents
- Treating a resident like a child
- Strained or tense relationships, frequent arguments between a staff person or caregiver and the resident
- Intentional and repeated verbal/telephone harassment or physically stalking intended to potentially/actually frighten, intimidate or harass the resident
- Intentionally threatened or actually attempted to cause harm to the resident's health or safety or physical damage the resident's property
- Use of demeaning statements, harassment, threats, insults, humiliation or intimidation
- Purposely withholding cigarettes or some form of desired food, entertainment or requested activities from the resident
- Placing unreasonable restrictions on the resident's mobility, such as, not charging a motorized wheelchair battery so the resident is unable to be independently mobile
- Placing unreasonable restrictions on the resident's ability to communicate, either verbally or in writing, with other residents or other persons of choice
- Presence of emotional or mental abuse may also indicate that financial exploitation might be occurring

NEGLECT – "KEY TRIGGERS"

Possible/Actual Indicators of Neglect: From the state regulatory perspective, neglect of a resident as defined in RCW 74.34.020(15) means:

(a) A pattern of conduct or inaction by an individual or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or, that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(b) An act or omission by an individual or entity with a duty of care that demonstrates serious disregard of consequences

of such magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare or safety, including but not limited to conduct prohibited under RCW 9A.42.100. [Felony crime of Endangerment with a Controlled Substance (Methamphetamine)].

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- Report by a resident of being mistreated or neglected
- Withholding, misusing or delaying food, fluids, clothing, shelter, personal hygiene, medicine, comfort, safety, help or other needed supports (eyeglasses, hearing aids, mobility equipment) or other essentials included in an implied or contractual agreement of responsibility to a resident receiving services
- Unattended/untreated health/dental problems and/or inadequate care of a resident
- Poor personal hygiene with evidence of significant lack of nail care for fingers and/or toes
- Resident is lying/sitting in urine and feces for extended periods of time
- Inadequate medical/health care services, including not having needed medically-necessary prescriptions/medications initially purchased or renewed in a timely manner
- Failure to do medication administration as per the resident's assessed need and agreed upon comprehensive care plan
- Hazardous or unsafe living conditions such as improper wiring, no heat or running water, no functioning toilet
- Unsanitary and unclean living conditions such as dirt, fleas, lice on person, soiled bedding and personal clothing, fecal/urine smell, inadequate clothing
- Allowing the physical environment to deteriorate to the point that residents are subject to hazardous situations, such as electrical, water and structural hazards
- Staff person or caregiver has fallen asleep or is intoxicated while on duty
- Facility residents with cognitive impairments and known potential for assaultive behaviors are left alone and unsupervised
- Failure to feed or assist a dependent resident who requires help with eating
- Resident develops dehydration or malnutrition due to lack of appropriate care
- Failure to carry out orders for treatment, therapy, diagnostic testing, administration of medications, unless refusal by resident
- Failure to provide care and services per the resident's comprehensive care plan in certain circumstances
- Failure to answer a resident's call light or bell in a reasonable time frame or provide assistance as assessed and agreed to as needed for a resident
- Failure to adequately supervise the whereabouts and/or activities of a resident with such assessed needs, resulting in a resident being reported as missing and when found is hypothermic and with substantial injuries of unknown source, cause or circumstance
- Failure to protect a resident from another resident, regardless of whether or not the other resident's actions are willful or due to cognitive impairment
- Failure to report a resident's chest pain and shortness of breath to supervising staff
- Failure to consult with a resident's attending health care practitioner when the resident's condition requires medical consultation or intervention or both
- Failure to assess and evaluate a resident's status or failure to institute care interventions as required by the resident's condition which results in harm to the resident or demonstrates a clear and present danger for harm
- Failure to transfer a resident in need of emergency help/care 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
- Failure of facility staff to refrigerate potentially hazardous food and resident(s) acquire(s) food borne illness
- Failure to provide an adequate number of nutritionally balanced, properly prepared and medically appropriate meals which can or does result in weight loss pattern or other parameters of poor nutritional status that are not the result of a medical condition for the resident(s)
- Pressure ulcer ("bedsore") development without evidence of resident having one or more predisposing clinical condition/s that may increase risk of pressure ulcer development
- Lack of, or insufficient, treatment of pressure ulcers regardless of cause, such as, drainage/foul odor, dirty or no bandages over ulcers, exposure of bone in ulcer site(s), skin/sores coated with dried stool
- Contractures that become fixed, even in a resident with certain neurological conditions, due to lack of medical consultation or appropriate assessment and management of such a clinical condition

PHYSICAL ABUSE – "KEY TRIGGERS"

Possible/Actual Indicators of Physical Abuse: The willful action of inflicting bodily harm or physical mistreatment. In instances of abuse of a resident 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.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of physical abuse presently or in the recent past
- Unexplained black eyes, welts, pressure marks, lacerations, rope marks, imprint injuries, sprains or dislocations, broken bones, untreated injuries or sores
- Report of, or evidence of, being pushed, slapped, hit, shaken, spit upon, struck with or without an object, pinched, choked, kicked, shoved, prodded or burned
- Tightening a physical device used as a restraint to cause pain
- History of current and/or past broken bones in various stages of healing
- Open wounds, cuts, punctures, untreated injuries in various stages of healing
- Broken eyeglasses/frames with pattern of contusions over bridge of nose
- Sudden change in the resident's usual behavior
- Staff person or caregiver's refusal to allow outsiders/visitors to see a resident alone
- Finger marks possibly associated with being grasped, squeezed or restrained in some manner
- Research findings* suggest that, when compared to "normal", "accidental" or "non-intentional" bruises, ***"suspicious"***, ***"inflicted"***, or ***"abusive" bruises more likely may be:*** 1) Significantly larger in size (2 inches in diameter or more); 2) Located on the head (especially the face/neck) and the trunk/torso of the body, rather than predominantly on a resident's legs or arms; 3) Found on a resident's genitals, buttocks, soles of feet, or, arm (right or left, depending on a resident's dominant arm, often raised to block an alleged attack); and, 4) Residents taking medications that interfere with blood coagulation (i.e., warfarin) may be more likely to have multiple bruises, but these bruises usually do not last any longer than bruises of residents not on such medications.

* Wiglesworth, Austin, Corona, Schneider, Liao, Gibbs, & Mosqueda. (2009). Bruising as a marker of physical elder abuse. *Journal of the American Geriatrics Society*, 57, 1191-1196.

- Bruises of varying sizes and ages in locations not usually susceptible to trauma (head, inner arms/thighs, ears, scalp, buttocks)
- Multiple emergency room visits for unexplained, implausible or vague explanations for ill-health or injuries
- Delay between onset of illness or detection of injury (spiral fracture) and actions to seek medical or emergency treatment
- Malnutrition or dehydration without illness/disease-related causes
- Burns to the palms of hands, soles of feet, buttocks that may conform to shape of the allegedly heated object
- Immersion burns of hands/wrists and/or feet/ankles with likely bilateral burn symmetry like "gloves" or "stockings" on upper or lower limbs
- Physical punishment, confinement or involuntary seclusion
- Throwing food or water on a resident
- Controlling behavior through corporal punishment such as withholding food and medications
- Pulling a resident's hair or pinching a resident's cheeks to get him or her to open their mouth
- Hair loss with red or "spongy" scalp

SEXUAL ABUSE – "KEY TRIGGERS"

Possible/Actual Indicators of Sexual Abuse: Any form of non-consensual sexual conduct of any kind that can result from threats, force or inability of the resident to give consent. Sexual abuse also includes any sexual conduct between a staff person who is not a resident or client of a facility or a staff person of a program authorized under chapter 71A.12 RCW and a resident or client living in that facility or receiving service from a program authorized by chapter 71A.12 RCW, whether or not it is consensual. (Chapter 71A.12 RCW is State Services for Persons with Developmental Disabilities.)

Sexual abuse/assault includes but is not limited to any nonconsensual sexual conduct, such as unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Remember, ***sexual conduct*** may also include interactions that do NOT involve touching. In instances of abuse of a resident 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.

"KEY TRIGGERS" for timely action may include, but are not limited to, the following:

- A resident's report of being sexually assaulted or raped currently or in the recent past
- Non-touching offense such as voyeurism by a staff person, caregiver or anyone in a position of power over resident(s), including but not limited to: knowingly viewing, photographing or filming a resident for the purpose of arousing or gratifying sexual desire without the knowledge or consent of the resident and in a place where the resident would have a reasonable expectation of privacy
- Forcing the resident receiving services to view pornographic material in any media form, even if no inappropriate physical touching takes place
- Unwarranted, intrusive intimate touching of the resident receiving services by any facility staff during bathing, dressing, toileting, incontinence care
- Molesting the resident receiving services including unwanted touching and forced kissing
- A family member displays affectionate gestures to a resident that are observed to progress to be too lingering and possibly seductive in nature
- A staff member, caregiver, volunteer or family member takes nude photograph/s of one or more residents
- Any sexual activity (such as, rape, sodomy, sexual penetration, sexual harassment, sexual threats and coercion, sexually explicit photographing) that occurs when the resident cannot or does not consent
- Any sexual contact (such as, staff asking resident for sexual touching, kissing, intimate hugging, "dating") between a staff person and a resident or client living in a facility or receiving service from a contracted program authorized under chapter 71A.12 RCW, whether or not it is consensual
- A staff member or caregiver exposes his/her genitals to a resident
- Bite marks, bleeding, bruising, infection, scarring, or irritation in or near the resident's genitals, thighs, rectum, mouth or breasts
- Unexplained sexually transmitted disease or genital/anal pain, itching, discharge or infection
- Unexplained bleeding, wounds or pain from orifices (oral, vaginal, anal) or intermittent vaginal or anal spotting or bleeding
- Torn, stained, or bloody underclothing including incontinence care products
- Belatedly recognized pregnancy or possible miscarriage of a pregnancy
- Any physical evidence of rape such as bruising in the perineal area, vaginal tears, abnormal redness/ bleeding or pain in the vaginal or anal areas, or, the potential for or actual presence of semen
- Sending a resident sexually explicit messages
- Cueing or encouraging a resident to perform sexual acts
- Resident demonstrates atypical regressive behaviors (withdrawal, shying away from being touched, depression, difficulty eating or sleeping, difficulty walking or sitting, fear) in the presence of a particular staff person or caregiver or other people with unsupervised access to the resident in the facility or on outings
- Resident reacts to possible offender in inappropriate or romantic ways
- Comments of potential concern made by a resident, such as, "She is my girlfriend;" "He loves me;" or, "I'm his favorite girl."

Appendix J

Protecting Seniors / Taxpayers from Fraud

Washington State Office of the Attorney General
Medicaid Fraud Control Unit
P.O. Box 40114 - Olympia, WA 98504
Phone: (360) 586-8888
Fax: (360) 586-8877
MFCUreferrals@atg.wa.gov

WHAT IS MEDICAID?

Medicaid is health insurance for qualifying low-income and needy people. Medicaid eligible recipients can include children, the elderly and persons with a disability. Each state designs and administers its own Medicaid program. The federal government jointly funds the program with the state as long as the program complies with the requirements mandated by the Centers for Medicaid and Medicare Services (CMS).

WHAT IS MEDICAID FRAUD?

Medicaid Fraud is generally defined as the billing of the Medicaid program for services, drugs, or supplies that are: unnecessary; not performed; more costly than those actually performed; purportedly covered items which were not actually covered.

MEDICAID COVERED SERVICES

Medicaid covered services include in-home care, respite care, hospital care, skilled nursing home care, residential adult family care services, and professional services provided by physicians, laboratories and other health care professionals.

MEDICAID FRAUD CONTROL UNIT

Established in 1978, the Washington State Medicaid Fraud Control Unit (MFCU) investigates and prosecutes fraud committed by Medicaid providers. This Unit also monitors complaints of resident abuse or neglect in Medicaid funded nursing homes, adult family homes and boarding homes. This Unit provides assistance to law enforcement in investigating and prosecuting facility-based crimes committed against vulnerable adults. The MFCU also independently investigates and prosecutes provider fraud committed against the Medicaid program, regardless of the location of the offense (the fraud can occur in home, in a facility, in a provider's office, or any other location in Washington). This Unit is part of the Criminal Justice Division of the Attorney General's Office.

NOTICE

Concerned about abuse, neglect or violation of residents rights?

Report Online:

www.dshs.wa.gov/altsa/reportadultabuse

Call:

Aging & Long-Term Support Administration

1-800-562-6078

TTY Users: 1-800-737-7931

If you need help in resolving any problems or have questions about licensed long-term care facilities, contact the State Ombuds

1-800-562-6028

Washington State Department of Social & Health Services

Transforming lives

February 2017

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.

The Washington State Department of Social and Health Services

DSHS 22-1749 (10/17)