



WISCONSIN DEPARTMENT
of HEALTH SERVICES

Abuse: Prevention, Investigation and Reporting

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Abuse: Prevention, Investigation and Reporting

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Prevention & Response

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Warning Signs of Abuse

- (Physical Abuse) Bruises, broken bones, sprains, dislocations, unexplained injuries
- (Emotional Abuse) Seeming more passive, withdrawn, anxious, agitated, fearful or non-communicative
- (Sexual Abuse) Torn, stained, or bloody clothing, undergarments. Sexually transmitted illnesses, vaginal or anal bleeding, pain, and/or itching. Can be hands on or hands off.



Warning Signs, continued

- (Financial Exploitation) Non-payment of cost share, forged documents, unexplained disappearance of funds or valuable possessions, no spending money
- (Neglect) Individual is underweight, frail, weak or dehydrated, lack of appropriate food and or medications, isolated from others

Who are the Abusers

- Can be anyone!
- Most likely to be spouses, intimate partners, adult children, or other family members
- Caregivers or others in a position of trust



2018 Elder Adult at Risk Statistics

- 63% of alleged abuser were relatives.
- Relatives means sons, daughters, spouses, grandchildren and other relatives.
- A total of 11,353 total reports were received in Wisconsin.
- A total of 8,792 total reports of elder abuse were received.
- 2,561 referrals were made to Adult Protective Services.
- 87.3% of allegations occurred at the elder's place of residence.
- Less than 10% of incidents occurred at nursing homes or CBRFs.

Prevention

- Know the warning signs of abuse.
- Know that abuse often happens by persons most trusted.
- When doing a pre-admission assessment or assessments after admission, note comments made by resident or others, gestures that could signal abuse or undue influence.
 - Unexplained injuries
 - Cowering from specific people
 - Changes in socialization, self-isolation or isolation by others

Prevention

- Watch biases: Residents with dementia can report abuse; staff who are most trusted or most liked could be grooming residents for abuse: investigate all allegations.
- Know what to do - do something!
 - Safety of affected resident(s) first
 - Have and know policies that address each step of your response and investigation, such as removing staff or others for the period of investigation; how to involve law enforcement, APS, DQA, ombudsman, Victims' Services

About Sexuality & Consent

- Residents have rights related to all relationships, but some relationships require more vigilance and assessment than might others.
- Providers must assess the capacity to consent of residents involved in any sexual relationship.
- Findings of incapacity related to POA-HC decisions or judgment of incompetence does not automatically mean a resident cannot participate in a sexual relationship.

Continued next slide



Sexuality & Consent

- More about vigilance and assessment:
 - Doing nothing leaves a provider or others open to liability for sexual assault. This should not be a reason to completely disregard the relationship, however, if ability to consent is determined.
 - Be aware of crossed boundaries between caregivers and residents – residents can sometimes get infatuated with the caregiver or misinterpret attentions.
- When in doubt, call the ombudsman for education, support services, information about due process rights:

1-800-815-0015



DOCUMENT
YOUR
WORK
and
REPORT TIMELY!



Investigating & Reporting Requirements

Karen Anderegg

Office of Caregiver Quality (OCQ), Supervisor

Division of Quality Assurance

Wisconsin Caregiver Law

- OCQ provides administration of Caregiver Law
- Implemented October 1, 1998
- Protects individuals, living in regulated healthcare settings, from abuse, neglect and misappropriation
 - Background checks
 - Ch. DHS 12
 - Investigation and reporting requirements
 - Ch. DHS 13

Investigating and Reporting Requirements

- <https://www.dhs.wisconsin.gov/publications/p00976.pdf>
- DHS 13.05
 - Consistent method for reporting incidents of caregiver misconduct for all entities regulated by DQA
- DHS 13.03
 - Definition of abuse, neglect and misappropriation-Publication P-00976

Written Procedures

- How and to whom staff are to report incidents
 - How internal investigations will be completed
 - How staff will be trained on the procedures related to allegations of caregiver misconduct
- How residents will be informed of those procedures

Incident Reporting

An entity can learn of an incident from:

- Verbal or written statement from a resident
- Verbal or written statement from someone in a position to have knowledge of the incident
- Discovering an incident after it occurred
- Hearing about an incident from others
- Observing injuries (physical, emotional or mental)

Recognizing Misconduct in Facilities

- Resident Perspective
- Staff Perspective
- Family/Visitors

Discovery of Caregiver Misconduct

- Immediately protect residents
- Make initial report to DQA for SNFs
- Investigate all allegations of misconduct
- Document the results of the investigation
- Report allegations/incidents to DQA as appropriate

Investigations of Misconduct

- Know the who, what, where, when, why and how
- Preserve evidence
- Document the effect on the resident
- Document the investigation
- Report to law enforcement

Potential Biases of Administrator During Investigation

- Preconceptions of facility staff and residents based on previous interactions
- Personal interest in perception of facility
- Time constraints

Types of Questions to Ask

- Open-ended questions
 - Avoid questions that can be answered “yes” or “no”
- Simple/Clear questions
- One question at a time
- Avoid leading questions
- Gather enough information to tell the story
 - Who, what, when, where, why and how

Possible Indicators of Deception

- Freudian slips
- Offensive vs. defensive
- Embellishing
- Non-verbal signs

Entity Investigating and Reporting Tools

- Caregiver Misconduct Reporting Requirements Worksheet (F-00161), non-NH only.

<https://www.dhs.wisconsin.gov/caregiver/complaints.htm>

- Flowchart of entity Investigation and Reporting Requirements (F-00161A), non-NH only

Reporting Process and Timelines

- Misconduct Incident Reporting System
 - **BNHRC**
 - F-62617 Alleged NH Mistreatment, Neglect, Abuse-Immediately
 - F-62447 Misconduct Incident Report-Within 5 business days
 - **Other DQA entities**
 - F-62447 Misconduct Incident Report-Within 7 calendar days
 - Unreported incidents
 - Retain 30 most recent investigations

Reporting for CBRFs

- DHS 83.12(2)(a)2
 - 7 calendar days
- DHS 83.12(2)(b)
 - Non-caregiver/resident
- DHS 83.12(3)
 - Injuries of unknown sources

Reporting for AFHs

- DHS 88.11
 - Immediately when knows or suspects abuse

Reporting for RCACs

- DHS 89.34(18)
 - Resident Rights – Free from Abuse
- DHS 13.05(3)(a)
 - “Entity” shall report 7 days from knowing or should have known
- DHS 13.05(3)(b)
 - DSPS for credentialed person in 7 days

Relevant Abuse Tags for NHs

- F600- Abuse & Neglect of a Resident
- F602- Misappropriation and Exploitation of a Resident
- F603- Involuntary Seclusion
- F604- Physical Restraints
- F605- Chemical Restraints
- F606- Not employ staff or engage individuals who have findings
- F607- Develop and implement abuse policy
- F608- Reporting of a crime
- F609- Reporting Abuse
- F610- Investigating abuse thoroughly , misappropriation etc....

OCQ Referrals

- Department of Safety and Professional Services (DSPS)
- County Adult-at-Risk Agencies
- Department of Justice (DOJ)
- Office of Inspector General (OIG)
- Regional Offices



Residents' Rights Related to Abuse Reporting, Investigation & Prevention

Kim Marheine

Ombudsman Services Supervisor

State of Wisconsin Board on Aging and Long Term Care

Resident Rights in Managing Allegations of Abuse

- Residents have the right to be free from abuse, neglect, exploitation and misappropriation of property.*
- Residents have the right to have their allegations taken seriously, to have a prompt and thorough investigation and access to all appropriate resources and supports.

*For the purpose of this presentation the term "abuse" is used as a broad term to include all types of abuse

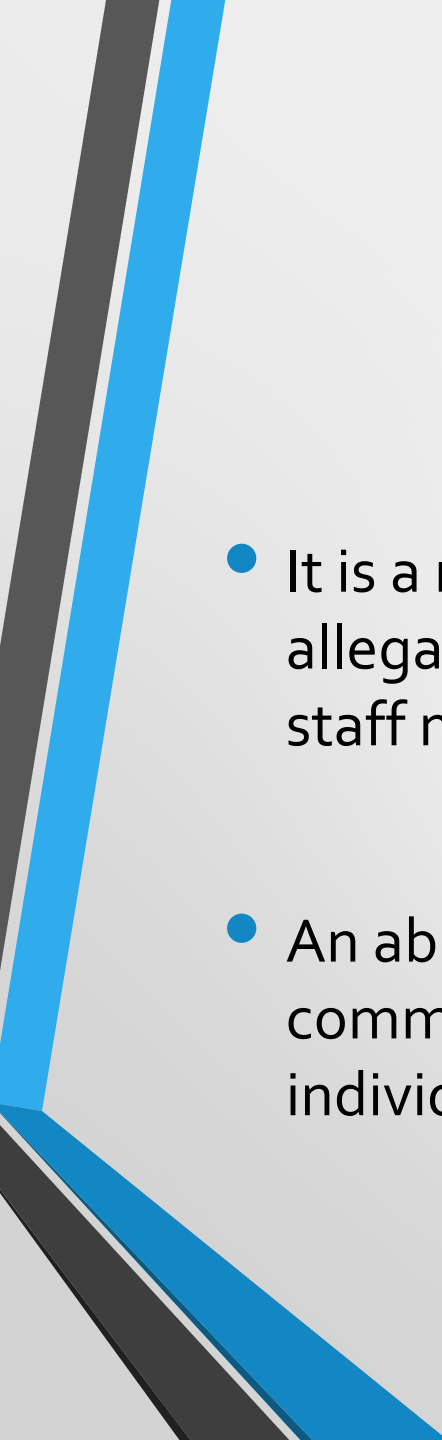
Resident Rights in Managing Allegations of Abuse

- Residents have the right to have contact with law enforcement, advocacy through an ombudsman or other resource of their choice, and victims' services.
- Residents have the right to voice grievances and to expect a prompt response.
- Residents have the right to make an allegation of abuse without fear of retaliation.

*For the purpose of this presentation the term "abuse" is used as a broad term to include all types of abuse

Resident Rights : Staff Responsibilities

- Staff have an obligation to report all allegations of abuse, and to do so immediately according to the community's policy and regulatory requirement.
- Staff have an obligation to aid in the protection of all residents' rights, ensuring that all who come in contact with residents comply with those rights.
- Everyone: residents, families, friends, and staff should understand residents' rights to be free from abuse, provider responsibilities to protect residents from abuse, signs of abuse, and how to report abuse.

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- It is a myth to think that staff respond to and report allegations of abuse only if the alleged abuser is another staff member.
 - An abusive act is abuse regardless of whether it is committed by staff, family, another resident or an outside individual.

Ombudsman Program Response to Allegations of Abuse

- Ombudsmen are not the investigators of allegations of abuse, but are often the first point of intake from a resident or family member.
- Ombudsmen may consult with a provider to ensure that they have promptly addressed a resident's allegation of abuse, but do not otherwise assist a provider with an investigation, nor do they provide any sort of approval of an investigation.

Ombudsman Program Response to Allegations of Abuse

- Ombudsmen may talk with a resident or family member about an allegation of abuse in order to gather information about their expectations for resolution and to inquire about need for victims' support services.
- Ombudsmen may follow up with providers to ensure that residents and families have received communications about the status of an investigation and have been offered the desired supports and services.

Ombudsman Program Response to Allegations of Abuse

- In seeking resolution to an allegation of abuse as well as in preventing abuse, ombudsmen are a good source of resident, family and staff education.
- Ombudsmen seek to empower residents in order to make themselves less vulnerable to abuse by knowing names and roles of staff and visitors, by remaining alert to unusual circumstances, and by speaking out promptly when they feel they may have been abused.
- Ombudsmen may also visit a community on an unscheduled basis to talk with residents about signs of subtle retaliation or any other changes in their care perceived as a result of having reported an allegation of abuse.



Working with Adult Protective Services: Scope & Services

Doreen Goetsch


Bureau of Aging and Disability Resources

Department of Health Services

Scope of Adult Protective Services

Has the statutory authority to investigate allegations of:

- Abuse: (physical, sexual, emotional)
- Neglect (self-neglect as well as neglect by others)
- Financial Exploitation (misappropriation)



Adult At Risk and Elder Adult At Risk Agency

- Every county has both an AAR (age 18 to 59) and an EAAR (age 60 plus) agency
- Important to know who that is and how to contact them
- When in doubt, REPORT!!!!

The Elder Adult at Risk Agency's Response to a Report

- A visit to the residence of the elder adult at risk
- Observation of the person, with or without consent of the guardian or POA
- An interview with the person, in private if possible
- An interview with the guardian, agent under a POA, or a caregiver



APS Response continued

- A review of the treatment and patient health care records
- A review of financial records that are maintained by a financial institution, a caregiver, or a member of the family



Role of Adult At Risk Agency

- Focus on resident/victim's immediate health, safety and welfare.
- Refer to the Office of Caregiver Quality (OCQ) misconduct incidents in a facility covered by Wisconsin's Caregiver law.
- Investigate abuse, neglect, and misappropriation (financial exploitation) by non-caregivers.



Investigation Process

Molly Gutt

Office of Caregiver Quality, Investigator

Division of Quality Assurance

After the Report

- Screened by OCQ
 - Non credentialed caregiver
- Referrals made
- Investigatory merit
 - Notices sent

OCQ Investigation Process

- Accused receives a Notice of Investigation letter
 - Facility receives a copy
- Two types of investigation
 - Field
 - Desk
- Recommendation of finding
 - Substantiated
 - Unsubstantiated

Finding

- No reasonable cause to substantiate allegation
 - Priors allegations maintained by OCO
- Reasonable cause to substantiate allegation
 - Appeal process
 - Caregiver misconduct registry
 - Rehabilitation review

Appeal of Substantiated Findings

- Caregiver may request an appeal of substantiated finding
- Appeal letter to Division of Hearing and Appeals
 - Name
 - Case Number
 - Brief recitations of reason for appeal
- Administrative Proceeding
 - Pre-hearing
 - Hearing
 - Decision
- Rebuttal Statement/Rehab Review
- Unsubstantiated findings are not open to the public

Resources

- Division of Quality Assurance (DQA)
- Office of Caregiver Quality (OCQ) (links to caregiver website, MIR)
- DHS Adult Protective Services (APS)/Local APS (DHS link to APS page)
- Ombudsman/Board on Aging and Long Term Care (BOALTC) (online complaint form, website)