BOARDING HOME GUIDEBOOK

- Prevention & Protection
- Incident Identification
- Investigation
- Reporting

PARTNERS IN PROTECTION

JULY 2011

First Edition

Washington State Department of Social & Health Services
Aging and Disability Services Administration
Division of Residential Care Services

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, the boarding home must consider other possible examples, questions, and triggers. The boarding home is responsible for the identification, protection, investigation, reporting, and prevention of abuse/neglect.

Washington State
Department of Social
& Health Services

ADSA Aging & Disability
Services Administration

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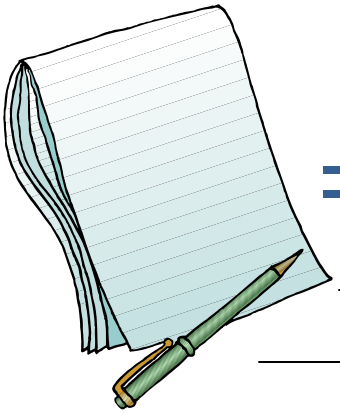

Notes

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Washington State's Long-Term Care Ombudsman Program (LTCOP)
Disability Rights Washington (DRW)
Office of the King County Prosecuting Attorney's Elder Abuse Project, Criminal Division
Office of the King County Medical Examiner
Aging Services of Washington (ASW)
Washington Health Care Association (WHCA)

ADVOCACY FOR AND DEDICATION TO RESIDENTS

Each resident who lives and receives care and services for health and safety in a licensed BH deserves our full efforts as "Partners in Protection" to protect him or her from abandonment, abuse, neglect (possible criminal mistreatment) and financial exploitation.

The Department dedicates this Guidebook to all former, current and future residents who live and receive care in licensed Boarding Homes (BHs). The Department recognizes and thanks the following parties including but not limited to residents, residents' families and other parties who, respectively, advocate for themselves, their loved ones or their clients in this licensed long-term care residential setting.

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/pages/Archaeology/documents/WAStateMedicalExaminers-Coroners.pdf

- For access to a complete archive of the Department's letters and other basic information and links to other resources for BH professionals, residents and families, advocates, interested parties, and the general public, visit: http://www.adsa.dshs.wa.gov/professional/bh.htm

- For access to the most current criminal history disclosure information from the Department of Social and Health Services Secretary's List of Crimes and Negative Actions that may be amended or updated at any time, visit: http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml and select Boarding Homes (the last bullet under Item #1)

- 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 financial exploitation, visit: http://www.adsa.dshs.wa.gov/Library/publications/brochurestext.htm#abuse_mandated

CHAPTER I
INTRODUCTION & PURPOSE

This document provides guidelines for boarding homes related to:

- Resident protection; and
- Recognizing, reporting and investigating circumstances of events/allegations of abandonment, abuse, exploitation, financial exploitation, and, neglect of vulnerable adults living in boarding homes.

The guidelines in this document are designed to assist boarding homes in meeting the requirements of Washington State's Vulnerable Adult Act, also known as chapter 74.34 RCW – Abuse of Vulnerable Adults. Boarding homes should become familiar with the guidelines in order to best identify abuse/neglect issues, protect residents, and implement plans to prevent further problems. Because the guidebook only contains limited information, it does not replace the boarding home's good judgment.

The guidebook also provides overview information to the general public about the minimum regulatory requirements of facilities to be in compliance with chapter 74.34 RCW and other selected regulatory requirements.

The Guidebook is Intended for Use Primarily by:

- Boarding home licensees, operators and their employees; and
- Department of Social and Health Services employees.

The Guidebook Includes:

- General information to be applied in determining whether abuse, neglect, mistreatment, abandonment, or financial exploitation has occurred for residents residing in boarding homes.
- The boarding home's responsibility in reporting, investigating, and taking appropriate protective, corrective and preventative measures; and
- The rights and responsibilities of mandated and permissive reporters, as defined in chapter 74.34 RCW, and any other persons reporting to the Department's Complaint Resolution Unit toll-free hotline at 1-800-562-6078.

All Boarding Homes are Required to:

- Develop and implement policies and procedures (including for the use of volunteers and students) for:
  - Resident protection;
  - Incident/event identification;
  - Actions to protect residents pending the outcome of alleged or suspected incident/event investigations;
  - Determination of circumstances surrounding the incident/event; and
  - Reporting the incidents/events as required, by both the facility designated reporter and the individual mandated reporter.

- Designate one or more responsible staff persons to do the facility's reporting required by state law. The facility's staff persons must know the names of these responsible parties.

- Ensure that both the individual mandated reporter and facility designated reporter report immediately to:
  - The Department's hotline whenever there is "reasonable cause to believe" that abandonment, abuse of any type (physical/mental/verbal/exploitation), financial exploitation or neglect has occurred to a vulnerable adult; and
  - To both the Department's hotline and to law enforcement whenever one or more staff persons witness or have "reason to suspect" that physical assault, sexual abuse, or an incident of physical assault between vulnerable adults has caused more than minor bodily injury.

- Also, ensure that mandated reporters report to law enforcement if they suspect any criminal mistreatment (neglect) of a vulnerable adult has occurred; and

- Report the death of a boarding home resident, as required, to their county Coroner/Medical Examiner by chapter 68.50 RCW – Human Remains, and chapter 74.34 RCW – Abuse of Vulnerable Adults.

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

Boarding home resource: http://www.aasa.dshs.wa.gov/professional/bh.htm

CHAPTER II
REGULATIONS RELEVANT TO RESIDENT PROTECTION

All boarding homes must be in compliance with all applicable state, county and municipal statutes (laws), and any rules, codes and ordinances written under these statutes including those that prohibit discrimination. Because laws and rules may change, the boarding home must access relevant laws and rules frequently and become familiar with these provisions.

Chapter 70.129 RCW – Long Term Care Resident Rights requires the boarding home to provide and assure protections to each resident.

RESIDENT PROTECTION – REPORTING ABUSE AND NEGLECT

State law in chapter 74.34 RCW includes definitions and provisions for required reporting to the Department's hotline (1-800-562-6078) whenever a boarding home and any of its staff persons have reasonable cause to believe that abandonment, abuse, financial exploitation or neglect of a vulnerable adult has occurred. See excerpt from RCW 74.34.035 below. Also see WAC 388-78A-2630 for details.

RCW 74.34.035 **Reports - Mandated and permissive - Contents - Confidentiality**.

(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.

Other Applicable Boarding Home Statutes/Rules

This Guidebook may refer to portions of other regulatory requirements applicable to boarding homes 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 this Guidebook Provides Hyperlinks to these Selected Regulations:

- Chapter 18.20 RCW – Boarding Homes
- Chapter 43.43 RCW – Washington State Patrol – Criminal Background Checks
- Chapter 70.129 RCW – Long-Term Care Resident Rights
- Chapter 74.34 RCW – Abuse of Vulnerable Adults
- Chapter 388-78A WAC – Boarding Home Licensing Rules
- Chapter 388-110 WAC – Contracted Residential Care Services – Including Specialized Dementia Care Program BHs

CHAPTER III
BOARDING HOME REPORTING REQUIREMENTS

24 Hour Reporting Hotline 1-800-562-6078

Every boarding home is required to: (1) protect residents; (2) identify, investigate and determine the circumstances of alleged or suspected events; and, (3) report to the Department, law enforcement, the county Coroner or Medical Examiner, and the Department of Health's appropriate disciplining authority, depending on the circumstances.

The boarding home must always use good judgment in determining the best course of action to be taken to protect their residents. Refer to Appendix D for a summary of reporting guidelines for boarding homes. Also refer to Appendix G for problem-solving procedures upon discovery of an incident/allegation.

The following is a reminder of what the boarding home must do and the order in which it should be done. Remember, that *reporting and investigation may be done at the same time*.

FIRST PRIORITY: Protect the victim/resident and other residents from harm or further harm.

SECOND PRIORITY: Perform an investigation of the incident, and report to the Department, law enforcement, and other entities as required by state law. The investigation must be thorough enough to determine the circumstances of the event.

Facilities are Required to Report to:

1. The Department's Complaint Resolution Unit's (CRU) 24 Hour Hotline:
   - The hotline number, 1-800-562-6078, is available 24 hours a day, seven days a week; the time and date of phone messages are recorded.

2. Law Enforcement:
   - In an **emergency**, dial 9-1-1 or your local emergency services number.
   - For **non-emergency** situations, use the local number specified by your law enforcement authorities. The boarding home should have this number readily available for staff. You can also locate police, sheriff and other law enforcement agencies for the state, cities and counties in Washington at: http://www.the911site.com/911pd/washington.shtml or use your local phone directory.

3. Coroner/Medical Examiner:
   - Call the number specified by your county's Coroner or Medical Examiner to report any resident death in which there may have been abuse or neglect (criminal mistreatment), even if the death otherwise appears to be due to natural causes.

- Refer to WAC 388-78A-2640(1)(c) and (4) for requirements related to death of a resident. If a boarding home facility, operator or staff person is unsure whether a resident's death should be reported to their county's Coroner or Medical Examiner – REPORT IT!
- You can locate your county's Coroner or Medical Examiner contact information at: http://www.dahp.wa.gov/pages/Archaeology/documents/WAStateMedicalExaminers-Coroners.pdf

4. Department of Health (DOH):
   - In certain circumstances, the boarding home is required to report an employee who is subject to the uniform disciplinary act, chapter 18.130 RCW, such as a nurse or nursing assistant – registered/certified, to the appropriate disciplining authority at the 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.

Method of Reporting:
By telephone.

Who Should Report for the Boarding Home:
A responsible facility investigator or a designated representative assigned to do the facility's mandated reporting.

When to Report:
- Immediately for allegations of abandonment, abuse, neglect, exploitation, and financial exploitation. Immediately means as soon as possible after discovery of the incident and as soon as the resident(s) are protected.
- No more than 24 hours after discovery of the incident for substantial injuries of unknown source.

Where to Report by Telephone:
- Dial 9-1-1 first for any life-threatening emergency. Then call the hotline number after the emergency has been handled and residents have been protected.
- The hotline number at 1-800-562-6078, unless directed otherwise.
- Call law enforcement by dialing 9-1-1 unless directed otherwise.
- Call your county Coroner or Medical Examiner when a resident dies, if it is the result of possible abuse or neglect or other reportable circumstances.
- Call the Department of Health's disciplining authority, when applicable, to report alleged unprofessional conduct or impaired functioning of licensed, registered or certified staff.

What to Report to the Department:
- All alleged incidents/events involving abandonment, abuse, exploitation, financial exploitation, and neglect or mistreatment, including injuries of unknown source.
- Substantial injuries of unknown source (not related to suspected abuse or neglect).
- When there is a reason to suspect an incident is sexual or physical assault.

- When there is reasonable cause to believe a crime, other than those listed on prior page, has occurred.
- Medication errors that are probable abuse, neglect, or negligent treatment**.**
- Refer to Appendix E for CRU Hotline questions associated with mandated reporting.

NOTE: Incidents between residents were not set apart, in the law, from other incidents for reporting to the Department so the reporting requirements above apply for resident-to-resident incidents/events.

What You May *Not* Need to Report to the Department:
You *may not* need to report to the Department *if*, before the 24-hour period is up, through the process of evaluation and determining the circumstances of an event you decide that the substantial injury is reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or a known sequence of prior events.

The facility does not need to report superficial injuries as listed below to the Department. However, the boarding home does need to investigate the circumstances of the incident and assure that there is documentation and retention of evidence of its investigative actions, findings, and implementation of appropriate measures, if needed.

- Superficial injuries of unknown source (not incidents of suspected abuse or neglect).
- Superficial injuries determined by a process of evaluation to be reasonably related to the resident's condition, diagnoses, known and predictable interactions with surroundings, or known sequence of prior events.

What to Report to Law Enforcement:

- When there is a reason to suspect an incident is sexual assault.
- When there is reason to suspect an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.
- An incident of physical assault between vulnerable adults that 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 vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.
- An incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.
- When there is reasonable cause to believe a crime, other than assault, has occurred.

What to Report to County Coroner or Medical Examiner:

- A facility must report the death of a resident living in a boarding home 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 DOH's Disciplining Authority for License Holders:

- The boarding home must report to the DOH, any employee/staff person who is a licensed nurse or other professional, or a nursing assistant – registered/certified, who is under the disciplinary authority of the DOH, and, for whom there are allegations of abandonment, abuse, neglect, or financial exploitation.

CHAPTER IV
THE INVESTIGATION PROCESS

QUALITY, not quantity, is the most important feature of any investigation.

All alleged or suspected incidents of abandonment, abuse, neglect, exploitation, financial exploitation or mistreatment including injuries of unknown source must be thoroughly investigated. See WAC 388-78A-2700(2)(c) for details. Refer to Appendix F to review the boarding home responsibility table.

Protecting the Resident from Further Harm:

- Protecting the resident from further harm means keeping the resident safe. Each situation of resident protection will be different. The boarding home must evaluate each resident when any observed or reported accident or incident is likely to adversely affect the resident's well-being.
- Each boarding home and its staff persons must take the actions that best assure resident protection, given each specific event/incident under review and investigation.
- Examples of actions that might be implemented include but are not limited to:
  - You should dial 9-1-1 when the resident: (1) Has an acute/serious, life-threatening medical condition or complaint; (2) Is medically unstable; or, (3) Has an immediate health risk.
  - Ensuring that **any** suspected or accused staff person does not have unsupervised access to **any** resident until the BH investigates and takes action to ensure resident safety, per WAC 388-78A-2450(3)(a) – Staff;
  - Having a trusted person stay with the resident;
  - Allowing the resident to stay in an area he/she feels is safe, such as day room areas (solarium, recreation room, living or dining rooms) or a wellness center; and/or
  - Safeguarding the resident's property.

Thoroughness of Investigative Actions:
The boarding home must investigate to determine, as far as possible, the circumstances of any event, incident or accident that is alleged or suspected to have occurred to one or more residents receiving care and services in the boarding home.

A thorough investigation is a systematic collection, review, evaluation and documentation of evidence, information and findings that describe and explain an event or a series of events. The boarding home must do a thorough investigation to determine if abandonment, abuse, neglect, financial exploitation, or an accident jeopardizing or affecting a resident's health or safety occurred.

If the facility's investigative actions and subsequent findings substantiate or verify that the alleged or suspected event, incident or accident occurred, the boarding home must institute and document appropriate measures taken to prevent similar future situations for the residents.

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 Boarding Home and Its Staff Persons Must Also Immediately:

- Protect other residents during the course of an investigation;
- Take any action necessary to treat the ill effects experienced by the resident as a result of the alleged or suspected event, incident, or, accident; and
- Document any necessary measures to be taken to prevent similar future situations if the alleged incident is substantiated.

Objectivity of the Investigator:
The investigator of any event/incident must be objective and neutral during the course of the facility's investigation. The investigator must (1) not allow personal feelings to influence the investigation, and (2) base decisions on the facts not assumptions. Facility Investigators must:

- Begin with a "ruling out" of the fact that abandonment, abuse, neglect, mistreatment, or financial exploitation could have occurred; and
- Not begin with a presumption of guilt or innocence of an individual.

The investigator must look at the incident/event fairly and without bias. The investigator must collect as much accurate data as needed to be able to reach a reasonable conclusion.

Timeliness of the Investigation:
The facility must begin the investigation as soon as possible after the discovery of the incident, to collect accurate data related to the alleged or suspected incident/event, including injuries of unknown source. Any delay in starting the investigation can cause valuable information or physical evidence to be lost, altered or contaminated. Remember that reporting and investigative activities may be able to be done at the same time.

Evidence of Thoroughness of the Investigation:
In order to provide evidence of the thoroughness of the investigation, the boarding home must document investigative actions and findings for any alleged or suspected neglect or abuse or exploitation, accident or incident jeopardizing or affecting a resident's health or life.

A thorough investigation may, but does not always, require two phases of fact gathering:

- The first phase of investigation must be completed within 24 hours of knowledge of the incident, and begun, if possible, as soon as the event is identified and the alleged victims are protected.
- If the first phase of investigation is not successful in determining a reasonable cause, an extended or second phase must follow.

Each 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(s). It should also give the boarding home enough information to substantiate/validate the allegations, if appropriate. The amount of documentary

evidence, and time and resources necessary for an investigation will vary depending upon the nature of the allegation or event.

Two Steps to Each Phase of a Thorough Investigation:

1. Data collection; and
2. Data analysis.

Data Collection: The "WHO/WHAT/WHEN/WHERE" of the Incident:
The boarding home should review the following questions to determine which may apply to the particular incident/event to be investigated. Because these examples do not include everything, you may need to add other questions that specifically relate to the alleged or suspected event/incident under investigation. In addition, you do not need to use all of the questions, therefore select only those questions that relate to the specific incident/event.

WHO:

- Who witnessed the alleged or suspected incident/event?
- Who is (are) the alleged suspect(s) or who may have contributed to the occurrence of the incident/event?
- Who is (are) the alleged victim(s)?
- Who spoke to the alleged victim(s) regarding the incident/event?
- Who else may have information related to the incident/event?

WHAT:

- What is the alleged or suspected incident/event?
- What is the chronological order of action leading up to alleged/suspected incident?
- What are the injuries?
- What information does/do the alleged victim(s) have regarding the incident/event?
- What did the discovering staff person(s) or witness(es) see, hear or smell?
- What did these staff persons/witnesses do in relation to first discovering the incident/event?
- What information do other staff members have of the incident(s) or factor(s) leading up to the incident/event?
- What was the functional, mental and cognitive status of the alleged victim(s) before and after the incident/event?
- What is known about the alleged suspect(s) or person(s) who may have contributed to the occurrence of the incident/event?
- What was happening to the alleged victim(s) just prior to the incident/event?
- What were the victim(s) and alleged perpetrator(s) doing at the time of the incident?
- What precipitating factors were identified?

- What did the physical environment, where the incident occurred, look like? Were there any spills or tripping hazards? Were any medical devices being used, such as, physical restraints, personal alarms, use of medical oxygen?

WHEN:

- When was the suspected or alleged incident/event discovered? By whom?
- When did the suspected or alleged incident/event occur? (Be as specific as possible related to time of day or night)

WHERE:

- Where did the suspected or alleged incident/event 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 suspected or alleged incident/event or injury occur?
- How was this suspected or alleged incident/event or injury avoidable? (Were there factors that made this incident/event or injury unavoidable?)
- Why did the suspected or alleged incident/event or injury 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 (During the First 24 Hours)
For Phase One initial investigative actions, consider only the elements that are appropriate to the circumstances surrounding the alleged or witnessed event/incident. Because the following list does not include everything, you may need to add other relevant elements to your investigative plan.

- Interview the alleged or suspected resident victim.
- Interview witnesses, including but not necessarily limited to:
- Assigned caregiver or staff persons;
  - Caregiver or staff persons in immediate area;
  - Caregiver or staff persons from work period(s) prior to the incident/event discovery**;**
  - Remote or potential witnesses, such as visitors, family, roommates; and
  - Alleged perpetrator.
- Review the resident victim's medical conditions.
- Review the resident victim's normal interactions with the environment.
- Observe environment where incident/event was likely to have occurred.
- Assess current cognitive status of alleged or suspected resident victim.
- Physical exam.
- Diagnostic work, if needed.
- Comprehensive review of the active records of the resident victim and others as appropriate. Refer to WAC 388-78A-2140 – Negotiated Service Agreement Contents and WAC 388-78A-2410 – Content of Resident Records.

Depending on the nature of the incident/event to be investigated, a comprehensive review may include, but is not limited to, the following elements:

- **Key Identifying Information:**
  - Contact information for others, such as, primary health care provider, resident's representative (if one) and individual to contact in case of emergency, illness or death;
  - Individual notified of significant change in resident's condition with date and time of notification;
  - Written acknowledgement of receipt of required information, such as, facility's rules and regulations governing resident conduct and responsibilities and resident rights information per RCW 70.129.030 – Notice of Rights and Services;
  - Assessment and reassessment information;
  - Clinical information such as admission weight, blood pressure and other laboratory tests required by the negotiated service agreement;
  - Negotiated service agreements; [WAC 388-78A-2140]
  - Plan for appropriate behavioral interventions, if needed; [WAC 388-78A-2140]
  - Ability of resident to leave the facility's premises unsupervised; [WAC 388-78A-2140]
  - Communication plan, if special communication needs are present; [WAC 388-78A-2140]
  - Orders for medications, treatments and modified/therapeutic diets, including any directions for resident's refusal related to these orders;
  - Medical and nursing services provided by the boarding home for resident;
  - Documentation consistent with WAC 388-78A-2120 – Monitoring Resident Well-Being, including staff interventions or responses related to such monitoring, and, any modifications made to the resident's negotiated service agreement;
  - Disclosure, transfer, and discharge notice requirements as specified in RCW 70.129.110 – Long-Term Care Resident Rights and in WAC 388-78A-2710 – Disclosure of Services;
  - When available, copies of any resident-related legal documents, such as, court established guardianship, advance directive or living will, durable power of attorney for health care or finances, or both; and
  - History of similar incidents/events, accidents or injuries of unknown source involving either the resident victim or alleged staff persons involved, or both.
  - See "Preservation of Evidence" on page 15.

Phase One of the INITIAL Investigation Should Enable the Individual Responsible for the Facility Investigation to:

- Answer "who, what, when, where, why, and how";
- Record the "who, what, when, where, why, and how" information; and
- Establish a reasonable cause or known source of the incident/event or injury within 24 hours of the incident/event or injury.

If the facility's assigned investigator is unable to establish a reasonable cause or known source, then further investigation is required.

When the Boarding Home May Not Need to Complete the Investigation:
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 investigative elements**.**

When Additional Reporting May be Necessary:
If during any phase of investigative activities, the facility's designated investigator has a reason to suspect abuse or neglect, they must immediately report to the Department any: (1) Circumstances when the death of a resident should be called to the county's Coroner or Medical Examiner, and, (2) Events that require your additional and timely reporting to law enforcement.

PHASE TWO: EXTENDED INVESTIGATION (After the First 24 Hours)
Further investigation to gather additional information is required if Phase One of the facility's initial investigation did not establish reasonable cause or source of alleged or suspected incident/event or injury of unknown source within 24 hours.

The following Phase Two elements may need to be included and considered:

- Interview an expanded sample of witnesses, historians;
- Expand the time frame surrounding the incident/event/injury for collecting data;
- Follow-up on new information;
- Obtain related professional expertise; and
- If the suspected perpetrator is a staff person, interview other residents the named staff person was in contact with or assigned to work with.

Phase Two of the extended investigation should allow the facility 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 must be reported to the Department as "unknown".

Refer to Chapter III – Facility Reporting Requirements, pages 5-8. See also Appendix B page 32 and Appendix C page 33 (Algorithms for Abuse and Neglect).

Actions Required Following the Investigation:
The boarding home is required to document its Phase One (initial), and, if applicable Phase Two (extended), investigative actions and findings for any alleged or suspected neglect or abuse or exploitation or incident/event jeopardizing or affecting a resident's health or life. When necessary, the boarding home is also required to institute and document appropriate measures to prevent similar future situations whenever the alleged or suspected incident/event is substantiated.

Evidence of Investigation – Initial and Extended Phases:
The boarding home must maintain a systematic and secure method of identifying and filing resident records for easy access. The boarding home may have a variety of source

documents that record the required evidence of the facility's initial or extended phases of investigation, or both.

The boarding home must protect and retain resident records as required by law, rule and Medicaid contract, if applicable. These records include but are not limited to maintaining documentation of evidence and findings of the facility's investigations of alleged or suspected incidents/events and accidents, including injuries of unknown source, whether the evidence/documentation is maintained in the resident's active, inactive or closed record.

Evidence of the boarding home's investigative actions and findings must be readily available to authorized representatives of the Department and other parties as authorized by law. 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/event or accident, including injuries of unknown source.

Preservation of Evidence:
The first step of proper evidence collection is thorough documentation recorded as soon as possible. Identification, protection, collection, preservation and security of relevant evidence identified during the course of the boarding home'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 on the article of evidence when appropriate, such as on the back of a picture or on the individually packaged and sealed bag of evidence.

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: laboratory test results, monitoring notes, negotiated service agreements, staff attendance records, names of emergency services responders to the scene and other such written evidence.

3. **Physical evidence**: If law enforcement will be arriving on the scene, 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, physical evidence should be photographed, then secured and preserved from contamination until law enforcement can take custody of it. Examples of physical evidence include but are not limited to: weapons, the resident's body, care supplies and equipment, clothing, linen, medication or other items at the scene.

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 boarding home must establish their own internal policies and procedures to guide their investigators 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 abandonment, abuse, exploitation, financial exploitation, neglect, or mistreatment, including 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;
- Where in the facility to find supplies for the collection of physical evidence, such as, plastic or paper bags, zip lock bags, marking pens, and, labels/seals;
- How to protect the integrity of physical evidence – such as, packaging each item individually; not permitting pieces of evidence collected from different individuals to come in contact with or placed on the same surface as each other preventing the accidental transfer of evidence; and proper handling of wet/damp pieces of evidence;
- How to maintain a documented chain of custody for physical evidence; and
- How to properly transfer evidence from one person or location to another, such as from the facility to law enforcement.

CHAPTER V
INDIVIDUAL MANDATED REPORTING REQUIREMENTS

24 Hour Reporting Hotline 1-800-562-6078

State law at chapter 74.34 RCW contains the individual mandated reporter requirements. Please note that the individual mandated reporting requirement does not take the place of the facility's separate mandated reporting required in Chapter IV.

Mandated reporter, according to RCW 74.34.020(11), includes but is not limited to an employee of the Department; an employee of a facility; and an operator of a facility, for the purpose of reporting alleged or suspected incidents of abandonment, abuse, exploitation, financial exploitation, neglect, or mistreatment, including injuries of unknown source.

The Person Mandated to Report is:

- Any boarding home staff person who observes the incident/event or hears the resident/victim state it happened.
- Any boarding home staff person who hears about an incident from a permissive reporter who has direct knowledge of the incident/event.

The Person Not Mandated to Report is:

- The boarding home staff person who hears about the incident/event from a mandated reporter and who believes that the report has been made.

Where to Report:

1. The Department's 24 Hour Hotline:
   - The Department's Complaint Resolution Unit's (CRU) Hotline number is 1-800-562-6078. This Hotline is available 24 hours a day, seven days a week, and the time and date of phone messages are recorded.

2. Law Enforcement:
   - In an emergency, dial 9-1-1 or your local emergency services number.
   - For non-emergency situations, use the local number specified by your law enforcement authorities.

3. Coroner/Medical Examiner:
   - If circumstances surrounding a resident's death may or do come under the jurisdiction of the Coroner or Medical Examiner, due to the possible presence of abuse or neglect or other reportable circumstances, call your county's Coroner or Medical Examiner's office to immediately and accurately report this death, even if the death otherwise appears to be due to natural causes. When in doubt, REPORT IT.

4. State Department of Health:
   - In certain circumstances, an individual mandated reporter is required to report another license holder or a nursing assistant – registered/certified to the

appropriate disciplining authority at the DOH, Health Professions Quality Assurance Division. Report to the disciplining authority as soon as possible. Contact DOH's Office of Customer Service at (360) 236-4700 or via the Internet at http://www.doh.wa.gov/hsqa/Complaint.htm

When to Make a Report to the Department:

- When an individual mandated reporter has reason to suspect an incident is sexual or physical abuse, he/she must report as soon as the resident/victim is protected from further harm.
- When a mandated reporter has reasonable cause to believe an incident is abandonment, abuse, neglect (negligent treatment), exploitation, or financial exploitation, the report must be made immediately. This would include medication errors that you believe are a result of probable abuse, neglect or negligent treatment.

As an individual mandated reporter, if you report in good faith, you cannot be held liable for any damages resulting from reporting.

What to Report to the Department:

Individual mandated reporters must immediately report to the Department's CRU Hotline:

- When there is a reasonable cause to believe an event/incident is abuse, abandonment, neglect, or financial exploitation.
  - Reasonable cause to believe has been defined as "a belief that the incident probably happened" based upon personal observation of the resident/victim, records, other people and various other sources of relevant information. (See the definition of "reasonable cause to believe" in Appendix A.)
- When there is a reason to suspect an incident is sexual or physical assault.
  - Reason to suspect has also been defined as "a belief that the incident could have happened" based upon observations and other sources of information. (See the definition of "reason to suspect" in Appendix A.)
  - Sexual assault includes, but is not limited to, unwanted inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, sexual harassment, and sexual relations between a resident and a staff person.
  - Physical assault includes the attempt to injure another person, unlawfully touching another person, physical assault or action that causes fear of harm in another person, including an incident between vulnerable adults that caused more than minor bodily injury. NOTE: An incidental push or gentle contact may not be assault unless the person intended to do harm or create fear.
- When there is reasonable cause to believe a crime, other than assault, has occurred.
- Medication errors that are probable abuse, neglect, or negligent treatment.

NOTE: Incidents between residents were not set apart, in the law, from other incidents for reporting to the Department so the reporting requirements above apply for resident to resident incidents/events.

What to Report to Law Enforcement:

Individual mandated reporters must immediately report to law enforcement when there is:

- A reason to suspect an incident is sexual assault.

- A reason to suspect an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.
- An incident of physical assault between vulnerable adults (resident to resident) that 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 vulnerable adults or involving the same vulnerable adults; or there is an attempt to choke a vulnerable adult.
- An incident of physical assault between vulnerable adults (resident to resident) that caused minor bodily injury and did not require more than basic first aid, when requested by the injured vulnerable adult or his or her legal representative or family member.
- Reasonable cause to believe a crime, other than assault, has occurred.

What to Report to County Coroner or Medical Examiner:
A mandated reporter must timely and accurately report the death of a resident living in a boarding home 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, the county Coroner or Medical Examiner is responsible for investigating the cause and manner of death to decide the most appropriate death certification for that resident. See the following for examples:

- The death is due to a contagious or suspected contagious disease that may represent a public hazard, such as, a sudden illness with a high fever or rash right before death;
- The death apparently resulted from drowning, hanging, exposure, strangulation, starvation, alcoholism, suffocation or smothering; or,
- The death occurred within a year after resident suffered burns or was in an accident resulting in physical injury.

What to Report to DOH's Disciplining Authority:

- If you believe that unprofessional conduct or impaired practice may exist by any person subject to the uniform disciplinary act, chapter 18.130 RCW, you are required to make a timely report to the appropriate disciplining authority in the Health Systems Quality Assurance Division. You can reach their Office of Customer Service at (360) 236-4700 or via the Internet at http://www.doh.wa.gov/hsqa/Complaint.htm

Information to be Included in a Mandated Reporter's Report:
RCW 74.34.035(8) requires that each report, oral or written, 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, financial exploitation, neglect or self-neglect;
- Any history of previous abandonment, abuse, 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, exploitation, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult.

Information about Confidentiality and Immunity for a Mandated Reporter:

- The identity of the person making a mandated report is kept confidential unless that person consents or there is a judicial proceeding as provided in RCW 74.34.035(9).
- A person making a mandated report in good faith or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding is immune from liability resulting from the report or testimony. [RCW 74.34.050(1)]
- The identity of the person making a mandated report will not be kept confidential when the Department determines that the report or complaint was not made in good faith. [RCW 74.34.180(1)]

Failure to Make a Mandated Report (Non-Reporting):

- An individual mandated reporter who is required to make a report under RCW 74.34.053(1) and who knowingly fails to make the report is guilty of a gross misdemeanor.
- Failure to report resident abuse or neglect is a crime and may be prosecuted.
- Licensing action may be taken by the appropriate professional disciplining authority based upon failure to report, by those professionals, of incidents of suspected abuse or neglect.

False Reporting:

- A person who intentionally, maliciously, or in bad faith makes a false report of alleged abandonment, abuse, financial exploitation or neglect of a vulnerable adult is guilty of a misdemeanor. [RCW 74.34.053(2)]
- The identity of the person making a mandated report will not be kept confidential when the Department determines that the report or complaint was not made in good faith. [RCW 74.34.180(1)]

Reporting an Event/Incident to a Supervisor:

- Remember that for the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual abuse and physical abuse, the person mandated to report to the Department is:
  - Any boarding home staff person who observes the incident or hears the victim state it happened.
  - Any boarding home staff person who hears about an incident from a permissive reporter who has direct knowledge of the incident.
- Your reporting obligation under the law is NOT met if you ONLY report to your supervisor. The law states that each facility employee is a mandated reporter. Therefore, you must make the reporting call when you have reasonable cause to believe or reason to suspect the incident/event is reportable. To protect the resident/victim from further harm, a facility should have policies and procedures in place that direct staff to notify the responsible parties in the facility. A boarding home's procedures should tell you what you are to do if the person responsible for the alleged or suspected incident is the person to whom you usually report.

- However, the staff person may need to consult with their supervisor to assist in making the determination if there is a reasonable cause to believe or a reason to suspect the incident/event is reportable.

Reporting to a Supervisor Prior to Making the Required Reporting Call:
A mandated reported cannot be required to inform the supervisor before reporting the incident/event to the appropriate authorities. See the following for some explanation of this issue:

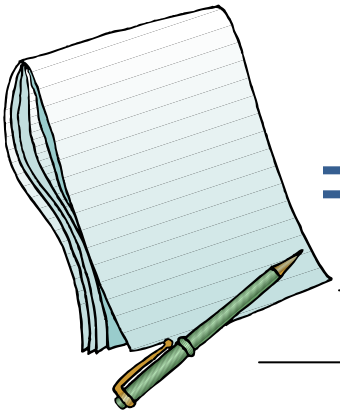
- No facility may develop policies or procedures that interfere with mandated reporting per RCW 74.34.035(7). Each and every mandated reporter must be allowed to report as required before reporting to the supervisor.

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. [RCW 74.34.180(3)]
- However, a mandated reporter may be terminated, suspended, or disciplined by the employer for other lawful purposes. This could include, but is not limited to, when a facility exercises its authority to terminate, suspend, or discipline any employee who engages in workplace reprisal or retaliatory action against a whistleblower. [RCW 74.34.180(4)]

Resident Discharge
When a resident (or others unassociated with the facility) makes a complaint on behalf of another resident or on behalf of him or herself:

- As long as the Department has substantiated the complaint, neither the resident making the complaint, nor the resident who is the subject of the complaint, may be discharged from the facility.
- An action, by the facility, to discharge a resident who makes a complaint or who was the subject of a complaint, substantiated by the Department within one year from the date a complaint was made, is presumed to be a retaliatory discharge and prohibited by law.
- The presumption that the discharge was motivated by the complaint may be disproved, and a discharge may therefore be permitted, by showing that the increased needs of the resident cannot be met by the reasonable accommodation of the facility or that the discharge action was begun prior to the complaint having been filed. [RCW 74.34.180(2)]
- In addition to the mandated reporter requirements related to resident transfer or discharge, boarding home facilities must continue to meet state law related to resident discharge and not discharge a resident unless those requirements are met.
- Refer to RCW 70.129.110 – Disclosure, Transfer and Discharge Requirements, WAC 388-78A-2050 – Resident Characteristics, and, WAC 388-78A-2710 – Disclosure of Services, for specific requirements for all licensed boarding homes.



Notes

APPENDIX A
DEFINITIONS

The following are definitions of the most frequently used words related to abuse, neglect, and financial exploitation identification, reporting, and investigation in boarding homes. Various guidelines and comments are included. This chapter also contains both legal references and state guidelines. See **Appendix H** for 'Key Triggers' to assist you in identifying abuse, neglect, and financial exploitation.

Definitions	Guidelines & Comments
"ABANDONMENT" as defined in RCW 74.34.020(1) means 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. (excerpt)** (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 provider or employee 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(2) 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.	In general, you must assume that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a boarding home client/resident. This means that instances of abuse of any resident (whether comatose, aware, or not) cause physical harm, pain, or mental anguish.

Definitions	Guidelines & Comments
"ABUSE" (Cont.) A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings: See the definition of "willful".	Emergency or short-term monitored separation from other residents/clients 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. The term ***willful*** per WAC 388-78A-2020 "means the deliberate, or non-accidental, action or inaction by an alleged perpetrator that he/she knows or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish" to a boarding home's resident or client. The term ***"willful"*** does ***not*** mean that an individual or staff person intended to cause harm, pain, anguish, or injury to a client or resident. **Willful inaction may include**, **but is not limited to:** a boarding home staff person's refusal to provide the necessary care and required services, or, intentional deprivation of a resident/client, or both.
"ABUSE - 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.	Compromised mental or physical capacity may make a resident/client more susceptible to deception, undue influence or pressure. This includes those residents who are incapable of perception or who are unable to express themselves. 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.
"ABUSE - MENTAL" as defined in RCW 74.34.020(2)(c) means any willful action or inaction of mental or verbal abuse. 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, purposely withholding cigarettes or some form of entertainment, or something that is rightfully the resident's, or placing any unreasonable restrictions on the resident or client's mobility, or, on their ability to communicate with other persons, either verbally or in writing.

Definitions	Guidelines & Comments
"ABUSE – MENTAL" (Cont.)	**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, such as 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, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately. Assault is a crime and requires intent to cause harm. **See also Appendix B for Abuse Definition Diagram (page 32).	**Physical Abuse** includes the use of restraints including chemical restraints, unless the restraint is consistent with boarding home licensing requirements, per WAC 388-78A-2090(6)(e) – Full Assessment Topics and other applicable regulations. **NOTE:** Physical contact with a resident for the purpose of retaliating constitutes abuse. Such contact is physical abuse even if this contact is in response to a physical attack or verbal abuse from a client or resident. Such abuse is never justifiable. As used in these guidelines, an assault is always abuse, but some abusive actions may not amount to an assault.
"ABUSE - SEXUAL" as defined in RCW 74.34.020(2)(a) means any form of non-consensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact 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 service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.	Sexual abuse includes any unwanted sexual contact and can range from sexual exhibition to rape. Be alert to a pattern of potential "grooming" behaviors or activities being directed towards a particular resident. "Grooming" is a process of manipulation intended to reduce a victim's resistance to sexual abuse. In instances of sexual 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. Sexual contact may include interactions that do not involve touching. Refer back to Preservation of Evidence (page 15).

Definitions	Guidelines & Comments
"ACCIDENT" – As referenced in this Guidebook, an accident means an "unexpected, unintended event that can cause a resident bodily injury."	**Foreseeable incidents/events are NOT accidents.** Various licensing rules provide guidance to boarding home 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.
"BODILY HARM" as defined in RCW 9A.04.110(4)(a) means physical pain or injury, illness or an impairment of physical condition. **NOTE:** Chapter 9A.04 RCW is known as the Washington Criminal Code.	**Per** RCW 9A.04.110(4): (b) "Substantial bodily harm" means bodily injury which involves a temporary but substantial disfigurement, or which causes a temporary but substantial loss or impairment of the function of any bodily part or organ, or which causes a fracture of any bodily part; (c) "Great bodily harm" means bodily injury which creates a probability of death, or which causes significant serious permanent disfigurement, or which causes a significant permanent loss or impairment of the function of any bodily part or organ.
"FINANCIAL EXPLOITATION" as defined in RCW 74.34.020(6)(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,	**Others may financially exploit a resident for personal gain or profit by breach of fiduciary duty, deception, intimidation, or undue influence.** Financial exploitation acts may include but are not limited to: • Scams – "stranger" and "sweetheart" • Identity theft (RCW 9.35.020) • Theft by taking/deception/embezzlement (RCW 9A.56.030-050) • Undue influence, coercion and fraud; • Abuse of trust: powers of attorney or legal guardianships

Definitions	Guidelines & Comments
"FINANCIAL EXPLOITATION" (Cont.) 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.	**Intentionally left blank**
"INCIDENT" as referenced in this Guidebook, an incident/event means: • An occurrence or event involving a resident in which mistreatment, neglect, abuse, or financial exploitation is alleged or suspected; or • A substantial injury of unknown source, or cause, or circumstance.	All boarding homes must determine the circumstances of all events or incidents and accidents as well as any alleged or suspected neglect or abuse or exploitation jeopardizing or affecting a resident's health or life. There are other facility reporting requirements, depending on the nature and circumstances determined to be associated with incidents, events, accidents, or, abuse and neglect allegations. The purpose for adding this definition of "incident" to these guidelines is to assist in identifying when a boarding home must determine the circumstances of an event and document their investigative actions, findings, and the appropriate measures taken to mitigate against resident injury, if such incidents or allegations are substantiated. All investigations must attempt to determine if such injury results from abuse or neglect. However, it may not always be possible to determine the cause of an incident/event or accident. Not all occurrences that happen to facility residents are events or incidents that require investigation. 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 a process of evaluation or assessment to assist in preventing reoccurrence.

Definitions	Guidelines & Comments
"INCIDENT" (Cont.)	An allegation is a statement or gesture made by someone (regardless of capacity or decision-making ability) that indicates abuse, neglect, or financial exploitation may have occurred.
"INJURIES OF UNKNOWN SOURCE" means any injury sustained by a boarding home resident where the source of the injury was: • Not observed directly by a staff person; or • Not identified through the process of assessment for 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 or client's condition, diagnosis, known and predictable interactions with surroundings or related to a known sequence of prior events. **NOTE:** Injuries of unknown source may be either **superficial** or **substantial** in nature.	It is not always possible to determine the cause of an injury. **SUPERFICIAL INJURIES** of unknown source includes injuries limited to: the surface layers of the skin, easily treated with first aid, not requiring a licensed practitioner's orders for treatment (such as sutures or diagnostic x-rays), and, *are* 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 causes and appropriate measures to prevent similar future situations. Such assessment documentation, whenever applicable, must be in the resident's active record. **SUBSTANTIAL INJURIES** of unknown source includes 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 include injuries occurring in areas *not* generally vulnerable to trauma. **NOTE:** ALL substantial injuries of unknown source must be thoroughly investigated. ALL injuries (regardless of the extent) occurring in non-vulnerable areas will be considered substantial injuries.

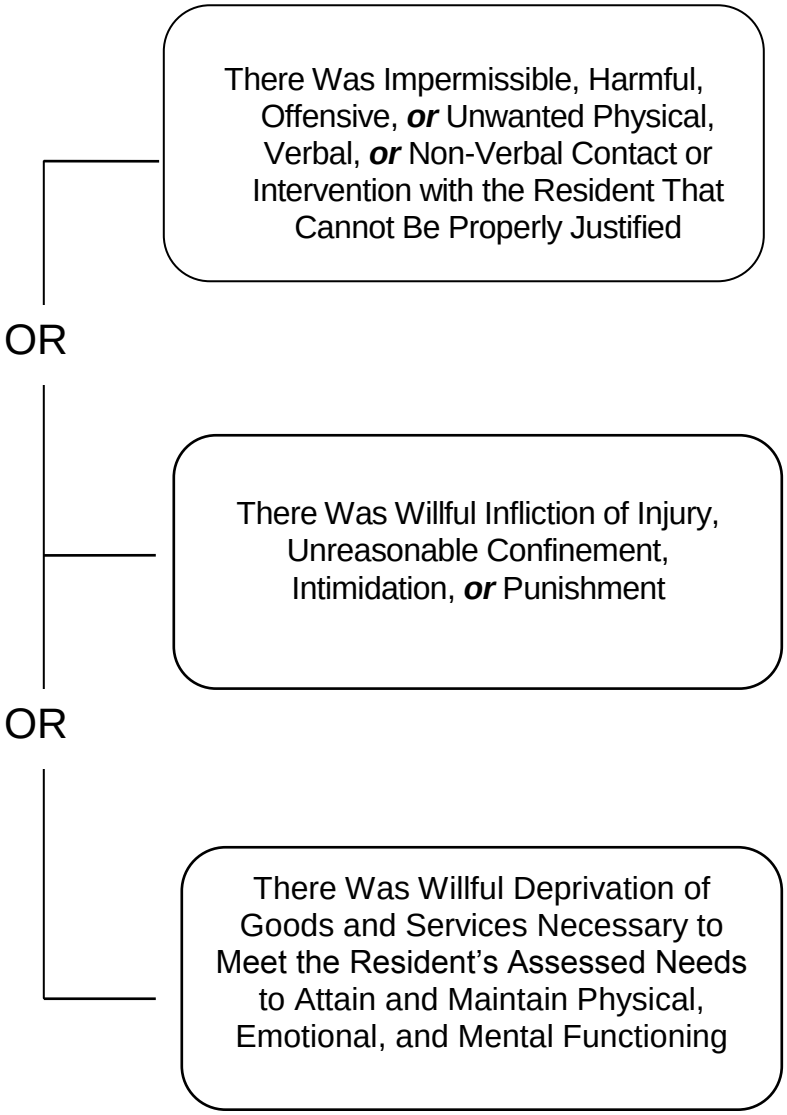
Definitions	Guidelines & Comments
"MANDATED REPORTER" as defined in RCW 74.34.020(11) includes but is not limited to, an employee of a facility; and an operator of a facility…	For the purpose of the definition of **mandated reporter**: **"Facility"** includes but is not limited to a residence licensed or required to be licensed under chapter 18.20 RCW (boarding homes)… Therefore, ***any*** licensee, manager, employee, and contractor associated with a licensed boarding home in Washington state is an individual mandated to report abandonment, mental/verbal abuse, physical abuse, sexual abuse, neglect, exploitation, and, financial exploitation of any vulnerable adult.
"NEGLECT" as defined in RCW 74.34.020(12) 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. In certain cases, neglect may be the crime of criminal mistreatment per RCW 9A.42.020-037.	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. *The definition of neglect does not include the element of intent to do harm by a provider or staff person*. In other words, neglect may occur even if the provider or staff person did not intend to cause harm. Based on the definition of neglect, neglect can be determined when it is more probable, or likely, than not that harm potentially could have or actually did happen to one or more residents because care and services were not provided. **NOTE*:*** Neglect can be an investigative action finding even if no apparent negative outcome has occurred, but the likelihood for deterioration of the resident's physical, mental or emotional conditions exists. Investigative actions by the boarding home must consider the likelihood for negative outcome(s) for each resident involved in an event or incident, or, the subject of an allegation. As referenced in RCW 74.34.020(12)(b), RCW 9A.42.100 explains the felony crime of Endangerment with a Controlled Substance (Methamphetamine).

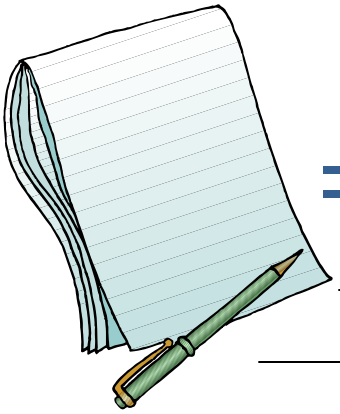
Definitions	Guidelines & Comments
"NEGLECT" (Cont.)	For example, one staff who fails to administer a resident's 4 PM heart and lung medications has failed to provide goods. During an investigation, the facility would need to fully consider the resident's medical conditions *before* a final determination could be made if this one time omission "likely" could or did result in harm to the client or resident. "Serious disregard of consequences" means that the facility or individual actually had knowledge, or should have known (based on training or educational background), that the act committed or omitted was a clear and present danger to the resident's health, welfare, or safety; or that the act was committed or omitted with reckless disregard of its clearly dangerous consequences. **NOTE:** Neglect does not include failure to provide treatment or service that a resident has refused, with knowledge and understanding of the results of the refusal.
"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.	Based on federal law and Washington state law, all state and local staff and volunteers associated with the Long-Term Care Ombudsman's Office are permissive reporters.
"REASONABLE CAUSE TO BELIEVE" as referenced in RCW 74.34.035 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; ▪ Resident records – active, inactive, or closed; ▪ Other persons who may have relevant information; ▪ Resident behavior; ▪ Other relevant information. A mandated reporter may rely upon one or more of the above sources.	**Intentionally left blank**

Definitions	Guidelines & Comments
"REASON TO SUSPECT" as referenced in RCW 74.34.035 means a mandated reporter thinks, based on information readily obtained from various sources, it is **possible** that an incident of sexual or physical assault could have happened. **Sources of information may include:** • Personal observation of the incident; • The resident who is subject of incident; • Resident records – active, inactive, or closed; • Other persons who may have relevant information; • Resident behavior; and • Other relevant information.	RCW 74.34.035 requires a mandated reporter to: **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. **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 or there is reasonable cause to believe that an act has caused fear of imminent harm. • An incident of physical assault between vulnerable adults that 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. • A fracture. • A pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults. • An attempt to choke a vulnerable adult. • When requested by the injured vulnerable adult or his/her family member or legal representative, an incident of physical assault between vulnerable adults that caused minor bodily injury and did not require more than basic first aid.
"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 known characteristics of BH residents 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 boarding home's environment and premises.

Definitions	Guidelines & Comments
"VULNERABLE ADULT" as defined in RCW 74.34.020(16) (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; • Receiving services from an individual provider under RCW 74.34.020; or • Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.	RCW 74.34.005 **– Findings** The legislature finds and declares that: (1) Some adults are vulnerable and may be subjected to abuse, neglect, financial exploitation, or abandonment by a family member, care provider, or other person who has a relationship with the vulnerable adult; (2) A vulnerable adult may be home bound or otherwise unable to represent himself or herself in court or to retain legal counsel in order to obtain the relief available under this chapter or other protections offered through the courts; (3) A vulnerable adult may lack the ability to perform or obtain those services necessary to maintain his or her well-being because he or she lacks the capacity for consent; (4) A vulnerable adult may have health problems that place him or her in a dependent position; (5) The department and appropriate agencies must be prepared to receive reports of abandonment, abuse, financial exploitation, or neglect of vulnerable adults; (6) The department must provide protective services in the least restrictive environment appropriate and available to the vulnerable adult.
"WILLFUL", as defined in WAC 388-78A-2020, means, the deliberate or non-accidental action or inaction by an alleged perpetrator that he/she knows or reasonably should have known could cause a negative outcome, including harm, injury, pain, or anguish.	**The definition of "willful" does not mean there must be or had to have been an element of intent by a provider or caregiver associated with the deliberate or non-accidental action or inaction that resulted in one or more negative outcomes to resident(s).**

APPENDIX B
DEFINITION DIAGRAM – ABUSE



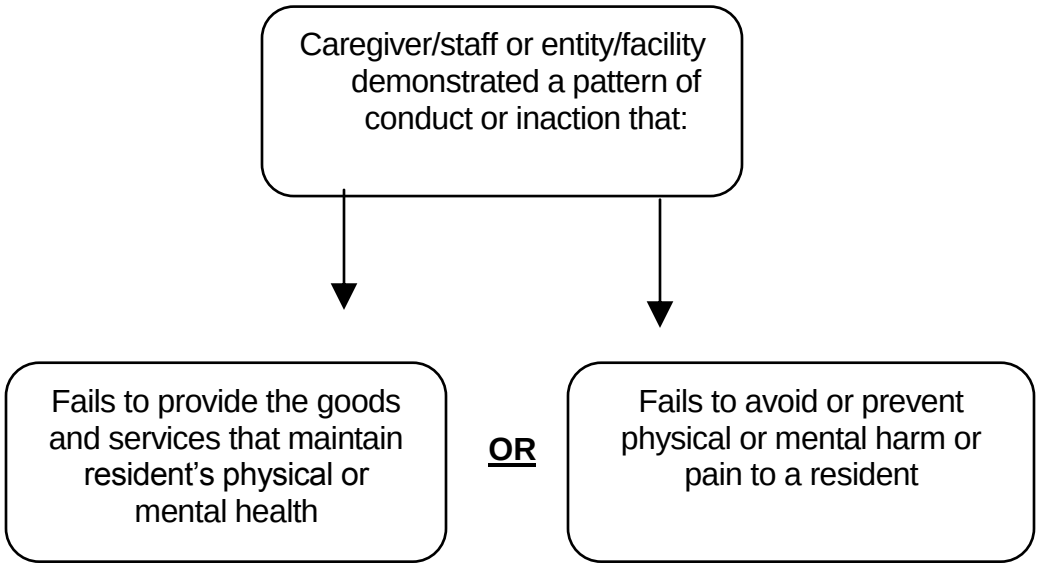


Notes

APPENDIX C
DEFINITION DIAGRAM – NEGLECT

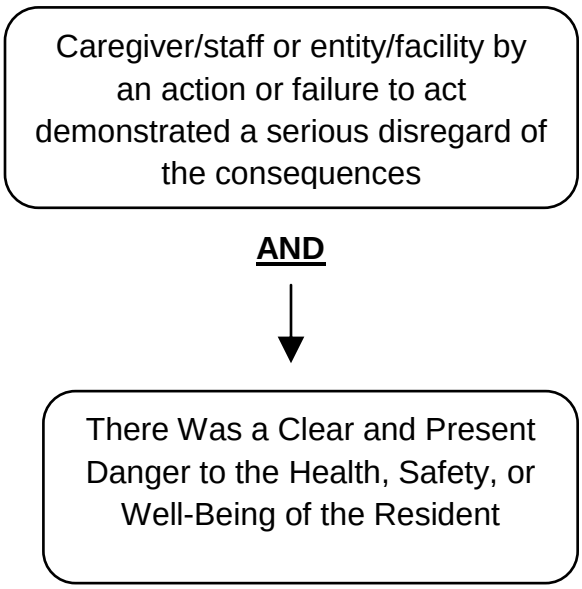
The boarding home licensing rules have two definitions of neglect: Neglect has occurred if either 1 or 2 below are present.

1) Neglect may result from a pattern of conduct or inaction by a caregiver/staff person or entity/facility. (Pattern means more than one occurrence.)



OR

2) Neglect may result from a one-time act or omission by a caregiver/staff person or entity/facility.



APPENDIX D
REPORTING GUIDELINES FOR BOARDING HOMES

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					√a	
Abuse, neglect, mistreatment, or negligent treatment	√	√				
Sexual or physical abuse/assault with bodily harm	√	√				
EXPLOITATION, INCLUDING FINANCIAL EXPLOITATION	√	√			√a	
INJURIES OF UNKNOWN SOURCE* (Not incidents of abuse or neglect)						
Substantial	√					
Substantial reasonably related						
Superficial, Unknown						
NON-STAFF TO RESIDENT						
Abuse/Assault, Neglect	√b	√				
Exploitation	√b	√				
RESIDENT TO RESIDENT						
Mental abuse with psychological harm	√					
Mental abuse without psychological harm**						
Physical abuse/assault with bodily harm	√	√				
Physical abuse with psychological harm	√					
Physical abuse without bodily or psychological harm**						
Sexual abuse/assault	√	√				
Exploitation	√	***				
UNEXPECTED DEATH						
Possible R/T abuse or neglect	√	√	√			
Suicide	√	√	√			
Not related to abuse/neglect but suspicious****	√	****	****			

Legend:

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.

OTHER REPORTING REQUIREMENTS FOR BOARDING HOMES

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	√					
Risk of Discontinuance of Services (such as no food, water, or care supplies)	√					
Transfer/Discharge Notifications	Other*					
Communicable Disease Outbreak	√c			√		
Fire	√					√d
Explosion	√					√
Missing Resident	√e	√				

Legend:

c. Depending on the specific nature of a communicable disease outbreak, the BH 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 Washington State Fire Marshal's Office by completing their official "Fire Incident Report' form. This form can be found at: http://www.wsp.wa.gov/fire/docs/inspections/450004_Fire_Incident_Report.pdf

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

* In order to reduce overpayments, the BH 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 BH 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

STATE HOTLINE QUESTIONS [1-800-562-6078]

December 2008

To make an official facility report, listen to the main message and then press "2". If you wish to bypass the next menu, press the number that represents the type of incident you will be reporting.

#	TYPE OF INCIDENT
1	Follow-up Call
2	Resident-to-Resident Incident
3	Staff-to-Resident Incident
4	Injury of Unknown Source
5	Resident Fall
6	Exploitation/Misappropriation of Resident Property
7	Other Types of Resident Incidents
8	Medication Error

The following standard information is required by facilities making reports to the state hotline:

ALL TYPES OF INCIDENTS:

1. Caller's first and last name;
2. Name of the facility followed by phone number;
3. The name of the resident(s) who is/are involved in the incident;
4. Identify if the doctor and responsible parties were notified of the incident;
5. The resident's diagnosis;
6. The resident's mental status;
7. The resident's ambulatory and transfer status, or if wheelchair bound, identify if the resident self-propels and if he/she was using an assistance device;
8. The date and time of the allegation, incident, or injury, **or** the date and time when the allegation, incident or injury was first discovered;
9. Identify if the care plan has changed.

In addition to the above questions, be prepared to provide the following information when calling to report:

FOLLOW-UP CALL – Select 1:

1. Identify the date of the initial report;
2. Identify the conclusion of the investigation;
3. Identify measures put in place to prevent a reoccurrence.

A RESIDENT-TO-RESIDENT INCIDENT – Select 2:

1. Describe the incident and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom;
4. Identify if there was evidence of psychological harm;
5. Identify if the incident is isolated or a pattern;
6. Describe the plan to prevent further incidents.

ALLEGATION OF STAFF TO RESIDENT ABUSE OR NEGLECT – Select 3:

1. Describe the alleged incident, and any injuries;
2. Identify if the incident was sexual in nature;
3. Identify if it was witnessed and if so, by whom;
4. Identify if there was evidence of psychological harm;
5. Identify the correct spelling and name of the employee(s) including their middle initial;
6. Identify the employee's title and if a nursing assistant, if he or she is registered or certified;
7. Identify the employee's date of hire and date of birth;
8. Identify the employee's social security number;
9. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
10. Identify if the employee has had previous warnings or incidents at your facility;
11. Describe the measures taken to protect the resident during the investigation;
12. Describe measures taken to prevent reoccurrences of the incident.

AN INJURY OF UNKNOWN SOURCE – Select 4:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed.

RESIDENT FALL – Select 5:

1. Describe other falls within the last 12 months;
2. Identify witnesses;
3. If staff involved, state their name and explain the circumstances;
4. Identify if the care plan was followed at the time of the fall;
5. Identify the action taken to prevent reoccurrences.

EXPLOITATION OR MISAPPROPRIATION OF RESIDENT PROPERTY – Select 6:

1. Describe the details of the exploitation or misappropriation of property including the dollar amount;
2. Identity if local law enforcement has been notified, if so, identify the case number;
3. Identify the alleged perpetrator and identify the person's title or relationship to the resident;
4. If an employee is involved, identify their name including the middle initial, title, date of hire, date of birth and social security number;
5. Identify the action taken to prevent reoccurrences.

OTHER TYPES OF RESIDENT INCIDENTS – Select 7:

1. Describe the injury, location on the body, the size, and if a bruise, describe the color;
2. Identify if the injury was sexual in nature;
3. Identify if treatment was required and if further treatment will be needed;
4. Identify witnesses;
5. Identify the action taken to prevent reoccurrences.

MEDICATION ERROR – Select 8:

1. Identify the correct spelling and name of employee(s) involved including their middle initial;
2. Identify the employee's title and if a nursing assistant, if he or she is registered or certified;
3. Identify the employee's date of hire and date of birth;
4. Identify the employee's social security number;
5. Describe the action, if any, taken with the employee, (if suspended or terminated, identify the dates);
6. Identify if the employee has had previous medication error incidents at your facility;
7. Describe the medication error. Include the time and date of the medication error, the name and dosages of the medication and when it was discovered.

If you believe there is further information relevant to the event/incident that is not addressed in the questions outlined, please feel free to leave that information at the end of your call.

APPENDIX F

RESPONSIBILITY TABLE FOR BOARDING HOMES

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

	BOARDING HOME RESPONSIBILITIES	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 administrative decisions 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)(3) • WAC388-78A-2460(7) • WAC 388-78A-2700(1)(2)
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-2595 • WAC 388-78A-2600(1) • WAC 388-78A-2700(2)(c) • WAC 388-78A-2730(2)(c)

APPENDIX G

Problem Solving Procedures for Facilities Upon Discovery of An Incident/Allegation

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 against further occurrences
3. Institute other interventions as needed

PHASE I

1. Begin investigation upon discovery of the event/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, or 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 residents' active record(s); and **(2)** The details of the investigation according to the requirements and facility protocol

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

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

Record findings that validate this conclusion

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

RESIDENT TO RESIDENT

Record details of the incident.

Report to the Department all incidents: of sexual abuse that result in psychological harm to the victim; of physical abuse that results 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 with bodily harm

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; financial exploitation

STAFF TO RESIDENT

Record details of the incident.

Report to the department: All incidents

Report to law enforcement: sexual abuse; physical abuse with bodily harm; financial exploitation

d. The cause/circumstance of the event/incident cannot be determined in Phase I investigation

PHASE II

1. Gather additional facts
2. Analyze for likelihood of abuse / neglect / financial exploitation

Cause identified: Go back to **Phase I**

e. Cause of incident still undetermined after Phase II investigation

1. Record details of investigation
2. For a Substantial injury: **Call Hotline 1-800-562-6078**

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/financial exploitation, call as required
3. Do needed re-assessment, care revision, staff training and equipment modification to assure resident's safety

APPENDIX H
KEY TRIGGERS

This appendix includes types of possible/actual indicators of types of abuse or neglect of vulnerable adults. The appendix does not include everything.

EXPLOITATION/FINANCIAL EXPLOITATION "KEY TRIGGERS"

Possible/Actual Indicators of Exploitation/Financial Exploitation: 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. This can include the illegal or improper use of a vulnerable adult's funds, property, or assets without informed consent that may result in monetary, personal, or other benefit, gain, or profit for the perpetrator; or monetary or personal losses for the vulnerable adult.

A financial exploiter can be an individual, an institution, or someone who has power of attorney for the vulnerable adult. 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 vulnerable adult'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
- Missing bank checks or financial statements/records usually in resident's possession
- Adding additional unauthorized names on 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 apartment without his/her knowledge or consent
- Bills not paid by resident's 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)
- Sudden appearance of previously uninvolved relatives claiming rights to a vulnerable adult's possessions/resources
- Unexpected sudden transfer of assets to a family member or someone outside the family
- Providing services that are <u>not</u> necessary or denying services that <u>are</u> necessary per assessment, plan of care and negotiated service agreement
- 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 identify 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: Any willful action or inaction of mental, emotional or verbal abuse of a vulnerable adult that can cause or result in mental, psychological or emotional pain or suffering, anguish, or distress. 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.

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

- A vulnerable adult's report of being verbally, emotionally or mentally mistreated
- Terrorizing and/or threatening harm or deprivation to a vulnerable adult 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/apartment for fear of certain persons or other residents
- Treating a vulnerable adult like a child
- Strained or tense relationships, frequent arguments between a staff person or caregiver and the vulnerable adult
- 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:

(a) A pattern of conduct or inaction by a person 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 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.

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

- Report by a vulnerable adult 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 vulnerable adult receiving services
- Unattended/untreated health/dental problems and/or inadequate care
- 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 assistance or medication administration as per the resident's assessed need and agreed upon plan of care and negotiated service agreement
- 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 negotiated service agreement 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 vulnerable adult 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. Physical abuse includes the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately. 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.

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

- A vulnerable adult'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

- 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*, 1991-1196.
- Bruises of varying sizes and ages in locations not usually susceptible to trauma (head, inner arms/thighs, ears, scalp, buttocks)
- 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 vulnerable adult's usual behavior
- Staff person or caregiver's refusal to allow outsiders/visitors to see a vulnerable adult alone
- Finger marks possibly associated with being grasped, squeezed or restrained in some manner
- 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
- Use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and, this includes restraints that are otherwise being used inappropriately
- 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 contact of any kind that can result from threats, force or inability of the vulnerable adult to give consent. Sexual abuse also includes any sexual contact 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 vulnerable adult 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 includes any unwanted sexual contact and can range from sexual exhibition to rape. 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.

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

- A vulnerable adult'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 vulnerable adult receiving services to view pornographic material in any media form, even if no inappropriate physical touching takes place
- Unwarranted, intrusive intimate touching of the vulnerable adult receiving services by any facility staff during bathing, dressing, toileting, incontinence care
- Molesting the vulnerable adult 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 vulnerable adult 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 vulnerable adult 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
- 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
- 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;” “I’m his favorite girl.”

APPENDIX I

DSHS SECRETARY'S LIST OF CRIMES & NEGATIVE ACTIONS

Crimes:

A person who has a crime listed below is denied unsupervised access to vulnerable adults, juveniles, and children.

If "(5 or more years)" or "(3 or more years)" appears after a crime, the person cannot be in a position to be left alone with a vulnerable adult unless 5 or more years or unless 3 or more years has passed since the date of the conviction.

After 5 or 3 years has passed, an overall assessment of the person's character, competence, and suitability to have unsupervised access will determine denial.

Abandonment of a child
Abandonment of a dependent person
Abuse or neglect of a child
Arson 1
Assault 1
Assault 2
Assault 3
Assault 4/simple assault (3 or more years)
Assault of a child
Burglary 1
Child buying or selling
Child molestation
Commercial Sexual Abuse of a Minor/Patronizing a juvenile prostitute
Communication with a minor for immoral purposes
Criminal mistreatment
Custodial assault
Custodial interference
Custodial sexual misconduct
Dealing in depictions of minor engaged in sexual explicit conduct
Extortion
Forgery (5 or more years)
Incest
Indecent exposure/Public indecency (Felony)
Indecent liberties
Kidnapping
Malicious harassment
Manslaughter
Murder/Aggravated murder
Promoting pornography
Promoting prostitution 1
Prostitution (3 or more years)
Rape
Rape of child
Robbery
Registered sex offender
Robbery
Selling or distributing erotic material to a minor
Sending or bringing into the state depictions of a minor
Sexual exploitation of minors
Sexual misconduct with a minor
Theft 1
Theft 2 (5 or more years)
Theft 3 (3 or more years)
Unlawful imprisonment
Vehicular homicide (negligent homicide)
Violation of child abuse restraining order
Violation of the Imitation Controlled Substance Act (manufacture/deliver/intent)
Violation of Uniform Controlled Substance Act (manufacture/deliver/intent)
Violation of the Uniform Legend Drug Act (manufacture/deliver/intent)
Violation of the Uniform Precursor Drug Act (manufacture/deliver/intent)
Voyeurism

Negative Actions are considered under individual program law and rule and may lead to denial of unsupervised access to vulnerable adults.

A **negative action** is an administrative or civil action taken against an individual and may include:

- A finding that an individual abused, neglected, exploited, or abandoned a vulnerable adult, juvenile or child issued by an agency, an Administrative Law Judge, or a court of law. A finding by an agency is not a negative action if the individual was not given the opportunity to request an administrative hearing to contest the finding
- Termination, revocation, suspension, or denial of a license, certification, and/or State or Federal contract
- Relinquishment of a license, certification, or contract in lieu of an agency negative action
- Revocation, suspension, denial or restriction placed on a professional license
- Department of Health disciplining authority finding
- A protection order issued under chapter 74.34 RCW. (A conviction for violation of a protection order issued under chapter 74.34 RCW is evidence that a protection order was issued).

The preceding **Appendix I** is the Department's List of Crimes and Negative Actions dated 2/15/2010 and may be amended or updated at any time. Check the Department's Web site frequently to be sure your facility is always working with the most current criminal history disclosure information. This can be accessed online at http://www.dshs.wa.gov/bccu/bccucrimeslist.shtml under Residential Care Services/Boarding Homes Also, keep current with any provider letters on related topics.

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 the rights of a resident in a nursing home, adult family home, or boarding home? Contact:

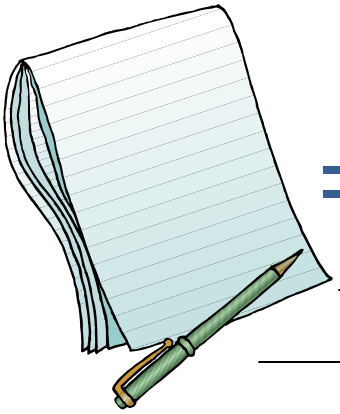
Aging & Disability Services Administration
1-800-562-6078

If you need help in resolving any problems or questions about adult family homes, nursing homes, and boarding homes, contact: STATE OMBUDSMAN

1-800-562-6028

January 2003

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES



Notes

DSHS does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.