Indiana Department of Health

Policies and Procedures

Title: Long-Term Care Abuse and Incident Reporting Policy	**Policy #**: IDOH-CSHR-LTC-002
Scope: ☐ All Staff ☒ Limited Staff: Long term care providers and staff	**Approvals**:  Jordan Stover, JD Assistant Commissioner 4/01/2024 Date
Effective dates: 12/08/2023 – 12/08/2024	

Purpose

To facilitate compliance with state and federal law and regulation, as applicable, related to reporting of abuse and incidents in licensed long-term care facilities in Indiana.

Definitions

Definitions contained herein apply to comprehensive care facilities and/or licensed residential facilities as applicable.

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

2. **Alleged violation**: Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or other health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

3. **Deprivation of goods and services by staff**: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but **choose not to do it, or acknowledge the request** for assistance from a resident(s), which result in care deficits to a resident(s).

4. **Elopement**: Elopement occurs when a resident without decision making capacity leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so **OR** a resident with decision making capacity leaves the premises or a safe area, without facility knowledge, and does not return as per the resident plan of care or service plan, related to leaving the facility.

5. **Exploitation**: Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.

6. **Immediately**: Immediately means as soon as possible, in the absence of a shorter state time frame requirement, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

7. **Injuries of unknown source**: An injury should be classified as an "injury of unknown source" when **all** the following criteria are met:
    a. The source of the injury was not observed by any person
    b. The source of the injury could not be explained by the resident or clinical condition
    c. The injury is suspicious because of:
        i. the extent of the injury, or

ii. the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), or
iii. the number of injuries observed at one particular point in time, or
iv. the incidence of injuries over time

7. **Involuntary seclusion**: Involuntary seclusion is defined as separation of a resident from other residents or from the resident's room or confinement to resident's room (with or without roommates) against the resident's will, or the will of the resident representative.

8. **Mental abuse**: Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.

9. **Misappropriation of resident property**: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

10. **Mistreatment**: Mistreatment means inappropriate treatment or exploitation of a resident.

11. **Neglect**: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
    Neglect means:
    a. An act or omission that places a resident in a situation that may endanger the resident's life or health
    b. Abandoning or cruelly confining the resident
    c. Depriving the resident of necessary support, including food, clothing, shelter, and medical care
    d. Depriving the resident of education as required by statute

12. **Physical abuse**: Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object.

13. **Sexual abuse**: Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to:
    a. Unwanted intimate touching of any kind especially of breasts or perineal area
    b. All types of sexual assault or battery, such as rape, sodomy, and coerced nudity
    c. Forced observation of masturbation and/or pornography
    d. Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g., posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident.
    e. Generally, sexual contact is nonconsensual if the resident either:
        i. Appears to want the contact to occur, but lacks the cognitive ability to consent; or
        ii. Does not want the contact to occur

14. **Unusual occurrence**: An unusual occurrence includes, but is not limited to:
    a. epidemic outbreaks
    b. poisonings
    c. fires
    d. major accidents

15. **Verbal abuse**: Verbal abuse may be considered a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.

Policy Statement

Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal regulations and/or state rules and this policy, as applicable.

Procedures and Responsibilities

INSTRUCTIONS FOR SUBMITTING AN INCIDENT REPORT

B. Information to include in the report:

Note: Initial and follow-up report can be submitted together if all necessary information has been obtained within the timeframe for initial reporting.

1. Initial report should include:

a. Facility name and contact information
b. Name and job title of staff completing the report
c. Actual or identified date and time of the incident
d. Name(s) of resident(s) involved
e. Name and title of staff involved
f. Brief description of event
g. Type of injury(s) sustained
h. Immediate action taken to respond to the event and protect the resident
i. Preventive measures taken while the investigation is in process

2. Follow-up report should include:
   a. Results of the investigation
   b. Interventions implemented or corrective action taken
   c. Method in which facility will continue to monitor efficacy of plan/interventions
   d. Other persons or agencies to which the incident was reported

C. Report submission
   1. As of July 1, 2015, incident reporting by email, fax, or voicemail is not accepted. Incident reports are to be submitted online via the IDOH Gateway: https://gateway.isdh.in.gov/Gateway/SignIn.aspx
      a. If a reported incident also constitutes a suspicion of a crime, the, "Report of Reasonable Suspicion of a Crime Against a Resident" form may be submitted simultaneously through the document upload feature in the Online Incident Reporting System.
      b. Information related to an evacuation or an event involving the Emergency Management Agency must be reported. Information may be reported at any time to 317-460-7287.

   2. Incident reporting when the online system is nonoperational
      Note: When the IDOH Gateway online system becomes available, the complete information about the incident MUST be entered into the IDOH Gateway online system and include the date and time of the email or voicemail message. Failure to make a report in the IDOH Gateway online

system after an email or voicemail message could result in a deficient practice finding related to an unreported incident.

a. Incident Reporting Forms may be submitted via email ONLY when the IDOH Gateway online system is nonoperational. The Incident Reporting Form may be found on the IDOH Incident Reporting by Long Term Care Facilities website.
    i. Within 24 hours of emailing the Incident Reporting Form, the complete information about the incident MUST be entered into the IDOH Gateway online system. In the online submission, include the date and time the Incident Reporting Form was emailed.
b. Incidents may be submitted by phone ONLY when the IDOH Gateway online system and email are nonoperational. The incident may be called in to 317-460-7287. The voicemail message should include:
    i. Facility name and contact information
    ii. Name and job title of staff calling in the report
    iii. Actual or identified date and time of the incident
    iv. Name(s) of resident(s) involved
    v. Name and title of staff involved
    vi. Brief description of event
    vii. Type of injury(s) sustained

Legal Authorities and References

42 CFR 483
Indiana Code 16-28-2
410 IAC 16.2

Table of Contents:

COMPREHENSIVE CARE FACILITIES

A. Rules and Regulation Related to Incident Reporting

1. Federal regulation

"§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.",

2. State Rules

a. "410 AIC 16.2-3.1-13 Administration and management...(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:
(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:
(A) epidemic outbreaks;
(B) poisonings;
(C) fires; or

(D) major accidents.
If the division cannot be reached, a call shall be made to the emergency telephone number published by the division."

b. "410 IAC 16.2-3.1-28 Staff treatment of residents...(c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. (e) The results of all investigations must be reported to the administrator or the administrator's designated representative and to other officials in accordance with state law (including to the department) within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken."

B. Types of Incidents Reportable Under Federal and State Rules
    1. Abuse
        a. Staff to Resident Abuse: All allegations of staff to resident abuse must be reported. Staff may receive allegations from any source, including other staff, residents, family members, or other health care providers. Also, each occurrence must be reported. If staff are aware of or witnessed any abuse that occurs, it must be reported.
        b. Resident to Resident Altercations
            i. Mental/Verbal Conflict
                1. Required to report incidents such as bullying and threats of violence, among others.
                2. Not required to report:
                    - Non-targeted outbursts
                    - Physical contact as a result of accidental or spontaneous body movement
            ii. Sexual contact
                1. Required to report:
                    - Touching a resident's sexual organs and the resident being touched indicates the

touching is unwanted through verbal or non-verbal cues
- Sexual activity or fondling where the resident's capacity to consent to sexual activity is unknown
- Instances where the alleged victim is transferred to a hospital for examination and/or treatment of injuries resulting from possible sexual abuse
- Other unwanted actions for the purpose of sexual arousal or sexual gratification
    - **Note**: The above incidents are examples and reporting is not limited to the incidents outlined above.

2. Not required to report:
    - Consensual sexual contact between residents who have the capacity to consent
    - Affectionate contact such as hand holding or hugging or kissing a resident who indicates that he/she consents to the action through verbal or nonverbal cues

iii. Physical

1. 1. Required to report (the following are examples):
    - Any resident-to-resident altercation where a willful action results in physical injury, mental anguish, or pain must be reported. Willful actions include, but are not limited to hitting, slapping, punching, and choking.

2. Death of a resident that is unusual, violent, suspicious, or resulted from an accident.

3. Elopement

4. Epidemic outbreaks
    a. Required to report at least three residents with the same infection in one defined area (such as hall, unit, neighborhood, street, pod,

secured unit, vent unit) in a 48-hour period; or 10% or more of the current building census with the same infection.

b. Communicable disease reporting per current national and/or state standards and guidelines.

5. Equipment malfunction resulting in resident injury that requires medical treatment beyond an emergency department/ physician evaluation

6. Fires
    a. Required to report any fire within the facility due to any cause

7. Infestation – rodent and/or insect

8. Injuries sustained while a resident was physically restrained

9. Injuries of unknown source:
    - Required to report examples include, but are not limited to:
        a. Injuries whose origin is unobserved/unexplained
        b. Skin tears in sites other than the arms or legs
        c. Symmetrical skin tears on both arms
        d. Patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object
        e. Bilateral bruising of the inner thighs, and "wrap around" bruises that encircle the legs, arms, or torso.
        f. Facial injuries, including facial fractures, black eye(s), bruising, or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth

10. Major accidents
    a. Required to report examples include, but are not limited to:
        i. All fractures
        ii. Burns greater than first degree
        iii. Choking resulting in death or requiring hospital treatment

11. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs

12. Misappropriation of resident property/ exploitation

a. Required to report examples include, but are not limited to:
    i. Theft of personal property, such as jewelry
    ii. Unauthorized or coerced purchases on a resident's credit card
    iii. Missing prescription medications
    iv. Allegations of a resident being taken advantage of for personal gain through the use of manipulation, intimidation, threats, or coercion

13. Neglect
    a. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them to the resident resulting in (or potentially resulting in) physical harm, pain, mental anguish, or emotional distress. Examples include but are not limited to withholding food and/or fluids resulting in dehydration or weight loss, failing to respond to call lights/ medical equipment alarms resulting in medical treatment beyond an emergency department/ physician evaluation, direct care staff abandoning job without notification to any other staff person and leaving residents unattended, staff failing to identify, assess, monitor, and respond to a resident suffering an acute condition.

14. Poisoning and/or bioterrorism

15. Structural damage due to disasters such as tornadoes, flooding, earthquakes, explosions, or other catastrophes.

16. Suicide attempt – any

17. Utility interruption of more than four (4) hours in length in one or more major utilities to the facility. Examples include but are not limited to fire alarm, sprinkler system, phone services, electrical, water supply, plumbing with sewage and/or disposal backup, heat or air conditioning, or any interruption of utility services due to non-payment.

LICENSED RESIDENTIAL CARE FACILITIES

B. Rules Related to Abuse and Incident Reporting
    1. State Rules

a. "410 IAC 16.2-5-1.3 Administration and management...(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:
(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:
(A) epidemic outbreaks;
(B) poisonings;
(C) fires; or
(D) major accidents.
If the division cannot be reached, a call shall be made to the emergency telephone number published by the division."

C. Types of Incidents reportable under state rules
Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:

1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. The word "willful" means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm.
    a. Involuntary seclusion: Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative.
    b. Mental abuse: Verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering. Examples include, but are not limited to: humiliation, harassment, threats of punishment or deprivation, bullying
        i. Staff to resident - any episode
        ii. Resident to resident if it appears to be willfully directed toward a specific resident

c. Physical abuse: Willful act against a resident by another resident, staff, or other individuals. Examples include, but are not limited to: hitting, beating, slapping, punching, shoving, spitting, striking with an object, pulling/twisting, squeezing, pinching, scratching, tripping, biting, burning, using overly hot/cold water, and/or improper use of restraints.
d. Sexual Abuse: Sexual harassment, sexual coercion, or sexual assault. Examples include but are not limited to: nonconsensual sexual contact with a resident by another resident or visitor, any staff to resident sexual contact, any sexual contact involving a resident who lacks the ability to give consent because of cognitive impairment, gestures, sharing pornography, photographing resident's rectal, genital or breast areas, and/or exhibitionism.
e. Verbal Abuse: Oral, written, and/or gestured language that includes disparaging and/or derogatory terms to residents or their families, either directly or within their hearing.
    i. Staff to resident – any episode
    ii. Resident to resident - verbal threats of harm. Does not include random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language.

2. Death of a resident that is unusual, violent, suspicious, or resulted from an accident

3. Elopement: Elopement of a resident with cognitive deficits who was found outside the facility and whose whereabouts had been unknown or whose return involves law enforcement

4. Epidemic outbreaks: Required to report at least three residents with the same infection in one defined area (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48-hour period, or 10% or more of the current building census with the same infection AND required communicable disease reporting per current state standards and guidelines

5. Equipment malfunction resulting in resident injury that requires medical treatment beyond an emergency department/ physician evaluation

6. Fires: Any fire within the facility due to any cause

7. Infestation: Rodent and/or insect

8. Injuries of unknown source: Required to report examples include but are not limited to the following:
    a. Injuries whose origin is unobserved/unexplained
    b. Skin tears in sites other than the arms or legs
    c. Symmetrical skin tears on both arms
    d. Patterned bruises that suggest hand marks or finger marks, or bruising pattern caused by an object
    e. Bilateral bruising of the inner thighs, and "wrap around" bruises that encircle the legs, arms or torso.
    f. Facial injuries, including facial fractures, black eye(s), bruising, or bleeding or swelling of the mouth or cheeks with or without broken or missing teeth

9. Injuries sustained while a resident was physically restrained

10. Major accidents: Required to report examples include but are not limited to:
    a. All fractures
    b. Burns greater than first degree
    c. Choking resulting in death or requiring hospital treatment

11. Medication errors resulting in outcomes that require medical treatment beyond an ER/physician evaluation or monitoring vital signs

12. Misappropriation of resident property: Deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's property or money without the resident's consent. Includes any medication dispensed in the name of a resident.

13. Mistreatment: Staff treating a resident inappropriately or exploiting a resident. Examples include but are not limited to rough treatment, taking unauthorized photos or recordings of residents, romantic and/or inappropriate relationship between staff and resident that does not involve physical intimacy, acceptance from a resident or attempts to gain from a resident personal items or money through persuasion, coercion, or solicitation.

14. Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Examples include but are not limited to withholding food or fluids resulting in dehydration or weight loss, failing to respond to call lights/medical equipment alarms resulting in medical treatment beyond an emergency department/physician evaluation, direct care staff abandoning job without notification to any other staff person and leaving residents unattended, staff failing to identify, assess, monitor, and respond to a resident suffering an acute condition.

15. Poisoning and/or bioterrorism

16. Robbery or burglary

17. Structural damage due to disasters such as tornadoes, flooding, earthquakes, explosions, or other catastrophes

18. Any suicide attempt

19. Utility interruption of more than four (4) hours in length in one or more major utilities to the facility. Examples include but are not limited to fire alarm, sprinkler system, phone services, electrical, water supply, plumbing with sewage and/or disposal backup, heat or air conditioning, or any interruption of utility services due to non-payment.