OREGON ASSISTED LIVING AND RESIDENTIAL CARE





# Abuse Reporting and Investigation Guide for Providers

**April 2019**

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

# Table of Contents

# Introduction

Everyone has a duty to ensure resident protection and abuse prevention is a top priority. Reporting incidents of abuse or suspected abuse is a primary responsibility. **Providers and their staff members must follow and are accountable** for this responsibility at **all times.** Residents depend on all facility staff to ensure they are safe. They also depend on them to ensure the facility is free from abuse and neglect.

This guide helps providers understand the following:

- Definition and types of abuse
- Reporting duties
- How to use the abuse reporting system
- Requirements for Assisted Living Facilities (ALFs) related to abuse reporting
- Requirements for Residential Care Facilities (RCFs) related to abuse reporting

This guide provides an overview of how to report incidents of abuse or suspected abuse to Adult Protective Services (APS), as well as how to perform internal investigations of incidents involving injuries of unknown cause.

There are specific sections in this guide:

- Key definitions
- Applicable Oregon Administrative Rules (OARs)
- Interpretive guidelines for abuse
- Details on facility reporting and investigative processes
- Appendix materials

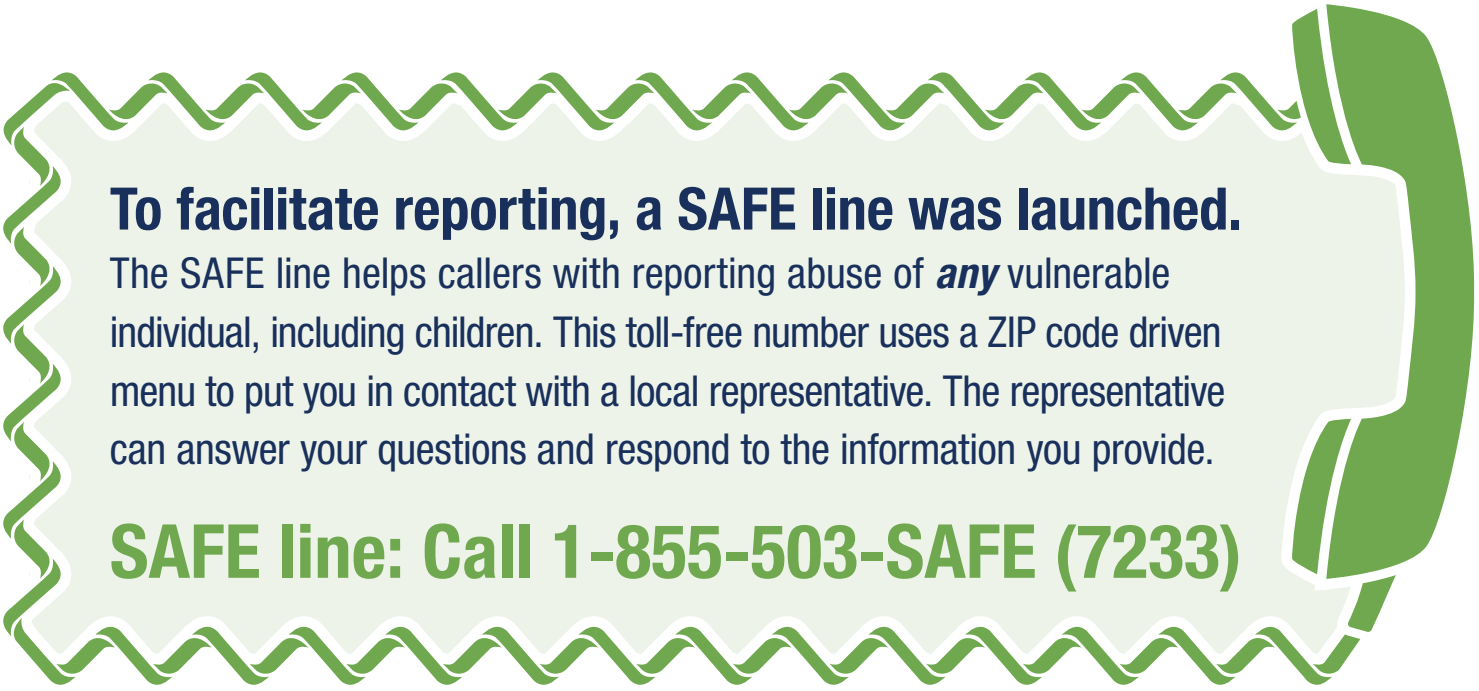
State laws require facilities to immediately (within 24-hours) report abuse and suspected abuse to the local Aging and People with Disabilities (APD) office or Area Agency on Aging (AAA) office. In addition, the facility must investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out. The eight types of abuse covered in this guide include:

- ☐ Physical abuse
- ☐ Neglect
- ☐ Abandonment
- ☐ Verbal or emotional abuse
- ☐ Financial exploitation
- ☐ Sexual abuse
- ☐ Involuntary seclusion
- ☐ Wrongful use of a physical or chemical restraint

This guide is for use by facility management and staff. It supports a system of reporting that, when followed correctly, ensures residents are protected and safe.

Incidents of abuse or suspected abuse are investigated by APS and processed by the Safety, Oversight and Quality Unit, which licenses and regulates facilities. These units within Aging and People with Disabilities work in partnership with providers to ensure state regulations are followed and vulnerable Oregonians are protected.

**Oregon Department of Human Services**
Aging and People with Disabilities
Safety, Oversight and Quality Unit
PO Box 14530, Salem, OR 97309
3406 Cherry Ave NE, Salem, OR 97303
Phone: (503) 373-2227
Fax: (503) 378-8966



## To facilitate reporting, a SAFE line was launched.

The SAFE line helps callers with reporting abuse of ***any*** vulnerable individual, including children. This toll-free number uses a ZIP code driven menu to put you in contact with a local representative. The representative can answer your questions and respond to the information you provide.

**SAFE line: Call 1-855-503-SAFE (7233)**

# General definitions

**Basic care:** Care essential to maintain the health and safety needs of an adult. It includes the following and more:

- Assistance with medication administration
- Medical needs
- Nutrition
- Supervision for safety
- Activities of daily living, such as:
  - Bathing
  - Dressing
  - Hygiene
  - Eating
  - Mobility
  - Toileting.

**Date of discovery:** The calendar date (month, day, and year) and time the facility staff first observed, found, or learned of an incident or injury.

**Date of incident:** The calendar date (month, day and year) an incident or injury occurred.

**Immediately:** For purposes of reporting to APS or law enforcement (if a crime is suspected), "immediately" means within 24-hours of when the abuse or suspected abuse was observed, found or learned of. In the case of an injury of unknown cause, a facility investigation must be completed within 24 hours and reported right away if abuse cannot be ruled out. The 24-hour period includes weekends and holidays.

**Incident:** An occurrence involving a resident, in which abuse is suspected. This includes injuries of unknown cause.

**Injuries of unknown cause:** Any injury should be classified as an "injury of unknown cause" when the source of the injury could not be explained by the resident or otherwise shown to be non-abuse by a thorough, documented facility investigation.

**Notification of finding or letter of determination:** A document from the Oregon Department of Human Services stating the outcome of each incident or problem alleged in a complaint. This includes whether a substantiated incident was determined to be abuse or a violation of a licensing rule. Letters of Determination are used when abuse has been apportioned to an individual.

**Safety plan:** A set of actions or procedures taken by a facility. This plan is a follow up to an incident of abuse, suspected abuse or injury of unknown cause. The plan should include thoughtful evaluation and service planning to carry out reasonable interventions to lessen future risk.

**Self-reported incident:** A notice of abuse or suspected abuse reported by a facility to APS. This should include injuries of unknown cause, if the facility investigation cannot reasonably conclude that the injury is not the result of abuse. Notification is made to the local APD/AAA office by a provider or designee. Oregon Administrative Rule requires facilities to immediately self-report **all** abuse or suspected abuse that meets definitions in OAR 411-020-0002.

# Staff training

All staff who work in a facility must receive pre-service and ongoing training. This is to ensure they understand their roles in abuse prevention, as well as abuse reporting and investigation. Preventing abuse should be each facility's objective. Successful prevention of abuse requires ensuring all staff are aware of rules and that facility management sets expectations for staff behavior.

Staff training should address each of the following:

- Prevention
- Awareness
- Investigation
- Reporting

## Follow up interventions, including safety plans

All staff in assisted living, residential care and memory care communities must receive pre-service orientation training on abuse and abuse reporting. This is required in OAR 411-054-0070(3)(a)(B). It is important for all facility staff to understand the following:

- Mandatory reporter responsibilities.
- Abuse self-reporting requirements.
- Specific facility policies and procedures related to abuse.
- Suspected abuse and injury of unknown cause investigations, responses and reporting.

In addition to pre-service training, each facility should schedule routine, ongoing continuing education on the above topics for all staff members.

# Abuse definitions and interpretive guide

This section of the guide covers Oregon Administrative Rules (OARs) that apply to the definitions of abuse. It is important that providers read, understand and know how each of these rules apply to the eight types of abuse incidents we investigate in Oregon's licensed facilities.

We strongly suggest all Community-Based Care (CBC) providers become familiar with the following OARs:

- 411-020: Adult Protective Services Rules
- 411-054: Residential Care and Assisted Living Rules

**To assist you:**

The following section outlines:

- A description of the rule.
- An interpretation, to help you understand the rule.
- Examples of the type of abuse.

## Physical abuse

### 411-020-0002 (1)(A):

(i) The use of physical force that may result in bodily injury, physical pain, or impairment; or

(ii) Any physical injury to an adult caused by other than accidental means.

(B) For purposes of these rules, conduct that may be considered physical abuse includes but is not limited to:

(i) Acts of violence such as striking (with or without an object), hitting, beating, punching, shoving, shaking, kicking, pinching, choking, or burning; or

(ii) The use of force-feeding or physical punishment.

(C) Physical abuse is presumed to cause physical injury, including pain, to adults in a coma or adults otherwise incapable of expressing injury or pain.

### Interpretation:

- All facility staff should be trained to recognize that acts of aggression are never appropriate, regardless of circumstances.
- The facility must immediately investigate any injury of unknown cause.
- If any act of violence is suspected or witnessed, the facility should report it immediately.

### Some examples of physical abuse include:

- Handling a resident roughly because staff are in a hurry to finish providing care.
- Striking or pushing a resident, for any reason.
- Shaking a resident who is agitated.

# Neglect

## 411-020-0002 (1)(b):

(A) For the purposes of these rules, Neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult, when that failure:

(i) Results in physical harm, significant emotional harm, unreasonable discomfort, or serious loss of personal dignity to the adult; or

(ii) Creates the risk of serious harm to the adult.

(B) The expectation for care may exist because of an assumed responsibility or a legal or contractual agreement, including, but not limited to, where an individual has a fiduciary responsibility to assure the continuation of necessary care or services.

(C) An adult, who in good faith, is voluntarily under treatment solely by spiritual means in accordance with the tenets and practices of a recognized church or religious denomination shall, for this reason alone, not be considered subjected to abuse by reason of neglect as defined in these rules.

## Interpretation:

- Failure to create a safe environment for all residents may constitute neglect.
  - ☑ This includes failure to follow medication or treatment orders, which results in risk of serious harm or physical harm to a resident.
    - If resident refusal results in failure to follow a medication or treatment order or fully carry out the service plan, the resident's refusal must be documented. The facility must show the right efforts were taken to obtain the resident's agreement.
- *Whether or not* a physical outcome is evident, the following should be reported immediately:
  - ☑ Significant emotional harm.
  - ☑ Unreasonable discomfort.
  - ☑ Loss of personal dignity.

## Some examples of neglect include:

- Failing to check on a resident as instructed by the resident's service plan, when it results in risk of serious harm or physical harm to a resident.
- Failing to protect residents from humiliation or loss of dignity.
- Medication errors that result in risk of serious harm or physical harm.
- Failing to address escalating resident behaviors.
- Failing to prevent or intervene in resident-to-resident altercations.
- Failing to evaluate an intervention, resulting in risk of serious harm or physical harm to a resident.
- Failing to properly address a resident's significant change in condition.

## Abandonment

### 411-020-0002(1)(c):

Abandonment includes desertion or willful forsaking of an adult for any period of time by an individual who has assumed responsibility for providing care, when that desertion or forsaking results in harm or places the adult at risk of serious harm.

### Interpretation:

- Leaving a resident at risk of serious harm without a caregiver present constitutes abandonment.

### Some examples of abandonment include:

- Leaving a resident with cognitive or physical impairment alone in an environment not secured that results in harm or places them at risk of serious harm.
- Leaving a resident with cognitive impairment alone at a medical appointment, thereby putting the resident at risk for wandering away or becoming confused and upset by unfamiliar surroundings.

## Verbal or emotional abuse

### 411-020-0002(1)(d):

(A) Verbal or emotional abuse includes threatening significant physical harm or threatening or causing significant emotional harm to an adult using:

(i) Derogatory or inappropriate names, insults, verbal assaults, profanity, or ridicule; or

(ii) Harassment, coercion, threats, intimidation, humiliation, mental cruelty, or inappropriate sexual comments.

(B) For the purposes of these rules:

(i) Conduct that may be considered verbal or emotional abuse includes but is not limited to the use of oral, written, or gestured communication that is directed to an adult or within their hearing distance, regardless of their ability to comprehend.

(ii) The emotional harm that may result from verbal or emotional abuse includes but is not limited to anguish, distress, fear, unreasonable emotional discomfort, loss of personal dignity, or loss of autonomy.

### Interpretation:

- Any threat of significant physical or emotional harm to a resident (or conduct that causes it) constitutes abuse.

- Inappropriate comments directed at or to a resident are considered abusive if they threaten or cause significant emotional harm. This includes the following:
  - Disrespectful or inappropriate names or gestures
  - Insults
  - Verbal assaults
  - Profanity
  - Ridicule
- An inappropriate act or altercation witnessed by a resident that causes them to feel fearful or frightened constitutes emotional abuse.
- Use of a video or audio recording of a resident to ridicule them constitutes emotional abuse.
- Some examples of verbal or emotional abuse include:
- Insulting or dehumanizing a resident by:
  - Using terms such as "feeder" to refer to a person who needs help eating or "screamer" for someone who often yells, within any resident's hearing distance. This is regardless of cognitive impairment.
  - Telling a resident with cognitive impairment that they are behaving "badly" or that they are "difficult" or "a problem."
  - Posting a video or photo of a resident on social media with a derogatory comment.

## Financial exploitation

### 411-020-0002(1)(e):

(A) Wrongfully taking, by means including but not limited to deceit, trickery, subterfuge, coercion, harassment, duress, fraud, or undue influence, the assets, funds, property, or medications belonging to or intended for the use of an adult;

(B) Alarming an adult by conveying a threat to wrongfully take or appropriate money or property of the adult if the adult would reasonably believe that the threat conveyed would be carried out;

(C) Misappropriating or misusing any money from any account held jointly or singly by an adult; or

(D) Failing to use income or assets of an adult for the benefit, support, and maintenance of the adult.

(E) The taking, borrowing, or accepting of assets, funds, property, or medications form an adult residing in a facility by an employee of the facility, unless the adult and employee are related and the action described in this paragraph does not constitute a wrongful taking as described in (A).

### Interpretation:

- Any theft or misuse of a resident's funds, property or medications constitutes abuse.
- Staff should never take or request money from a resident for staff's personal benefit.
- Theft or diversion of a resident's medications is an unacceptable form of abuse and will not be tolerated.

- Staff even threatening to take something a resident values is a form of abuse.
- Any financial exploitation is abuse, regardless of the following:
  - Amount
  - Type of resource
  - Property involved
  - Facility's action after the incident has occurred

### Some examples of financial exploitation include:

- Asking for or accepting a resident's money or belongings as a gift or under false pretenses.
- Borrowing a resident's money or belongings without their permission, even for a short time.
- Threatening to take a resident's money or belongings for any reason.

## Sexual abuse

### 411-020-0002(1)(f):

(A) Sexual contact with a non-consenting adult or with an adult considered incapable of consenting to a sexual act. Consent, for purposes of this definition, means a voluntary agreement or concurrence of wills. Mere failure to object does not, in and of itself, constitute an expression of consent;

(B) Verbal or physical harassment of a sexual nature, including but not limited to severe, threatening, pervasive or inappropriate exposure of an adult to sexually explicit material or language;

(C) Sexual exploitation of an adult;

(D) Any sexual contact between an employee of a facility and an adult residing in the facility unless the two are spouses or domestic partners .

(E) Any sexual contact that is achieved through force, trickery, threat, or coercion;

(F) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427, 163.465, 163.467, or 163.525 except for incest due to marriage alone.

### Interpretation:

- Sexual contact between any staff member and any resident constitutes abuse. It is prohibited, unless the caregiver and resident are legally married.
  - ☑ Sexual contact includes exposing residents to pictures or jokes of a sexual nature.
- Resident-to-resident sexual contact is abuse when one or both residents do not or cannot show consent.
  - ☑ Facilities must assess and intervene in resident-to-resident sexual behavior when there is not sound evidence of mutual consent.
- Any time sexual abuse is witnessed or suspected, the incident(s) must be referred to APS immediately.
  - ☑ Staff members must always be able to make referrals to APS without fear of retaliation or retribution from facility supervisors and managers.

### Some examples of sexual abuse include:

- Telling a resident a sexually explicit joke or comment.
- Sexual contact by a cognitively intact resident with other residents who do not or cannot give consent.

## Involuntary seclusion

### 411-020-0002(1)(g):

(i) Confinement or restriction of an adult to their room or a specific area; or

(ii) Placing restrictions on an adult's ability to associate, interact, or communicate with other individuals.

(B) In a facility, emergency or short-term, monitored separation from other residents may be permitted if used for a limited period of time when:

(i) Used as part of the care plan after other interventions have been attempted;

(ii) Used as a de-escalating intervention until the facility can evaluate the behavior and develop care plan interventions to meet the resident's needs; or

(iii) The resident needs to be secluded from certain areas of the facility when their presence in that specified area would pose a risk to health or safety.

### Interpretation:

- Requiring a resident to stay in an area or keeping a resident out of an area against their wishes, may be a form of abuse unless it is:
  - ☑ Used temporarily to deescalate a situation and allow facility staff time to explore other service plan options that can meet a resident's needs.
  - ☑ Used to keep a resident from a particular area that would pose a risk to the resident or to other residents.

### Some examples of involuntary seclusion include:

- Restricting residents from a common area during certain hours for the staff's convenience.
- Restricting a resident to or from their room or apartment against their wishes. This can only be done for a short-term period of time as part of:
  - ☑ An emergency
  - ☑ Monitored separation from other residents for a limited time
  - ☑ Criteria listed in 411-020-0002(1)(g)(B)

## Wrongful use of a physical or chemical restraint

### 411-020-0002(1)(h):

(A) A wrongful use of a physical or chemical restraint includes situations where:

(i) A licensed health professional has not conducted a thorough assessment prior to implementing a licensed physician's prescription for restraint;

(ii) Less restrictive alternatives have not been evaluated prior to the use of the restraint; or

(iii) The restraint is used for convenience or discipline.

### Interpretation:

- Inappropriate use of physical and chemical restraints may constitute abuse.
- Restraints must never be in use for convenience of staff or as a means of disciplining a resident.
- Restraints may only be used following an adequate assessment by a licensed health care professional. They should also not be used until after other, less restrictive options are explored.

### Some examples of wrongful use of a physical or chemical restraint include:

- Using side rails to keep an active resident in bed for the convenience of staff, when the restraint is not associated with an adequate assessment or when less restrictive alternatives have not been tried prior to use.
- Keeping a resident in a recliner, low-sitting chair, or sofa that they cannot get out of, for the caregiver's convenience.
- Using a device that limits a resident's mobility or access to his or her own body because of insufficient staff to provide supervision.
- Using sedating medications for the staff's convenience. As an example, a Med Tech giving a PRN Ativan* every night without an assessment, for the staff's convenience.

* PRN stands for "pro re nata." It means, take when needed. Ativan may be prescribed for anxiety, insomnia and other medical needs.

# Primary responsibilities: Protect residents and report

**It is crucial that providers understand that once abuse or suspected abuse has occurred, they have two primary responsibilities:**

1. **PROTECT residents**
2. **REPORT**
   - Abuse
   - Suspected abuse
   - Physical injuries from an unknown cause

## 1 Protecting residents

**The provider's first priority must be the protection of residents from further harm.** Each situation is different, but here are some examples of actions that staff might carry out:

- Ensure that staff keeps the alleged perpetrator away from the resident or other residents.
- Have a trusted person stay with the resident(s).
- Safeguard the resident(s)' well-being and property.
- Carry out individual, person-centered interventions as needed.
- Enhance staff skills to respond to these situations by providing additional training.

Resident-to-resident altercations are not an acceptable part of living, even when residents have cognitive impairment. Facilities are responsible for protecting residents from aggressive incidents. Failure to do so may be considered a form of neglect if the facility has failed to recognize risky behaviors and prevent altercations. Facility staff must report these altercations to APS.

Regular occurrences of resident-to-resident altercations may indicate that:

- Residents lack meaningful activity.
- A facility needs more staff to monitor and prevent altercations.
- Staff need more training in recognizing triggers or in how to intervene when incidents occur.

Involvement in altercations must be documented. Individualized interventions for prevention of incidents should be documented in resident service plans. These plans need to be carried out by staff.

## 2 Reporting incident(s)

**The provider's second priority must be to report the incident to the appropriate Adult Protective Services office.**

It is important that all providers familiarize themselves with the Oregon Administrative Rules related to abuse reporting and investigation. This way, appropriate policies and procedures are in place to assure: 1) the prevention of abuse and 2) an appropriate response to any incident is documented in facility practice, policies and staff guidelines.

*Here are the rules that apply to abuse reporting and investigation:*

## Abuse Reporting and Investigation: OAR 411-054-0028

(1) The facility must have policies and procedures in place to assure the prevention and appropriate response to any incident. In the case of incidents of abuse, suspected abuse, or injury of unknown cause, policies and procedures must follow the requirements outlined below. In the case of incidents that are not abuse or injuries of unknown cause where abuse has been ruled out, the facility must have policies and procedures in place to respond appropriately, which may include such things as re-assessment, monitoring, or medication review.

(2) ABUSE REPORTING. Abuse is prohibited. The facility employees, agents and licensee must not permit, aid, or engage in abuse of residents who are under their care.

(a) STAFF REPORTING. All facility employees are required to immediately report abuse and suspected abuse to the local APD office, or the local AAA, the facility administrator, or to the facility administrator's designee.

(b) FACILITY REPORTING. The facility administrator, or designee, must immediately notify the local APD office, or the local AAA, of any incident of abuse or suspected abuse, including events overheard or witnessed by observation.

(c) LAW ENFORCEMENT AGENCY. The local law enforcement agency must be called first when the suspected abuse is believed to be a crime (e.g., rape, murder, assault, burglary, kidnapping, theft of controlled substances, etc.).

(d) INJURY OF UNKNOWN CAUSE. Physical injury of unknown cause must be reported to the local APD office, or the local AAA, as suspected abuse, unless an immediate facility investigation reasonably concludes and documents that the physical injury is not the result of abuse.

(3) FACILITY INVESTIGATION. In addition to immediately reporting abuse or suspected abuse to APD, AAA, or the law enforcement agency, the facility must promptly investigate all reports of abuse and suspected abuse and take measures necessary to protect residents and prevent the reoccurrence of abuse. Investigation of suspected abuse must document:

(a) Time, date, place and individuals present;

(b) Description of the event as reported;

(c) Response of staff at the time of the event;

(d) Follow-up action; and

(e) Administrator's review.

***The following types of abuse outlined earlier in this guide MUST be reported immediately:***

- ☑ Physical abuse
- ☑ Neglect
- ☑ Abandonment
- ☑ Verbal or emotional abuse
- ☑ Financial exploitation
- ☑ Sexual abuse
- ☑ Involuntary seclusion
- ☑ Wrongful use of a physical or chemical restraint

## Facility investigative process

Physical injuries of unknown cause are considered suspected abuse. They must be reported to APS. **If** the facility conducts an immediate investigation that reasonably concludes the injury *was not the result of abuse,* then it is not necessary to report to APS.

- Any injury should be classified as an "injury of unknown cause" when:
  - ☑ The cause of the injury was not observed by any available witness; ***OR***
  - ☑ The cause of the injury could not be credibly explained by the resident.
- An internal investigation and a determination is expected to be made within 24-hours of the incident. The facility must document in the resident's record their determination about the injury of unknown cause.
- The facility must be able to explain the facility's investigative process and any steps taken during the internal investigation to the APS specialist. Facilities should also be prepared to provide documentation that all steps in the facility investigative process have been correctly followed.
- As soon as a determination is made that a facility investigation is unable to conclude the injury is not the result of abuse, then it must be reported.

Following are some examples of situations involving physical injury of unknown cause:

*Example A: A resident is heard calling for help. The resident is found on the floor next to his bed. He has a skin tear and a bruise on his arm. No one witnessed the apparent fall. Staff checked the resident for other injuries, level of consciousness, vital signs, etc. Staff treated the skin tear, make sure the resident is comfortable and safe, and begin an investigation. The resident explained that he had tripped on his way to the bathroom. The resident's service plan indicates that the resident ambulates independently and was not at risk for falls.*

Because the resident could explain the accident, this incident **would not** need to be reported to APS. However, the facility would be expected to:

- Document the investigation.
- Re-assess the resident's cognitive status and other relevant areas.
- Update the service plan with measures to prevent recurrence.
- Follow any other facility policies as appropriate.

*Example B: A resident with dementia is found in the courtyard laying in the flowerbed. He has a bump on his forehead and says his wrist hurts. The resident states that he was walking outside. He heard someone yell "get out of my way." He then felt himself be pushed and he fell into the flower bed. No one witnessed the incident.*

Staff immediately evaluated and assessed the resident's physical condition, performed appropriate treatment, and ensured his safety and comfort. The resident's service plan stated he can independently ambulate in the outside area, he uses a walker and he is only a little unsteady. Because no one witnessed the incident, the facility investigation could not reasonably conclude the incident was not abuse. Thus, this incident **would** need to be reported to APS.

*Example C: A resident with advanced dementia is found on the floor in his room next to a tipped-over commode. He has sustained a cut on the head. No one witnessed the incident.*

In the immediate investigation, it was found that a staff person acknowledged helping the resident onto the commode earlier, stating that she told the resident to push his call bell when he was finished. The resident's service plan directed that he required the assistance of one-person for transfers, and that he was not to be left alone on the commode. The staff person stated she had been in a hurry, did not remember that instruction, and thought he was capable of remembering to use the call bell.

Because neglect of care resulting in an injury is considered abuse, this incident would be reported to APS immediately upon obtaining the above information.

It is very important that facilities report instances of abuse or even suspected abuse. This system helps protect the resident and supports the facility. It is a check and balance to ensure that events that occur are objectively investigated, and that people are protected and kept safe.

In addition to immediately reporting abuse or suspected abuse to the local APS office and to law enforcement (when a crime is suspected) the facility must also:

- Promptly investigate all reports of abuse and suspected abuse.
- Take measures necessary to protect residents.
- Prevent the reoccurrence of abuse.

**Investigation of suspected abuse must include:**

(A) Time, date, place and individuals present;

(B) Description of the event as reported;

(C) Response of staff at the time of the event, including measures taken to immediately protect safety of residents;

(D) Follow-up action, including measures taken to prevent future reoccurrence to residents involved and other residents; and

(E) Administrator's review, including signature and date of review.

**Safety plans and interventions:**

It is important for facilities to thoroughly investigate potential abuse incidents. Facilities also need to take measures to prevent future occurrences. The Safety, Oversight and Quality Unit contacts facilities to ask what interventions have been put in place to mitigate future occurrences of abuse. These interventions are the facility's safety plan.

Facilities should be prepared to respond to the following questions, including:

- What is being done to ensure the safety of all residents?
- How is the facility monitoring the effectiveness of interventions?
- What documents (training, staffing plans, policies, etc.) can be provided to demonstrate implementation of the safety plan?

## Immunity and prohibition of retaliation

There are Oregon Administrative Rules that provide immunity and prohibit retaliation for anyone who makes a report of abuse. The rule that applies to Assisted Living and Residential Care is OAR 411-054-0028(4):

a. The facility licensee, employees and agents must not retaliate in any way against anyone who participates in the making of an abuse complaint, including but not limited to restricting otherwise lawful access to the facility or to any resident, or employee dismissal or harassment.

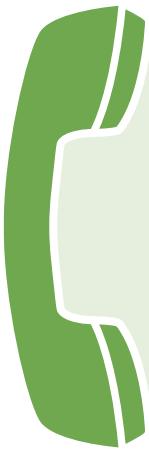
b. Anyone who, in good faith, reports abuse or suspected abuse shall have immunity from any liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint.

# Conclusion and resource information

**If you witness abuse or suspect that abuse may be occurring, your appropriate actions make a difference. They are the first step in protecting vulnerable individuals and in preventing future abuse.**

Make allegations of abuse or neglect directly to the local APS office or to the SAFE line listed below. Contact information for a local office in each area is available at: http://www.oregon.gov/DHS/Offices/Pages/Seniors-Disabilities.aspx

The facility reporting form is available at https://apps.state.or.us/Forms/Served/de0810a.pdf



**You may also call 1-855-503-SAFE (7233).** To facilitate reporting, a SAFE line was launched. The SAFE line helps callers in reporting abuse of ***any*** vulnerable individual, including children. This toll-free number uses a ZIP code driven menu to put you in contact with a local representative. This representative can answer your questions and respond to the information you provide.

**SAFE line: Call 1-855-503-SAFE (7233)**

*For more information on types of adult abuse and warning signs, visit our Oregon Department of Human Services website:* http://www.oregon.gov/dhs/abuse/Pages/index.aspx

# Abuse Decision Tree

You must follow the procedures below, if any incident results in either:

- Suspected abuse.
- An injury of unknown cause.

***A report to Adult Protective Services (APS) is not necessary if it does not result in either.***

## Discovery of an incident

- ☐ Immediately treat injury or harm to resident(s).
- ☐ Protect resident(s) from further harm.
- ☐ Carry out interventions as needed.

### Witnessed or suspected abuse

- ☐ Physical
- ☐ Neglect
- ☐ Abandonment
- ☐ Verbal
- ☐ Emotional
- ☐ Financial exploitation
- ☐ Sexual abuse
- ☐ Involuntary seclusion
- ☐ Wrongful restraint

**Report to APS within 24-hours.**

*Make a report to law enforcement first, if a criminal act is suspected.*

**Facility immediately conducts and documents an internal investigation**

Find out:

- Who
- Where
- What
- Why
- When
- How

### Injury or injuries of unknown cause

**Facility immediately conducts and documents an internal investigation (within 24 hours)**

Find out:

- Who
- Where
- What
- Why
- When
- How

**Cannot rule out abuse**

Facility needs to immediately report to APS.

**Abuse ruled out**

A report to APS is not required.

**Document a safety plan (preventative measures). Update service plans as needed.**

# Suspected Abuse or Unexplained injury Reporting Form

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Facility name: _____ Phone: _____

Address: _____

Facility type: ☐ Assisted Living Facility ☐ Residential Care Facility ☐ Memory Care

Person reporting the incident: _____

Title: _____

Date: _____ Time: _____ ☐ a.m. ☐ p.m. Date discovered: _____

Location of incident: _____

**Residents involved in incident:** (*Attach additional pages if necessary.*)

Residents name: _____ Gender: ☐ Male ☐ Female Date of birth: _____

Medicaid? ☐ Yes ☐ No Case Manager: _____

Relevant diagnoses: _____ POA or Guardian: _____

Residents name: _____ Gender: ☐ Male ☐ Female Date of birth: _____

Medicaid? ☐ Yes ☐ No Case Manager: _____

Relevant diagnoses: _____ POA or Guardian: _____

**Reported perpetrators (Not residents):** (*Attach additional pages if necessary.*)

Name: _____ Title: _____

Phone: _____ License or certificate #: _____

Name: _____ Title: _____

Phone: _____ License or certificate #: _____

**Witnesses:** (*Attach additional pages if necessary.*)

Name: _____ Relationship/Title: _____

Phone: _____

Name: _____ Relationship/Title: _____

Phone: _____

Name: _____ Relationship/Title: _____

Phone: _____

(*Attach additional pages to answer the questions below, if necessary*.)

Describe the incident. List any injury or adverse effect to the resident(s):

What immediate measures were taken to protect the resident(s)?

Who else was contacted (*such as law enforcement, ombudsman, licensing board, etc.*)?

Has this happened before to the same resident(s) or others? ☐ Yes ☐ No

Signature of person completing this report

Date signed

| | | | |
|---|---|---|---|
| **APS Office Use Only** | Branch office: | | |
| Date received: | Time received: | Received by: | Log number: |
| **Disposition** | | | |
| Local unit investigation? | ☐ Yes ☐ No | Investigator's name: | |
| Response priority: | ☐ Same day | ☐ Next day | ☐ Other |
| If other, describe: | | | |
| Referral to: | ☐ CBC Survey Unit | ☐ Compliance | ☐ Ombudsperson |

DHS | Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

Safety, Oversight and Quality Unit
3406 Cherry Ave NE
Salem, OR 97303
Phone: (503) 373-2227
Fax: (503) 378-8966

You can get this document in other languages, large print, braille or a format you prefer. Contact Safety, Oversight and Quality Unit at 503-373-2227. We accept all relay calls or you can dial 711.

APD 0472 (rev 04/2019)