

F608 – Reporting of Reasonable Suspicion of a Crime

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.

(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.

(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.

INTENT

The intent is for the facility to develop and implement policies and procedures that:

- Ensure reporting of crimes against a resident or individual receiving care from the facility occurring in nursing homes within prescribed timeframes to the appropriate entities, consistent with Section 1150B of the Act;
- Ensure that all covered individuals, such as the owner, operator, employee, manager, agent or contractor report reasonable suspicion of crimes, as required by Section 1150B of the Act;
- Provide annual notification for covered individuals of these reporting requirements;
- Post a conspicuous notice of employee rights, including the right to file a complaint; and
- Assure that any covered individual who makes a report to be made, or is in the process of making a report, is not retaliated against.

DEFINITIONS

“Covered individual” is anyone who is an owner, operator, employee, manager, agent or contractor of the facility (See section 1150B(a)(3) of the Act).

“Crime”: Section 1150B(b)(1) of the Act provides that a “crime” is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township or village, or any local unit of government created by or pursuant to State law.

“Law enforcement,” as defined in section 2011(13) of the Act, is the full range of potential responders to elder abuse, neglect, and exploitation including: police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners.

“Serious bodily injury” means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse (See section 2011(19)(A) of the Act).

“Criminal sexual abuse”: In the case of “criminal sexual abuse” which is defined in section 2011(19)(B) of the Act (as added by section 6703(a)(1)(C) of the Affordable Care Act), serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

GUIDANCE

NOTE: Once an individual suspects that a crime has been committed, facility staff must exercise caution when handling materials that may be used for evidence or for a criminal investigation. It has been reported that some investigations were impeded due to washing linens or clothing, destroying documentation, bathing or cleaning the resident before the resident has been examined, or failure to transfer a resident to the emergency room for examination including obtaining a rape kit, if appropriate.

NOTE: Please refer to the facility’s obligations under “Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility: Section 1150B of the Social Security Act,” (See S&C Memo: 11-30-NH, revised January 20, 2012, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf).

Required Policies and Procedures for Reporting Suspicions of a Crime

The following table describes the different reporting requirements that are addressed under 42 CFR 483.12:

	F608 42 CFR 483.12(b)(5) and Section 1150B of the Act	F609 42 CFR 483.12(c)
What	Any reasonable suspicion of a crime against a resident	1) All alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigation of alleged violations
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	State Survey Agency (SA) and one or more law enforcement entities for the political subdivision in which the facility is locates (i.e. police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	The facility administrator and to other officials in accordance with State law, including to the SA and the adult protective services where state law provides for jurisdiction in long term care facilities
When	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury _ not later than 24* hours	All alleged violations – Immediately but not later than 1) 2 hours – if the alleged violation involves abuse or results in serious bodily injury 2) 24 hours – if the alleged violation does not involve abuse and does not result in serious bodily injury.

*- Reporting requirements under this regulation are based on real (clock) time, not business hours.

A facility's policies and procedures for reporting under 42 CFR §483.12(b)(5) should specify the following components, which include, but are not limited to:

- Identification of who in the facility is considered a covered individual;
- Identification of crimes that must be reported;

NOTE: Each State and local jurisdiction may vary in what is considered to be a crime and may have different definitions for each type of crime. Facilities should consult with local law enforcement to determine what is considered a crime.

- Identification of what constitutes “serious bodily injury;”
- The timeframe for which the reports must be made; and
- Which entities must be contacted, for example, the State Survey Agency and local law enforcement.

There are instances where an alleged violation of abuse, neglect, misappropriation of resident property and exploitation would be considered to be reasonable suspicion of a crime. In these cases, the facility is obligated to report to the administrator, to the state survey agency, and to other officials in accordance with State law (see F609). Regardless, covered individuals still have the obligation to report the reasonable suspicion of a crime to the State Survey Agency and local law enforcement.

Some facilities may have policies and procedures where the administrator could coordinate timely reporting to the State Survey Agency and law enforcement on behalf of covered individuals who choose to report to the administrator. Risks to the covered individual for reporting to the administrator could be mitigated if an individual has clear assurance that the administrator is reporting it and submitting a collective report would not cause delays in reporting according to specified timeframes. Reports should be documented and the administrator should keep a record of the documentation. It remains the responsibility of each covered individual to ensure that his/her individual reporting responsibility is fulfilled, so it is advisable for any multiple-person report to include identification of all individuals making the report. In addition, a facility cannot prohibit or circumscribe a covered individual from reporting directly to law enforcement even if it has a coordinated internal system.

Surveyors must review whether the facility has included in its policies and procedures examples of crimes that would be reported. Examples of situations that would likely be considered crimes in all subdivisions would include but are not limited to:

- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery;
- Drug diversion for personal use or gain;
- Identify theft; and
- Fraud and forgery.

There are political subdivisions that have other examples for which instances of elder mistreatment are considered to be crimes. Because all reasonable suspicions of crimes must be reported, regardless of whether it is perpetrated by facility staff, residents, or visitors, it would be especially beneficial for the facility to work with local law enforcement in determining what

would not be reported (e.g., all cases of resident to resident conflict may not rise to the level of abuse and may not be appropriate to report to local law enforcement).

Annual Notification of Reporting Obligations to Covered Individuals

The facility must develop and implement written procedures that include, but are not limited to, notifying covered individuals annually of their obligations to report reasonable suspicion of crimes in the facility. Policies and procedures should include, but are not limited to the following:

- Identification of who are the covered individuals in the facility;
- How covered individuals are notified of the reporting requirements. Notification must include the following:
 - Each covered individual's independent obligation to report the suspicion of a crime against a resident directly to local law enforcement and the State Survey Agency;
 - The timeframe requirements for reporting reasonable suspicion of crimes:
 - If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual must report the suspicion immediately, but not later than 2 hours after forming the suspicion;
 - If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion.
- Penalties associated with failure to report:
 - If a covered individual fails to report within mandated timeframes, the covered individual will be subject to a civil money penalty of not more than \$200,000; and the covered individual may be excluded from participation in any Federal health care program (as defined in section 1128B(f)).
 - If a covered individual fails to report within mandated timeframes and the violation exacerbates the harm to the victim of the crime or results in harm to another individual, the covered individual will be subject to a civil money penalty of not more than \$300,000; and the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).
- The mechanism for documenting that all covered individuals have been notified annually of their reporting obligations. Documentation may include a copy of a notice or letter sent to covered individuals with confirmation that it was received or a completed training/orientation attendance sheet documenting the individual completed training on reporting obligations.

Retaliation

In order to encourage reporting of the suspicion of a crime, facilities should develop and implement policies and procedures that promote a culture of safety and open communication in

the work environment. This may be accomplished through prohibiting retaliation against an employee who reports a suspicion of a crime. Actions that constitute retaliation against staff include:

- When a facility discharges, demotes, suspends, threatens, harasses, or denies a promotion or other employment-related benefit to an employee, or in any other manner discriminates against an employee in the terms and conditions of employment because of lawful acts done by the employee.
- When a facility files a complaint or a report against a nurse or other employee with the state professional licensing agency because of lawful acts done by the nurse or employee for reporting a reasonable suspicion of a crime to law enforcement.

An example of retaliation would be if a staff member, on behalf of or as an agent of the facility, harasses an employee who had reported a suspected crime.

In addition to developing policies prohibiting retaliation for reporting suspicions of a crime, the facility must develop and implement policies and procedures for posting notice in a conspicuous location informing covered individuals of their right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint.

The sign may be posted in the same area that the facility posts other required employee signs, such as labor management posters. Size and type requirements for the sign should be no less than the minimum required for the other required employment-related signs.

INVESTIGATIVE PROTOCOL FOR REPORTING OF REASONABLE SUSPICION OF A CRIME

USE

Use this protocol during any survey, if based on a complaint or an investigation of abuse, neglect, misappropriation of resident property, or exploitation, the facility did not report a reasonable suspicion of a crime or an allegation of retaliation was received. Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602, and F603, which gathers information about what information was or was not reported by covered individuals and whether retaliation may have occurred.

The protocol below investigates whether the facility developed and implemented policies and procedures related to:

- Ensuring the reporting reasonable suspicion of crimes,
 - Notifying covered individuals of their reporting responsibilities,
 - Prohibiting and preventing retaliation, and
 - Posting notification of employee rights.

PROCEDURES

If the surveyor discovers an incident that has criminal implications and has not been reported by the facility, the facility should be encouraged to make the report to the appropriate agencies. If

the facility refuses, the surveyor should consult with his/her supervisor immediately, since the State Agency may need to assume this responsibility.

NOTE: For those covered individuals who did not report the reasonable suspicion of a crime, discuss with the State Survey Agency and next steps for referral for follow-up and possible sanctions.

Facility Policies and Procedures

Obtain and review the facility's policies and procedures to determine whether the facility is in compliance with the requirements at 1150B for:

- Ensuring the reporting reasonable suspicion of crimes,
- Notifying covered individuals of their reporting responsibilities,
- Prohibiting and preventing retaliation, and
- Posting notification of employee rights.

Observations

Observe whether the facility has posted notification of employee rights and whether the notification includes all of the required components.

NOTE the location of the notification, in relation to whether it is likely to be noticed by all employees.

Interview of State Professional Licensing Authorities

If there is an allegation of retaliation against of an employee, the surveyor should contact the appropriate State licensing board, to determine whether the facility had filed a complaint or report against the employee, and if so, what information was provided in the complaint or report.

Interview Staff

Interview staff who may have knowledge of the alleged incident to determine how did staff follow facility policies and procedures, such as what actions were taken when there was a suspected crime, when he/she may have last received training and/or notification regarding the reporting of suspected crimes, and whether there are any barriers to reporting. For an allegation of retaliation, interview staff about what occurred, how the facility retaliated against staff, and when.

Interview – Administrator

Interview the Administrator to determine the following:

- How the Administrator oversees the implementation of policies and procedures for reporting of suspected crimes;
- For an allegation of retaliation:
 - Whether any actions were taken against an employee, and if so, what actions and why;
 - Whether the facility had submitted a report to the State professional licensing agency, and if so, why.

Review of In-service Training/Orientation Records

Obtain and review documentation of training to determine whether covered individuals were notified annually of their responsibility to report allegations of crimes in the facility.

Review of Employee Personnel Records

If there is an allegation of retaliation against of the employee, obtain a copy of the employee's personnel records to determine if the facility may have taken any action against the employee which may be related to an employee's report of a suspected crime.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F608, the surveyor's investigation will generally show that the facility failed to develop and implement policies and procedures for any one or more of the following:

- Ensure the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases);
- Notify covered individuals annually of their reporting obligations;
- Post signage of employee rights related to retaliation against the employee for reporting a suspected crime; or
- Prohibit and prevent retaliation.

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

Examples of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety include, but are not limited to:

- The facility failed to develop and implement policies and procedures for covered individuals to identify and report a suspected crime to local law enforcement and the SA, resulting in failure to protect a resident from further potential criminal activity by an alleged perpetrator. A resident, with a cognitive impairment who was dependent on staff for care, reported to family members that she was "touched down there" and identified the alleged perpetrator. Family members reported this to the licensed staff person on duty; however, the staff told the family that the resident was confused. Staff did not report the family's allegation to anyone and failed to provide protection for the resident allowing ongoing access to the resident by the alleged perpetrator. The resident had emotional changes including crying and agitation and cowered with fear whenever the alleged perpetrator approached the resident recurring fear whenever the perpetrator approached the resident. The resident subsequently developed a sexually transmitted disease (STD). Based on interviews with various staff members, these covered individuals were not aware of their reporting responsibilities for a suspected crime, and assumed that this did not need to be reported because the resident was confused.

Examples of Severity Level 3 Noncompliance Actual Harm that is not Immediate Jeopardy include, but are not limited to:

- The facility failed to implement policies and procedures for covered individuals to report to law enforcement, the suspicion of a crime related to drug diversion. A resident was prescribed opioid pain medication to manage severe pain following recent surgery for a fractured hip. A resident had requested that staff review his pain medication as it was not effective over the weekend. The resident informed staff that he was unable to attend weekend daytime activities due to discomfort and lack of sleep from having pain at night. The resident stated that he received a different colored pill during the weekend, but it did not seem to work like the medication that was given during the weekdays. The facility's investigation revealed that the same staff nurse worked on each of the weekend night shifts when the resident was identified to have unrelieved pain. This staff nurse had access to the controlled medications for residents on that unit. During interview with the nurse aide who worked on the same shift as the nurse, the nurse aide stated that she saw the nurse coming out of the resident's room with the medication cup, and the nurse had told her that the resident was sleeping and she would give the medication later. The nurse aide reported that she then saw the nurse take the medication herself. She stated that she was afraid to report what she had seen since she did not want to jump into any conclusions or cause any trouble for the nurse. Interviews with other staff revealed they were not aware of facility policies or of their obligations to report a suspected crime including possible drug diversion.

Examples of Severity Level 2 Noncompliance No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include, but are not limited to:

- The facility failed to provide annual notification to staff on their obligations to report suspected crimes and to post signage of employee rights related to retaliation against the employee for reporting a suspected crime. Based on interviews with five staff members, the staff were not knowledgeable about their obligations to report suspected crimes to law enforcement and to the State Survey Agency, without fear of retaliation. The staff were not aware of the time frames for reporting a suspected crime and did not recall receiving training on reporting.

Severity Level 1: No Actual Harm with Potential for Minimal Harm

The failure of the facility to meet the requirements under this Federal requirement is more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

F609 -- Reporting of Alleged Violation

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§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 2 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.

INTENT

The facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.

NOTE: In cases where a deficiency is identified and CMS imposes a civil money penalty based on the noncompliance, CMS will reduce the amount of the penalty by 50%, if all of the following apply (See 42 CFR §488.438):

- The facility self-reported the noncompliance to CMS or the State before it was identified by CMS or the State and before it was reported to CMS or the State by means of a complaint lodged by a person other than an official representative of the nursing home;
- Correction of the self-reported noncompliance occurred on which ever of the following occurs first:
 - 15 calendar days from the date of the circumstance or incident that later resulted in a finding of noncompliance; or
 - 10 calendar days from the date the civil money penalty was imposed;
- The facility waives its right to a hearing under 42 CFR §488.436;
- The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, immediate jeopardy, or result in the death of a resident;
- The civil money penalty was not imposed for a repeated deficiency that was the basis of a civil money penalty that previously received a reduction; and

- The facility has met mandatory reporting requirements for the incident or circumstance upon which the civil money penalty is based, as required by Federal and State law.

DEFINITIONS

“**Abuse**,” is defined at §483.5 as “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.”

“**Alleged violation**” is a situation or occurrence that is observed or reported by staff, resident, relative, visitor 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.

“**Exploitation**,” as defined at §483.5, means “taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.”

“**Immediately**” means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 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.

“**Injuries of unknown source**” – An injury should be classified as an “injury of unknown source” when **both** of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; **and**
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

“**Misappropriation of resident property**,” as defined at §483.5, means “the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.”

“**Mistreatment**,” as defined at §483.5, is “inappropriate treatment or exploitation of a resident.”

“**Neglect**,” as defined at §483.5, means “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.”

“**Sexual abuse,**” is defined at §483.5 as “non-consensual sexual contact of any type with a resident.”

GUIDANCE

REPORTING ALLEGED VIOLATIONS

It is the responsibility of the facility to ensure that all staff are aware of reporting requirements and to support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Protection of residents can be compromised or impeded if individuals are fearful of reporting, especially if the alleged abuse has been carried out by a staff member. During investigations, some staff have stated that he/she was aware, or had knowledge, that the incident had occurred, but did not report because he/she did not think it met the definition of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property. Anecdotal reports have indicated that failure to report an alleged violation may be due to, but not limited to, the following:

- An individual’s allegation is not believed due to a history of reporting false allegations;
- Staff fear of retaliation, or fear losing his/her job;
- Sympathy for co-workers, for example, not wanting to cause trouble for the co-worker;
- Communication, cultural, or language issues; or
- Residents/resident representatives may fear retaliation.

An individual (e.g., a resident, visitor, facility staff) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as “abuse,” “neglect,” “mistreatment,” or “exploitation” in order to trigger the Federal requirements at §483.12(c). Rather, if facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered to be reportable and require action under §483.12(c). For example, if a resident is abused but does not allege abuse, the resident’s failure or inability to provide information about the occurrence is immaterial when the abuse may be substantiated by other supporting evidence. Another example is when a nurse aide witnesses an act of abuse but fails to report the alleged violation, the failure to report does not support a conclusion that the abuse did not occur and the facility would not meet the reporting requirements.

All alleged violations, whether oral or in writing, must be immediately reported to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency and adult protective services where State law provides for jurisdiction in long-term care facilities). Conformance with this provision requires that each State Agency has a means to collect reports, even during off-duty hours (e.g., answering machine, voice mail, fax, electronic transmission, etc.). The facility must have documentation of the report, including what was reported and the date and time when the report was made to the SA.

The definition of “immediately” means as soon as possible in the absence of a shorter State time frame requirement, but not later than 2 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.

If an alleged violation has been identified and reported to the administrator/designee, the facility must immediately report it and provide protection for the identified resident(s) prior to conducting the investigation of the alleged violation. In some situations, the facility may initially evaluate an occurrence to determine whether it meets the definition of an “alleged violation.” For example, upon discovery of an injury, the facility must immediately take steps to evaluate whether the injury meets the definition of an “injury of unknown source.” Similarly, if a resident states that his or her belongings are missing, the facility may make an initial determination whether the item has been misplaced in the resident’s room, in the laundry, or elsewhere before reporting misappropriation of property. However, if the alleged violation meets the definition of abuse, neglect, exploitation or mistreatment, the facility should not make an initial determination whether the allegation is credible before reporting the allegation.

NOTE: At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action, in accordance with §483.12(c)(4).

The phrase “**in accordance with State law**” modifies the word “officials” only. State law may stipulate that alleged violations and the results of the investigations be reported to additional State officials beyond those specified in Federal regulations. This phrase does not modify what **types** of alleged violations must be reported or the time frames in which the reports are to be made. States may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, exploitation, and misappropriation of resident property) to be reported, nor can the State establish longer time frames for reporting than mandated in the regulations at §§483.12(c)(1) and (4). No State can override the obligation of the nursing home to fulfill the requirements under §483.12(c), as long as the Medicare/Medicaid certification is in place.

Some States may have different reporting requirements that could go beyond the Federal requirements or are more specific than the Federal requirements. For example, some States require that all falls be reported to the SA. The SA should continue to manage and investigate these cases under its state licensure authority. If the State determines that these occurrences do meet the definition of abuse, neglect, mistreatment, or injuries of unknown source, as outlined in this guidance, the SA must assess whether the nursing home has met the requirements for reporting and investigating these cases in accordance with 42 CFR §483.12(c).

There may be instances where a report is required under 2CFR §483.12(c) [F609], but not under 42 CFR §483.12(b)(5)/Section 1150B of the Act[F608]. The following table describes the different requirements:

	F608 42 CFR 483.12(b)(5) and Section 1150B of the Act	F609 42 CFR 483.12(c)
What	Any reasonable suspicion of a crime against a resident	1) All alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property 2) The results of all investigation of alleged violations
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility	The facility
To whom	State Survey Agency (SA) and one or more law enforcement entities for the political subdivision in which the facility is locates (i.e. police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners)	The facility administrator and to other officials in accordance with State law, including to the SA and the adult protective services where state law provides for jurisdiction in long term care facilities
When	Serious bodily injury- Immediately but not later than 2 hours* after forming the suspicion No serious bodily injury _ not later than 24* hours	All alleged violations – Immediately but not later than 1) 2 hours – if the alleged violation involves abuse or results in serious bodily injury 2) 24 hours – if the alleged violation does not involve abuse and does not result in serious bodily injury. Results of all investigation of alleged violations – with 5 working days of the incident.

*- Reporting requirements under this regulation are based on real (clock) time, not business hours.

Refer to the CE Pathways for Abuse (Form CMS-20059) and Neglect (Form CMS-20130) and the Investigative Protocols for tags F602 and F603.

Key Elements of Noncompliance

To cite deficient practice at F609, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:

- Identify a situation as an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property;
- Report immediately an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property to the administrator of the facility and to other officials, including to the State survey and certification agency and adult protective services in accordance with State law; or
- Report the results of all investigations within 5 working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency).