



MISSOURI DEPARTMENT OF
**HEALTH &
SENIOR SERVICES**

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HEALTH &
SENIOR SERVICES

Free from Abuse & Neglect

Facility Reporting Decision Guide

When to report · What timeframe applies · How to document

Before We Begin



Disclaimer:

- **Material is Sourced from CMS' State Operations Manual (SOM)**
- **Guidance and Practices Discussed is Relevant to ALL Providers**

Today's Objectives



01

What the regulations require

State Statute and F600 · F609 · F610
Your legal framework

02

What triggers a report & what doesn't

The allegation standard explained

03

Key definitions

Abuse, neglect, SBI, exploitation

04

Reporting timeframes: 2 hours vs. 24 hours

When each clock applies and why

05

Resident-to-resident incidents

When willful action is reportable regardless of cognition

06

Real-world scenarios

Was a report required? Work through each together

07

How to report + what to include

Missouri channels, initial report, 5-day follow-up

08

Learning opportunities & key takeaways

What SLCR regional offices are seeing

What the Regulations Require

At the State Level



Section 198.070, RSMO

Abuse or Neglect of Residents

“When any...has reasonable cause to believe that a resident of a facility has been abused or neglected, he or she shall immediately report or cause a report to be made to the department.”

88.010 (22) Resident Rights

Free from Abuse

“Abuse is the infliction of physical, sexual or emotional injury or harm and includes verbal abuse, corporal punishment and involuntary seclusion.”

88.010 (25) Facility Must Report

Any Staff Can Report to SLCR

Staff must immediately report any suspected or observed abuse, neglect or dangerous conditions involving a resident or vulnerable person to the department.

What the Regulations Require Cont'd



At the Federal Level

F600 Resident Rights

Free from Abuse, Neglect & Mistreatment

Every resident has the right to be free from abuse, neglect, exploitation, and mistreatment. This applies to every resident, every shift, in every building.

F609 Facility Must Report

Report to Administrator & SLCR

When an allegation is made, staff reports to the Administrator and to SLCR within the required timeframe. The obligation is triggered by the allegation, not a confirmed finding.

F610 Facility Must Investigate

Thorough Investigation Required

A thorough investigation of all alleged violations must be conducted with the resident protected throughout. Results reported to SLCR within 5 working days.

Reporting and investigating happen together. Both are set in motion when the allegation is made.

What Triggers a Report?

The Allegation Standard — §483.12(c)(1)



✓ Must Report

- ✓ Abuse allegations: any type, any source
- ✓ Neglect allegations
- ✓ Exploitation or mistreatment
- ✓ Misappropriation of resident property
- ✓ Injuries of unknown source
- ✓ Resident-to-resident incidents involving willful action



Not Required — Examples

- Accidental falls with clearly documented cause and no neglect indicator
- Two residents arguing with no physical contact or threats
- Clinical events with known, documented cause
- Grievances about call light response times

When in doubt, report. "If you had to investigate to find out if abuse occurred, you already had an allegation." — SLCR Regional Office

Key Definitions

42 CFR §483.5 — just enough to make the decision



ABUSE

2 HOURS

Willful infliction of injury, confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. **"Willful": the action was deliberate, not that injury was intended.** Includes verbal, sexual, physical, mental, and technology-facilitated abuse.

NEGLECT

24 HOURS

Failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. No willful intent required; defined entirely by outcome. The facility is responsible even when the failure is systemic.

SERIOUS BODILY INJURY (SBI)

2 HOURS

Extreme physical pain, substantial risk of death, protracted loss of a bodily function, requires surgery, hospitalization, or rehabilitation. Criminal sexual abuse is automatically SBI. **Neglect resulting in SBI = 2-hour window, not 24.**

EXPLOITATION / MISAPPROPRIATION

24 HOURS

Exploitation: taking advantage of a resident for personal gain through manipulation, intimidation, threats, or coercion.

Misappropriation: deliberate misplacement, exploitation, or wrongful use of a resident's belongings or money without consent. Includes medication diversion.

Injury of Unknown Source — all 3 required: not observed · not explained by resident · suspicious due to extent, location, number, or pattern.

The 3-Step Decision Tree



Use this sequence every time an incident or allegation occurs

1

STEP 1 | Has an allegation been made?

Any report or observation that, if verified, *could* constitute abuse, neglect, exploitation, mistreatment, misappropriation, or injury of unknown source. Person does not need to say "abuse."

YES →

Continue →

NO →

No report required

2

STEP 2 | Does it involve ABUSE?

Willful infliction of injury, confinement, intimidation, or punishment. Includes verbal, physical, sexual, mental, and technology-facilitated abuse.

YES →

2 HOURS

NO →

Continue →

3

STEP 3 | Did it result in SERIOUS BODILY INJURY?

Extreme physical pain, substantial risk of death, protracted loss of bodily function, requires surgery, hospitalization, or rehabilitation. Criminal sexual abuse is automatic SBI.

YES →

2 HOURS

NO →

24 HOURS

Always required for all allegations: Protect the resident · Conduct thorough investigation
· Take corrective action if verified · Report results within 5 working days

Reporting Timeframes



The clock starts when any staff member learns of the allegation, NOT when it reaches management

2 HOURS

Report immediately

- ✓ Any allegation of ABUSE (verbal, physical, sexual, mental, technological)
- ✓ Any allegation resulting in SERIOUS BODILY INJURY — even if not abuse
- ✓ Injuries of unknown source where abuse is suspected
- ✓ Neglect resulting in serious bodily injury

24 HOURS

Report same day

- ⚠ Neglect (no abuse, no serious bodily injury)
- ⚠ Misappropriation of resident property / exploitation
- ⚠ Mistreatment not meeting the abuse threshold
- ⚠ Injuries of unknown source without abuse suspicion

5 Working Days: Submit the follow-up investigation report to your SLCR Regional Office (NOT the Adult Abuse & Neglect Hotline).

Resident-to-Resident Incidents



Understanding when these situations trigger a reporting obligation

The Key Question: Was the action deliberate? If yes, it is reportable regardless of the resident's cognitive status.

"Willful" Does NOT Mean Intentional Harm

"Willful" means the physical act itself was deliberate, not that the resident meant to cause injury. A resident with dementia who strikes another resident acted deliberately.

CMS surveyor guidance: Surveyors are directed not to rule out abuse simply because of cognitive impairment.

Must report when a willful action results in:

Physical injury | Mental anguish (fear, distress, withdrawal, etc.)
| Pain (verbal or nonverbal indicators)

A Common Point of Confusion

It can feel counterintuitive when a resident with dementia is involved on either side of an incident.

The regulatory framework is consistent: cognitive status does not change whether the reporting criteria applies. The investigation is what explores those details.

Not required:

Accidental contact, incidental nudges, non-targeted outbursts with no resulting injury, anguish, or pain, **but always assess, document, and monitor.**

"Behavioral episode" describes what triggered the incident, it does not answer the regulatory question of whether the act was willful and resulted in harm.

Recognizing Psychosocial Harm



Mental anguish is as reportable as physical injury. Here's how to recognize and document it.



Behavioral Indicators

- Withdrawal from activities or conversations
- Tearfulness, angry outbursts, agitation
- Fear or avoidance of specific staff/residents
- Cowering, trembling, panic attacks
- Difficulty sleeping, PTSD symptoms



Physical Pain Indicators

- Facial grimacing or guarding a body area
- New difficulty sitting or walking
- Vocalizations of pain or distress
- Refusal of care previously accepted
- Changes in vital signs or appetite



Distrust & Fear Patterns

- Shying away from being touched
- Avoidance of certain areas of the facility
- Statements expressing fear or feeling unsafe
- Withdrawal from previously enjoyed activities



Documentation Approach

- Record before/after mood and demeanor
- Note nonverbal cues: tone, gesturing, eye contact
- Apply the REASONABLE PERSON standard
- Track patterns over time, not just single events
- Coordinate with social services and practitioner

Reasonable Person Standard: when a resident's reaction is hard to assess, ask how would a reasonable person in these exact circumstances be affected?



Real-World Scenarios

9 situations drawn from Missouri SLCR regional offices

- | | |
|---------------------------------------|------------------------------|
| 1. Resident-to-Resident Verbal | 5. Pattern of Incidents |
| 2. Resident-to-Resident Physical | 6. Pattern of Incidents |
| 3. Allegation Dismissed as Delusional | 7. Misappropriation |
| 4. Staff Verbal Interaction | 8. Elopement |
| | 9. Neglect/Improper Transfer |

Scenario 1 | Resident-to-Resident Verbal Altercation



Should this have been reported?

What Happened:

Staff overheard Resident A yell "Shut up!" at Resident B from across the hall. Resident B yelled back. Staff observed Resident A attempting to enter Resident B's room while continuing to yell. Staff intervened, redirected Resident A, and separated both residents. Resident A was placed on 15-minute checks. No physical contact occurred. No threats of physical violence were made. Both residents calmed quickly.

Reporting was NOT required for this incident.

Key Issues:

- No physical contact occurred — verbal altercation only.
- No threats of physical violence — this was a noise dispute, not an expression of intent to harm.
- Staff intervened appropriately and both residents de-escalated quickly.
- Note: the staff response was strong — intervening, documenting, separating, monitoring. Good clinical management and a reporting obligation are two separate questions.

Scenario 2 | Resident-to-Resident Physical Altercation



Should this have been reported?

What Happened:

Resident A stood up from his wheelchair and shoved Resident B, knocking her to the ground. Resident B struck her head on the floor and complained of head pain. A bruise was visible at the temple. Resident A had a diagnosis of dementia with behavioral features. Staff documented the incident as a behavioral episode.

This situation called for a report to SLCR.

Key Issues:

- Shoving another resident to the ground is a deliberate physical act and willful under the regulatory definition.
- Resident B sustained a visible head injury and complained of pain. Physical injury and pain were present.
- A dementia diagnosis describes a clinical condition. It does not determine whether a physical act was deliberate.
- "Behavioral episode" describes what triggered the incident. The regulatory question is whether the action was willful and resulted in injury, anguish, or pain.
- Head injury with confusion warrants evaluation for serious bodily injury. Consider whether the 2-hour window applies.

Scenario 3 | Allegation Dismissed as Delusional



Should this have been reported?

What Happened:

A resident with significant cognitive impairment told multiple staff members that people were chasing him and that someone had hit him. Leadership concluded he was experiencing delusions. Later, facility video footage revealed that four staff members had dragged the resident across the floor by his arms and legs and physically assaulted him.

This situation called for a report to SLCR.

Key Issues:

- The resident stated he was hit. That is an allegation, regardless of cognitive status.
- A resident's cognitive status or history of confusion does not remove the reporting obligation when an allegation has been made.
- The investigation is what explores whether an allegation is valid. It begins alongside the report, not before it.
- Video evidence later confirmed actual staff-to-resident abuse that was entirely missed because no report was filed.

Scenario 4 | Staff Verbal Interaction



Should this have been reported?

What Happened:

A resident with dementia became agitated during morning care and began yelling at the CNA. The CNA raised her voice in response, telling the resident to "calm down" and "stop fighting me" while continuing to provide care. Another staff member overheard and reported to the charge nurse that the CNA had "yelled at" the resident. The charge nurse reviewed the incident and documented a counseling note.

This situation called for further evaluation and a reporting decision alongside that process.

Key Issues:

- A report from another staff member that a CNA "yelled at" a resident is an allegation worth evaluating carefully.
- The charge nurse's review and counseling note are good first steps, but they work alongside the reporting and investigation process, not instead of it.
- The key question: did the CNA's conduct constitute verbal abuse? That requires an investigation: interviews of witnesses, review of what was said and how.
- If the investigation finds the conduct constituted verbal abuse, a report was required at the time the allegation was made; not after the investigation concluded.

Scenario 5 | Pattern of Incidents



Should this have been reported?

What Happened:

The Administrator and DON witnessed Resident A throw a cup of water at Resident B in the dining room. Resident A then threw the cup at Resident B which resulted in an injury. Staff determined it was the cup that caused the injury and not Resident A. The next day, staff were told about a resident-to-resident altercation between Resident A and Resident C who were roommates. Staff did not witness the altercation and the residents remained roommates. A few weeks later, staff overheard Resident C yelling for help from her room. Resident C said Resident A had jumped on her, hit her and grabbed her hair. Staff documented the incident.

This situation called for a report to SLCR.

Key Issues:

- Throwing something at another resident is a deliberate action. This is resident-to-resident abuse.
- Being made aware an altercation occurred is being made aware of an abuse allegation.
- Not witnessing an alleged altercation does not negate the allegation.
- Staff are responsible to ensure residents' safety when made aware of an allegation.

Scenario 6 | Pattern of Incidents



Should this have been reported?

What Happened:

Monday: Resident A hit Resident B. Documented as a behavioral incident. Thursday: Resident A hit Resident C and pulled her hair. Facility concluded "no harm." Resident C had visible scratches and required pain medication. Resident B was later found to have needed lip stitches from Monday's incident. Both Resident B and C expressed fear of Resident A.

Both of these situations called for a report to SLCR.

Key Issues:

- Scratches and pain medication are not "no harm" — pain is a recognized outcome under the regulatory definitions.
- Fear is psychosocial harm. Both residents expressing fear of Resident A is a documented adverse outcome.
- A pattern of incidents involving the same resident also raises care planning and supervision questions.
- The reporting process is what sets the investigation in motion — the determination of harm is part of what the investigation explores.

Scenario 7 | Misappropriation



Should this have been reported?

What Happened:

A resident told staff her necklace was missing from her room. Staff looked for the necklace but were unable to locate it.

This situation called for further evaluation and a reporting decision alongside that process.

Key Issues:

- If it is believed the item was lost, it does not need to be reported.
- If it is believed an item was stolen, it needs to be reported.
- A thorough investigation must be conducted to make a report determination.

Scenario 8 | Elopement

Should this have been reported?



What Happened:

A resident went out the front door to get something from his car. The resident did not have a car. The door alarm went off, and staff arrived in under 60 seconds to investigate. Staff found the resident standing outside. He had no previous wandering tendencies. The resident was redirected back into the facility and placed on 15-minute checks.

Reporting was NOT required for this incident.

Key Issues:

- The resident had not exhibited any prior wandering tendencies.
- The alarm system sounded and staff responded appropriately and investigated per their policy.
- The resident was redirected and placed on increased observation.
- There were no extenuating circumstances that placed the resident at risk for harm.

Scenario 9 | Neglect — Improper Transfer



Should this have been reported?

What Happened:

Incident 1: A CNA transferred a resident requiring a two-person Hoyer lift without any assistive device. The resident sustained a fractured leg. The CNA was suspended, educated, and returned to work. Incident 2 (same CNA): The same CNA again performed a solo transfer on a resident requiring a two-person gait belt assist. The resident sustained a broken ankle.

Both situations called for a report to SLCR within the 2-hour window.

Key Issues:

- When care is not delivered as the care plan requires and a resident is harmed, that meets the definition of neglect under §483.5.
- A fractured leg and broken ankle are serious bodily injuries — the 2-hour reporting window applied to both incidents.
- Internal disciplinary steps and external reporting to SLCR serve different purposes — one complements the other.
- The repeated incident raises supervision questions that external reporting would have surfaced.

What to Include in Your Report



Initial report (within 2 or 24 hours) and 5-day investigation report

Initial Report (2 or 24 hours)

- ✓ Resident name, room, DOB, cognitive status
- ✓ Date, time, and exact location of incident
- ✓ Description of what occurred and how it was discovered
- ✓ Alleged perpetrator name and role (if known)
- ✓ Safeguards implemented to protect the resident
- ✓ Medical interventions taken (physician notified, ER, treatment)
- ✓ Other entities notified: APS, law enforcement — include case number
- ✓ A reachable callback number for SLCR

5-Day Investigation Report

- ✓ Timeline of investigation events
- ✓ Interviews: victim, perpetrator, witnesses, practitioners
- ✓ Record reviews completed during investigation
- ✓ Findings: verified, unverified, or inconclusive with rationale
- ✓ Corrective actions taken if allegation verified
- ✓ Evidence documented: photos, video, written statements
- ✓ Updates to initial report based on investigation findings

Deliberate omissions or misrepresentation can result in a separate deficiency citation at F609, independent of the underlying violation.

How to Report to Missouri SLCR



Channels, what to include, and helpful tips



Online (24/7)



Preferred method - available anytime



Hotline

1-800-392-0210

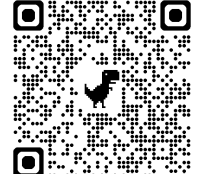
7 a.m. – 10 p.m. daily



FRI Forms



Initial



Follow Up

Tips for Complete, Useful Reports

- ✓ Include the resident's outcome to the best of your knowledge at the time. A follow-up call to SLCR is always appropriate if more is learned later.
- ✓ Include a reachable callback number — SLCR initiates triage on all self-reports within 24 hours.
- ✓ Online portal or Hotline submission is strongly preferred over fax/email
- ✓ The 5-day follow-up goes to your SLCR Regional Office — NOT the Adult Abuse & Neglect Hotline.
- ✓ After hours: use the online portal or Hotline. Don't leave a voicemail at the regional office Friday evening.

**Law enforcement required when reasonable suspicion of a crime. Document: date/time, recipient name, case number.
Keep this record on file at the facility.**

Learning Opportunities: What SLCR is Seeing



Under-Reporting

- ✘ Investigating before reporting. Both must happen simultaneously
- ✘ Allegations documented in nursing notes but never reported to SLCR
- ✘ Hesitating because of a resident's cognitive status
- ✘ Neglect from improper transfers resolved internally without SLCR report
- ✘ Pain and psychosocial harm not recognized as 'harm'. Only obvious visible injuries reported
- ✘ Neglect cases with SBI reported at 24 hours instead of 2 hours

Reporting Quality Gaps

- ⚠ Corporate-driven over/under reporting
- ⚠ Reports submitted without identifying the resident's outcome or harm
- ⚠ Reports submitted without a reachable callback number
- ⚠ 5-day follow-up sent to the Hotline instead of the SLCR Regional Office
- ⚠ Reporting patterns spike after a survey finding, then gradually drift back

Both columns represent real compliance risk. Consistent habits are the goal.

Key Takeaways



01

Report and investigate simultaneously. Never one before the other.

02

Default to 2 hours when in doubt. You cannot be cited for reporting too quickly — only too late.

03

Abuse triggers 2 hours. Neglect + serious bodily injury also triggers 2 hours.

04

Sexual abuse is automatically serious bodily injury — regardless of visible injury.

05

Cognitive impairment does not remove the reporting obligation on either side of an incident.

06

Both reports are required: initial (2 or 24 hours) AND results (5 working days to Regional Office).

07

Psychosocial harm counts. Fear, distress, and pain are recognized harms. No broken bone required.



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