

## Comparison of Federal and State Requirements/Definitions

FEDERAL	STATE
<p>The federal regulations have not changed. The Minnesota Department of Health (MDH) is enforcing the regulations as written and as required by CMS.</p> <p>A system for reporting to MDH has been developed to ensure that facilities are in compliance with the federal requirements.</p>	<p>The process related to facilities reporting to the Common Entry Point (CEP) has not changed. Facilities are to continue to report to the CEP just as they have for years.</p>
<p><b>NEW ELECTRONIC REPORTING PROCESS TO MEET FEDERAL REGULATIONS</b></p> <p>MDH must be capable of receiving reports 24 hours/day</p> <p>Facilities will send initial report to MDH within 24 hours of discovery of the incident</p> <p>Facilities will submit investigative report within five working days</p> <p><b>(MDH will no longer send a letter to request more information. The electronic system will inform the facility that an investigative report must be submitted to MDH at the time the initial report is made. Two days after the initial report is made to MDH, another e-mail will be sent to the facility reminding the facility to submit an investigative report.)</b></p>	<p><b>REPORTING TO THE CEP</b></p> <p>Facilities must make an oral report to the CEP within 24 hours of the discovery of the incident</p> <p>CEP Responsibilities:</p> <p>Must be capable of receiving reports 24 hours/day</p> <p>Screen for immediate risk and make the necessary referrals</p> <p>Notify lead agency within two working days of receipt of the report</p> <p>Report immediately to law enforcement when there is reason to believe a crime has been committed; report to law enforcement and ombudsman office if the report contains information about a suspicious death; report to adult protective services if there is an immediate need for protective services</p> <p><b>THE ABOVE PROCESS HAS NOT CHANGED</b></p> <p><b>MDH HAS HISTORICALLY SENT A LETTER TO THE REPORTING FACILITY REQUESTING THE INVESTIGATIVE REPORT. MDH WILL NO LONGER SEND A LETTER</b></p>

**FEDERAL****STATE****DEFINITIONS****MISTREATMENT**

(No definition provided at this time)

**ABUSE**

The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R 488.301)

1. Verbal abuse - The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability.
2. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault.
3. Physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
4. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.
5. Involuntary seclusion - Separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency

**DEFINITIONS****MALTREATMENT**

Abuse, neglect, financial exploitation, unexplained injuries, errors as defined in Minnesota Statutes 626.5572, Subdivision 17. (c) (5)

**ABUSE**

- a. An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
  1. assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
  2. the use of drugs to injure or facilitate a crime as defined in section 609.235;
  3. the solicitation, inducement and promotion of prostitution as defined in section 609.322;
  4. criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
- b. Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to the following:
  1. hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
  2. use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;
  3. use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
  4. use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
- c. Any sexual contact or penetration as defined in section 609.341, between a facility staff or a person providing services in the facility and a resident, patient, or client of the facility.
- d. The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

**FEDERAL****STATE**

or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.	
<b>MISAPPROPRIATION OF RESIDENT PROPERTY</b> The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent (42 C.F.R. 488.301)	<b>FINANCIAL EXPLOITATION</b> (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person: (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or (2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult. (b) In the absence of legal authority a person (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult; (2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult; (3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.
<b>NEGLECT</b> Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 C.F.R. 488.301)	<b>NEGLECT</b> (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is: (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and (2) which is not an accident or therapeutic conduct. (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to

**FEDERAL****STATE**

	<p>obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.</p> <p>Minnesota Statutes 626.5572, Subd. 17. (c)(5) defines <u>error</u> as:</p> <p>(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:</p> <p>(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;</p> <p>(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's pre-existing condition;</p> <p>(iii) the error is not part of a pattern of errors by the individual;</p> <p>(iv) if in a facility, the error is immediately reported as required under section 626.557 and recorded internally in the facility;</p> <p>(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and</p> <p>(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.</p>
<p><b>INJURIES OF UNKNOWN SOURCE</b></p> <p>An injury should be classified as an "injury of unknown source" when both of the following conditions are met:</p> <p>1.The source of the injury was not observed by any person <b>or</b> the source of the injury could not be explained by the resident: and</p> <p>2.The injury is suspicious because of the extent of the injury <b>or</b> 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.</p>	<p><b>UNEXPLAINED INJURIES</b></p> <p>If a reporter has reason to believe that the vulnerable adult has sustained an injury which is not reasonably explained</p>

## FEDERAL

### **Resident to Resident abuse is reportable under federal regulations,**

42 CFR 483.13 (b) states:

“The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.”

The intent for the above regulation states:

“Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.”

### **Accident**

No requirement to report accidents

### **Error**

There is no provision for error under the federal regulations. Incidents identified as an error and not reportable under Minnesota Statutes 626.557, **are reportable under the federal regulations.**

## STATE

### **Report not required (Minnesota Statutes 626.557, Subd. 3a)**

(b) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies.

(c) Accidents as defined in section 626.5572, subdivision 3.

(d) Events occurring in a facility that result from an individual's error in the provision of therapeutic conduct to a vulnerable adult, as provided in section 626.5572, Subdivision 17, paragraph (c), clause (4).

(e) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered.

### **Accident**

A sudden, unforeseen, and unexpected occurrence or event which:

(1) is not likely to occur and which could not have been prevented by exercise of due care; and

(2) if occurring while a vulnerable adult is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

### **Error Minnesota (Statute 626.557, Subdivision 17 (c) (4))**

(A)n Individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care.