



**LONG TERM CARE SECTION
HEALTHCARE FACILITY REGULATION**

**LONG TERM CARE FACILITIES REPORTING REQUIREMENTS FOR ABUSE,
NEGLECT AND EXPLOITATION AND OTHER ADVERSE EVENTS
&
GUIDANCE FOR CONDUCTING INVESTIGATIONS**

This document is intended for guidance purposes only, facilities are expected to remain up to date on CMS requirements for mandatory reporting as these requirements may change. This document is effective and current with reporting requirements as of 1/1/2026.

I. DEFINITIONS

Definitions used in this document are based on federal regulations and guidelines as well as state law.

- A. Abuse**, including resident to resident abuse, is the **willful** infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
- 1. Verbal Abuse** is any 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 their age, ability to comprehend, or disability. Verbal abuse includes but is not limited to, threats of harm and statements with the intent to frighten a resident.
 - 2. Sexual Abuse** is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.
 - 3. Physical Abuse** includes but is not limited to, hitting, slapping, pinching, kicking or controlling behavior through corporal punishment.
 - 4. Mental Abuse** includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.



- B. **Neglect** is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
- C. **Exploitation/Misappropriation of Resident Property** is the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent. Exploitation is further defined as taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
- D. **Mistreatment** is inappropriate treatment or exploitation of a resident.
- E. **Injuries of Unknown Source** is an injury for which both of the following conditions are met:
 - 1. 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**
 - 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., it’s 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.
- F. **Facility Reports** are official self-report notifications typically sent by the facility administrator or designee to the State Survey Agency or CMS Regional Office of incidents required by federal and/or state law, regulation or policy.
- G. **State Survey Agency** means the Department of Community Health (DCH), Healthcare Facility Regulation Division (HFRD).
- H. **Reasonable Person Concept** is a concept used to gauge the likely impact on a hypothetical “reasonable person” in situation where the resident is unable to speak for themselves.

II. **FEDERALLY MANDATED REPORTING REQUIREMENTS - WHAT MUST BE REPORTED AND WHEN MUST REPORTS BE MADE**

- A. The facility must ensure **ALL** allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to the State Survey Agency 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.



B. The results of facility investigations must be reported to the administrator or his/her designated representative, the State Survey Agency, and to other officials in accordance with state law within 5 working days of the incident.

C. Mandated reporters must immediately report to the State Survey Agency any knowledge that any resident or former resident has been abused or exploited while residing in a long-term care facility.

A “**mandated reporter**” is **any** administrator, manager, physician, nurse, nurse’s aide, orderly, or other employee in a hospital or facility, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, coroner, clergyman, police officer, pharmacist, physical therapist or psychologist, or employee of a public or private agency engaged in professional services to residents or responsible for inspection of long-term care facilities.

D. Notification of Law Enforcement is required if there is a reasonable suspicion of a crime. The expectation is for the notification to occur at the point where that suspicion for a crime is determined.

III. FACILITY INVESTIGATIONS

A. Federal regulation requires that a facility must have evidence that all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are **thoroughly investigated**. In addition, the facility must take action to prevent further potential abuse while the investigation is in progress.

B. See “Conducting A Thorough Investigation.”

IV. ADVERSE EVENT REPORTING STATE REQUIREMENTS

A. Adverse events should be reported to the Georgia State Survey Agency within 24 hours of the identification of the event that meets the following criteria:

- 1. Witnessed Falls** with Serious Bodily Injury (SBI) should be reported to the State Survey Agency once confirmation of a SBI status post fall has been identified. There is a specific option that would be selected on the FRI form for Witnessed Fall with Serious Bodily Injury with No Alleged Abuse. Please note that if there is any neglect suspected in the series of events leading up to the fall, it should be reported



under the abuse guidelines. As this is a witnessed fall and all information related to the events would be readily available, if all details are provided in an initial report, a follow up report is not required. The State Survey Agency reserves the right to request additional information is needed.

2. **Elopement** of a resident that places the resident at risk of harm or injury.
3. **Fire** at a facility should be reported as an adverse event if the outcome of the event had an impact to a resident. This adverse event submission is in addition to any required reporting to the local fire department and/or state fire marshal's office.

V. HOW TO REPORT

- A. Reports of alleged abuse, neglect, exploitation/misappropriation of resident property as well as adverse events must be submitted through the online portal:

<https://dch.georgia.gov/divisionsoffices/hfrd/facility-incident-report-form>

For assistance with any issues or follow up report submission:

Email: HFRDcomplaintintake@dch.ga.gov

VI. CONDUCTING A “THOROUGH” INVESTIGATION

Although there is no state or federal regulatory guidance for what constitutes a ‘thorough investigation’, the federal regulations clearly require the facility to have evidence that all alleged violations are “thoroughly investigated”. The following represents guidance on those components of an investigation that would constitute a “thorough” investigation. Therefore, it is important that the facility document all aspects of its investigation in order to provide evidence that all allegations were “thoroughly investigated”.

A. The Investigation

1. Specify the type of allegation that is being reported (i.e., physical abuse, sexual, verbal abuse, neglect, misappropriation/exploitation or injury of unknown origin).
2. Document the details of the incident. What allegedly occurred? When and where did the alleged incident occur? Who is the alleged victim? Who is the alleged



perpetrator? What is the physical description of the perpetrator? Did the victim identify the perpetrator?

3. Document the description of the injury. Describe the size, color, appearance, and location of any injuries, and what treatment was rendered, if any.
4. Develop a list of known and possible witnesses to the alleged incident. Interview and obtain signed statements where possible from staff, residents, and/or visitors or anyone who has, or might have, knowledge of the incident that is being investigated. Interview staff who cared for the resident(s) at the time of the alleged incident. Interview staff on other shifts who might have seen or heard anything, such as 24 hours prior to the alleged incident, to try and narrow down the time frame of the alleged occurrence and to document when the first sign any injury appeared. Interview residents in the same room, or residents in the immediate vicinity of where the alleged incident occurred, who might have seen or heard something. Also, do not forget visitors who might have witnessed the incident. Observe and document any unusual demeanor of the person being interviewed. Statements obtained from individuals who the facility determines to be actual witnesses need to be very specific, (i.e., what does “rough” mean to that individual?) Include the names, addresses and phone numbers of all individuals identified as actual witnesses.
5. Identify the cognitive status of the victim(s) and resident(s) who are witnesses. (Are they alert, oriented, and able to answer questions appropriately? This would help in determining if he/she would be a credible witness). Review a copy of the resident’s current MDS and the resident’s current care plan, if applicable to the incident. If the witness is not alert and oriented, but the facility is utilizing this witness’ statement in the investigation, explain why the witness is considered credible/believable, (i.e., he/she consistently repeats the same story and/or has a history of consistently providing accurate information).
6. Interview and obtain a written signed statement where possible from the alleged perpetrator(s).
7. If the perpetrator is an employee, review the perpetrator’s past performance (work history) or any previous incident. Interview coworkers and/or residents to gain knowledge of their experiences with the accused person.
8. If the perpetrator is a resident, review the perpetrator’s past behaviors documented in the resident record, including the MDS. Determine if the resident’s care plan was updated and implemented as appropriate.



9. Describe any action(s) taken by the facility to protect resident(s) and to prevent a possible reoccurrence during the investigation.
10. Note if there is any evidence of bias between the alleged perpetrator(s) and any of the witnesses, or there is evidence of conflict between witnesses. What is the relationship between the witnesses and perpetrator (i.e., professionals, friends, relatives and/or enemies)?
11. If agency personnel were involved, obtain a statement from the person. Identify the name of the agency and the contact person, and the name, address, and phone number of the employee.
12. If the allegation involves sexual abuse, document if the alleged victim was examined, and if so, obtain a copy of the examination or statement from the examiner.
13. If the allegation involved neglect, identify the staff member or members involved, the length of time involved, and any outcome to the victim. Be specific.
14. If the allegation involves misappropriation/exploitation, clearly identify the items and their approximate value. Obtain copies of bills, charge slips, vendor receipts, etc., if applicable.
15. Review the schedule and assignment(s) showing when and where the suspect was working at the time of alleged incident. Be specific as to the hall, section, and/or resident rooms.
16. Identify any medication(s) that may cause the resident to bruise easily or in any way be related to the nature of the injury.
17. If applicable, review facility procedures and staff training records if the incident may be related to unsafe technique used by staff.
18. Review and identify any nurses' notes or other facility records that may contain information about the incident.

B. Summary Report of Facility's Findings and Conclusions

1. Upon conclusion of the investigations, the nursing facility should prepare a summary report of the findings and conclusions. This summary report must include sufficient detail of the investigation to document that the facility conducted a thorough



investigation; any actions taken by the facility (i.e., staff training, disciplinary actions, etc.); a summary of the findings and a conclusion of the investigation (i.e., was the allegation substantiated or unsubstantiated.) See FACILITY INCIDENT REPORT FORM.

2. This summary report is required to be submitted to the State Survey Agency within 5 working days of the initial incident. The report may include copies of any additional documents the facility believes necessary to demonstrate that a thorough investigation was conducted.
3. The survey agency may require the facility to provide any additional information and/or documentation when it has reason to clarify the information provided, question the thoroughness of the facility's investigation or, whenever such documents may be necessary for purposes of pursuing administrative action related to the alleged perpetrator.



**GEORGIA DEPARTMENT
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