

EVENT REPORTS

References relevant to
Event Reports

24-hour and 5-day report forms

South Dakota Department of Health - Office of Health Care Facilities Licensure & Certification

11-30-2011

CMS Ref: S & C 11-30-NH

- ▶ Reporting reasonable suspicion of a crime in a Long Term Care (LTC): Section 1150B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility.



Time Period for Individual Reporting

Section 1150B establishes two time limits for the reporting of reasonable suspicion of a crime, depending on the seriousness of the event that leads to the reasonable suspicion.

- ▶ **1. Serious Bodily Injury – 2 Hour Limit:** If the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion...



Time Period – Serious Bodily Injury

- ▶ Public Act 111-148; Patient Protection and Affordable Care Act ;Title VI; Subtitle H – Elder Justice Act; Sec.2011. Definitions.

(19) Serious Bodily Injury –

(A) In general – The term ‘serious bodily injury’ means an injury –

- (i) involving extreme physical pain;
- (ii) involving substantial risk of death;
- (iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or
- (iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

(B) Criminal Sexual Abuse



Time Period for Individual Reporting

- ▶ **2. All Others – Within 24 Hours:** 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.



44:04:01:07.Reports

- ▶ Each licensed facility, when requested by the department, shall submit to the department the pertinent data necessary to comply with the requirements of SDCL chapter 34-12 and this article.
- ▶ Each facility shall also report to the department within 24 hours and any other licensed facility shall report to the department within 48 hours of the event

* any death resulting from other than natural causes originating on facility property such as accidents, abuse, negligence, or suicide;

* any missing patient or resident;

* any allegation of abuse or neglect of any patient or resident by any person.

Each facility shall report the results of the investigation within five working days after the event.



44:04:01:07.Reports cont.

- ▶ Each facility shall also report to the department as soon as possible
 - * any fire with structural damage or where injury or death occurs;
 - * any partial or complete evacuation of the facility resulting from natural disaster; or
 - * any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and
 - * other critical equipment necessary for operation of the facility for more than 24 hours.

Each facility shall notify the department of any anticipated closure or discontinuation of services at least 30 days in advance of the effective date.



44:04:01:01.Definitions. (1) Abuse

- ▶ “Abuse,” an intentional act toward an individual indicating that one or more of the following has occurred:
 - (a) A criminal conviction against a person for mistreatment toward an individual; or
 - (b) In the absence of a criminal conviction, substantial evidence that one or more of the following has occurred resulting in harm, pain, fear, or mental anguish:
 - (i) Misappropriation of a patient’s or resident’s property or funds’
 - (ii) An attempt to commit a crime against a patient or resident
 - (iii) Physical harm or injury against a patient or resident; or
 - (iv) Using profanity, making gestures, or engaging in other acts made to or directed at a patient or resident.
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(33) Neglect

- ▶ “Neglect,” a failure, without reasonable justification, to provide timely, consistent, and safe services, treatment, and care necessary to avoid physical harm, mental anguish, or mental illness to a patient or resident.



44:04:18:26. Grounds for revocation, denial, or suspension of nurse aide registry status.

- ▶ The department (DOH/OLC) may revoke a nurse aide's current registry status if the department determines after a contested case hearing pursuant to SDCL chapter 1-26 that the nurse aide has violated the meaning of abuse or neglect as those terms are defined in 44:04:01:01. The department may deny registry status to a nurse aide applying for registration if the nurse aide was convicted of criminal charges related to abuse or neglect of an individual. Registry status may be suspended by the department during the investigation of an allegation of abuse or neglect by a nurse aide following due process as outlined in 44:04:18:29. Notice and hearing process.
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Certified Nurse Aide (CNA)

- ▶ Hiring process:

 - Do complete checks – OIG, Nurse Aide registry, Background, References.

- ▶ Annual review – review for changes in information, not just change in name, address, and contact information.
Ask about criminal events.

Expectations for provider to have same information available for temp agency staff.



Reports

- ▶ Fax to 605.773.6667 Attention Complaint Coordinator or
- ▶ May Email as an attachment to doholccomplaint@state.sd.us or
- ▶ After 5:00 pm CST, weekends, holidays serious suspicion / events only Call 1.800.738.2301



INSTRUCTIONS FOR USE OF REQUIRED NURSING FACILITY EVENT REPORTING FORM - 44:04:01:07. Reports

1. Provide name of facility and requested facility information.
2. Include full name not initials of resident/patient and date of birth.
3. Include date and time of event being reported.
4. Include name of person completing the event/accident report.
5. Indicate by **X** mark the type of event being reported.

Death, other than natural causes – was there evidence of other factors such as accidents-fall in last 24-72 hours, abuse, negligence, or suicidal ideation. Law enforcement notified?

Missing patient or resident – the individual was away from the facility without staff knowledge of departure or exit time and destination.

Allegation of Abuse/Neglect – by definition in 44:04:01:01. Definitions (1) & (33).

Indicate whether facility personnel, family or visitors, or resident to resident.

Type of Abuse/Neglect suspected – indicate physical harm or injury, misappropriation of property or funds, use of profanity, gestures, or acts.

Fall(s) – While the provider doesn't have to report every fall there should still be a thorough internal investigation. The investigation should ascertain if there were injuries, providing treatment as necessary; determining what may have caused or contributed to the fall; look at and address the factors of the fall; and revise the individual's care plan and/or the facility practices, as needed, to reduce the likelihood of another fall. If during the internal investigation, there is evidence of neglect on the part of staff, this needs to be reported. Staffs not following the individual care plan, not using assistive equipment such as lifts appropriately are examples. Unless there is evidence suggesting otherwise when an individual is found on the floor, a fall is considered to have occurred.

Those falls that involve injury of a serious nature should be reported. If a fall occurs and the provider determines there were no injuries at that time but later there is discovery of an injury and it is of a serious nature, then the event should be reported.

Other – The provider should also report any fire with structural damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for the operation of the facility for more than 24 hours.

The examples provided for type of event are just those, not all inclusive.

6. Note if resident/patient is capable of providing an explanation of event or participate in the investigation.
7. Provide a brief explanation of the event being reported. Clearly identify the problem, providing a concise description of the problem. If additional room is needed indicate there is additional information and provide on another piece of paper. If initial and final report is one, be sure all elements are addressed, Who, What, When, Where, How, Why, and the conclusion.
8. **Department of Social Services notified** – indicate yes or no, provide date and time of notification, and whether the local or state ombudsman was notified.
9. **Law Enforcement notified** – indicate yes or no and provide date and time of notification.
10. **Law Enforcement Entity notified** indicate local, county, state, etc.
11. **FAX** the report to Complaint Coordinator at 605.773.6667 or **EMAIL** as an attachment to doholccomplaint@state.sd.us (After 5:00 pm CST, weekends, holidays may report serious suspicion/events ONLY per **PHONE** 1.800.738.2301. **Report ONLY Serious** – Serious Bodily Injury (involving extreme physical pain; substantial risk of death; protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical interventions such as surgery, hospitalization, or physical rehabilitation.) Criminal Sexual Abuse. Death, other than natural causes. Missing person/elopement.)
12. **Report** the results of the investigation within 5 working days after the event.
13. **If the event investigation is complete and no additional report will be filed indicate whether abuse/neglect allegation was substantiated. This may be done at the bottom of the reporting form where indicated. If abuse, neglect, or misappropriation involved a CNA forward their name, address, telephone number, social security number, hire date, and past reprimands with the report.**
14. The provider maintains the investigation report that includes the investigation, analysis, interventions, review of medications, care plans, policies & procedures, substantiation, etc.

How to Conduct and Document the Investigation

Focus on the “problem”. Clearly identify the problem, stay on message, say it clearly, and say it simply. Use simple terminology whenever possible. Don’t dazzle with medico-lingo.

Answer the questions:

Who: identify resident(s)/patient(s) involved, staff observers, family or other visitors. **It is best to get a first person report in writing whenever possible. If interviewing another resident/patient, family member or other visitor, quote as much as possible. Review staff schedules to ascertain that all possible individuals that may have knowledge of the event are interviewed. Each individual that is involved in any way should provide documentation for the investigation. There may be one individual who is providing the “story” for the record.**

THE INVESTIGATION REPORT IS SEPARATE FROM THE RESIDENT RECORD.

What: describe the event, use senses, be objective.

See – pallor, sweating, deformities, bruises, edema, redness, body fluid color, pupil reaction.

Feel – dampness, localized heat, pulses, localized coldness.

Hear – complaints, moaning, breathing pattern, heart sounds

Smell – fruity odors, fecal odors, foul smelling drainage, alcohol breath

When: document the time. Accuracy is critical.

Where: document the location, be as descriptive as possible.

How: description of how event may have occurred with the acquired information from those interviewed if there were no witnesses and/or the individual is not a good historian.

Why: other particulars such as care plan not followed, staff not available, resident contributing factors, etc. These are areas that may be fruit for litigation, but also great opportunities for review of system and education.

Conclusion: This is a summary statement that indicates an allegation or suspicion of abuse/neglect was either substantiated or not substantiated, terminating an employee or having them terminate themselves doesn’t automatically indicate whether the provider was able to substantiate an allegation, example - With completion of internal investigation, we were able to substantiate the allegation that (name) made inappropriate advances toward (name), it was our administrative decision to terminate employment and the board of nursing was notified; the provider made changes to a policy/procedure; education/reeducation was provided to staff; care plans were reviewed/revised as necessary; a plausible explanation was gained for how an injury of unknown origin occurred, personal property was found or restitution was made.

In the event reporting of death other than natural causes, missing individual, these are times where a staff “debriefing” maybe needed and is an opportunity to evaluate system processes and provide learning opportunity.

When forwarding the results of the investigation to the Department of Health Complaint Coordinator, all of the provider’s internal documentation does not need to be sent. Those items that have been indicated to be addressed: who, what, when, where, how, and why may be quantified and summarized with only the pertinent information shared in the report.

If the initial report and final report are two separate documents, don’t say “See initial report.” Instead provide a recap of the initial report and then proceed with the completed investigation and conclusion so all information is available in one document.

INSTRUCTIONS FOR USE OF 5-WORKING DAY INVESTIGATION REPORTING FORM

1. Provide name of facility, address, phone number, and fax number.
2. Include FULL name of patient/resident.
3. Include date and time of event and date of initial report.
4. Include name of person(s) completing investigation.
5. Indicate by **X** mark the allegation type.
6. Provide a brief background summary statement that indicates what the event was that prompted the initial report. **(DO NOT SAY SEE INITIAL REPORT)**.
7. Indicate by **X** mark if the initial suspicion/allegation was substantiated.
8. Provide a conclusion summary statement of the facility investigation. Clearly identify the problem, providing a concise description reflecting documentation of injury/harm to victim. If additional space is needed indicate there is additional information. **Clothing items, food items, hearing aids, and glasses need not be reported unless there is an evolving pattern. Otherwise, this is a facility internal investigation.**
9. Indicate by **X** mark any action taken by the facility with regard to the event.
10. Indicate by **X** mark if allegation involved facility personnel, if yes, provide the requested information.
11. Indicate by **X** mark if Department of Social Services was provided the investigative report, include the date and time provided.
12. Indicate by **X** mark if Law Enforcement was provided the investigative report, include the date and time provided or
13. Indicate if there is an ongoing law enforcement investigation and include which Law Enforcement Entity is handling the investigation.
14. **FAX** to 605.773.6667 Attention Complaint Coordinator.
15. **EMAIL** as an attachment to doholccomplaint@state.sd.us or
16. **MAIL** to Attention Complaint Coordinator – 615 E. 4th Pierre, SD 57501.

The provider maintains the investigation report that includes the investigation, analysis, intervention/actions, review of medications, care plans, policies & procedures, substantiation, etc.

