

New York State Department of Health Division of Residential Services

NURSING HOME INCIDENT REPORTING MANUAL

Revised 06/14/12

General information (NH DAL 11-12: Incident Reporting System)
http://nyhealth.gov/professionals/nursing_home_administrator/index.htm

Online Reporting Form (Nursing Home Surveillance)
<https://commerce.health.state.ny.us>

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I. GENERAL INFORMATION

1. INTRODUCTION

This manual is available to all skilled nursing facility staff responsible for reporting incidents to New York State Department of Health (NYSDOH). Information contained within describes revised reporting requirements, effective June 14, 2012. Staff of nursing homes and hospitals are required to report suspected instances of "abuse, mistreatment, and neglect" in order to protect the health and safety of persons residing in nursing homes. If there is reasonable cause to suspect that abuse, mistreatment and neglect has occurred in the nursing home, it must be promptly reported to the Department.

In addition, the failure of licensed health care personnel to report instances of physical abuse, mistreatment and neglect for patients who are residents of nursing homes constitutes professional misconduct. It is the intent of the New York State Department of Health to provide clear guidelines on what incidents to report, when to report, and to avoid reporting inconsistencies.

Nothing in this manual should be deemed to affect the requirement for facilities to report emergencies and disasters to the "State Warning Point", operated by the NYS Office of Emergency Management.

To report concerns with on-line submission:

New York State Centralized Intake Program
NHIntake@health.state.ny.us

Include your name, user name, and the facility/agency name in the email.

REPORTING ABUSE, MISTREATMENT, NEGLECT and MISAPPROPRIATION OF PROPERTY

In December 2004, the Centers for Medicare and Medicaid Services (CMS) issued guidance on the reporting requirements for nursing homes when there are alleged violations related to mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property. Federal regulations (42 CFR 483.13), and state regulations (10NYCRR 415.4) require the reporting of alleged violations of abuse, mistreatment and neglect, including injuries of unknown origin, immediately to the facility administrator and in accordance with state law, to the Department of Health. Additionally, Federal regulations require that alleged violations of misappropriation of resident property be reported immediately. CMS has defined 'immediately' as, "as soon as possible, but not to exceed **24 hours** after the discovery of the incident". (SOM Appendix PP - Guidance to Surveyors for Long Term Care Facilities Interpretive Guidelines §483.13(c) (2) and (4)).

NYS Public Health Law (PHL) Section 2803-d requires the reporting of abuse, mistreatment or neglect and misappropriation immediately to the Department upon having “reasonable cause” to believe that abuse, neglect or mistreatment or misappropriation has occurred. **Department regulations at section 81.1(d) (10NYCRR section 81.1(d)) defines “reasonable cause” to mean that upon a review of the circumstances, there is sufficient evidence for a prudent person to believe that physical abuse, neglect or mistreatment has occurred.**

Circumstances to be reviewed that may lead to a “reasonable cause” conclusion might include, but are not limited to:

- A statement that physical abuse, mistreatment, or neglect has occurred;
- The presence of a physical condition (e.g. a bruise) which is inconsistent with the history or course of treatment of the resident; or
- A visual or aural observation of an act or condition of abuse, mistreatment or neglect.

This does not negate an individual staff person’s responsibility to report instances of abuse, neglect or mistreatment to NYSDOH in accordance with mandatory reporting guidelines. This may be separate and apart from the facility report, in which circumstance; the staff person would be considered a third party complainant.

Facilities must report to the Department alleged violations of abuse, mistreatment, neglect, injuries of unknown origin, or misappropriation of resident property, if and when the “reasonable cause” threshold has been achieved. This might occur without or before the facility investigation into the incident, or it may occur at any time during the investigation. If the “reasonable cause” threshold has not been achieved, notification to the DOH is not required under the aforementioned federal and state regulations and state law.

OTHER REPORTABLE INCIDENTS

The Department of Health has determined that occurrence of specified incidents are reportable to the Department as listed in the educational PowerPoint, that can be found on the Health Commerce System and in the Dear Administrator Letter web page.

http://nyhealth.gov/professionals/nursing_home_administrator/index.htm

This manual contains:

- Questions and answers on both general matters and on specific reporting categories.
(The questions and answers are only examples and do not cover all situations).
- The DOH policy concerning failure to report.
- The DOH policy regarding untimely reporting of incidents.
- Specific guidelines for each reportable incident.

PLEASE NOTE:

- **For purposes of facility reported incidents, long-term care facilities must report abuse, neglect, and misappropriation within 24 hours** after the reasonable cause threshold is concluded.
- All other reportable incidents are to be communicated to the NYSDOH by the next business day.

The Incident Reporting Line phone number, 1-888-201-4563, may be used in case of an emergency such as loss of Internet or computer service. If circumstances dictate reporting via the hotline, that contact will be sufficient and there will be no need to report online. If a provider continues to report via the hotline they will be redirected to the website.

The Centralized Complaint Intake Unit will prepare summaries of all reported incidents, and enter these into the federal complaint tracking system. A case number will be assigned and sent to you in an email on the next business day.

If you have questions regarding incident reporting that are not addressed in this manual, we will work with you to assist your facility in complying with the reporting requirements. You may direct your questions to the Centralized Complaint Intake Unit at **1-888-201-4563**.

2. INCIDENT REPORTING PROCEDURE

Once a facility/staff member has "reasonable cause" to believe a violation of abuse, mistreatment, neglect, injuries of unknown origin, or misappropriation of resident property has occurred, it must be reported to the NYSDOH. Simultaneously, the facility is required to initiate an investigation. The facility must access the Health Commerce System to submit an electronic incident reporting form to the Department of Health to complete the reporting requirements.

Incidents can be submitted via the HCS Internet Portal, <https://commerce.health.state.ny.us>, any day of the week, or time of day.

Using your username and password, log onto the HCS Internet Portal, and proceed to the Nursing Home Surveillance and Reporting System to enter information on the electronic Incident Form. Instructions for the Incident Form can be found either by clicking on the Instruction link found on the left hand side of the form, or through the Instruction link found within the Dear Administrator Letter section.

PLEASE NOTE:

REPORTING INCIDENTS TO NYSDOH DOES NOT RELIEVE THE FACILITY FROM THE REPORTING REQUIREMENTS OF OTHER AGENCIES.

IF A DETERMINATION IS MADE THAT AN EVENT IS NOT REPORTABLE TO NYS DOH, THIS DOES NOT RELIEVE THE FACILITY OF ITS RESPONSIBILITY TO INVESTIGATE, DOCUMENT AND RETAIN THE INVESTIGATION DOCUMENTATION, AND TO TAKE APPROPRIATE ACTION.

3. REVIEW OF FACILITY INVESTIGATION OF INCIDENTS

As a routine part of every standard survey and for selected complaint surveys, the Department utilizes an abuse protocol that is designed to determine whether facility staff is fully aware of their internal reporting responsibility in the facility, along with their reporting responsibilities to the Department of Health, and whether the facility met its investigative responsibilities as discussed in this manual.

The facility must always report when the reasonable cause threshold is met. Facilities will not be cited for failure to report if there was no “reasonable cause” to believe that abuse, neglect, mistreatment or misappropriation of property occurred. In those cases, notification to the Department is not required under federal or NYS regulations. This does not negate the facility’s responsibility to investigate all incidents. The investigative information must be retained by the facility for evidence that an adequate and thorough investigation was completed.

4. FACILITY REPORTING REQUIREMENTS

In order for a facility to meet compliance standards, facilities are required to report incidents according to the regulatory requirements, as set forth in 42 CFR 483.13 (c) Staff treatment of residents (F224 and F226).

Federal regulations (42 CFR 483.13), and state regulations (10NYCRR 415.4) require the reporting of alleged violations of abuse, mistreatment, neglect, including injuries of unknown origin, and misappropriation of property immediately to the facility administrator and in accordance with state law, to the Department of Health. As indicated in Section 1 of this manual, immediately has been defined to mean “as soon as possible”, but no later than 24 hours after the discovery of the incident.

5. THE ELDER JUSTICE ACT

The Elder Justice Act requires reporting of any reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act, § 6703(b)(3). This requires certain individuals in long term care facilities to report a reasonable suspicion of a crime committed against a resident. Those reports must be submitted to one law enforcement agency of jurisdiction and the State Survey Agency. For New York State, these reports must be made to the

NYSDOH and at least one local law enforcement agency by the facility and individuals as defined to include the owner, operator, employee, manager, agent, or contractor. The Medicaid Fraud Control Unit, which has jurisdiction to investigate and prosecute instances of abuse, mistreatment, neglect and misappropriation of resident funds, qualifies as a local law enforcement agency for these purposes. Guidelines for making a timely report include:

- Serious bodily injury: Report within two hours
- All others: Report to be made within twenty-four hours

The facility must develop and maintain policies and procedures that ensure compliance with Section 1150B. The Act prohibits retaliation by a long term care facility against any individual who makes such a report and establishes distinct penalties, including a fine of up to \$200,000 for failure by an individual to report within the timeframe noted above (up to \$300,000 if failure to report in timely manner exacerbates the harm to the victim of the crime).

In addition, facilities are required to conspicuously post notice to employees informing them of their reporting obligations, and to annually provide personal notice of such obligations to those employees covered by the reporting obligations. Further information on this can be found in the CMS, S&C Letter 11-30, Reporting Reasonable Suspicion of a Crime in a Long Term Care Facility.

6. GENERAL QUESTIONS AND ANSWERS

6 a. How will confidentiality of incident reports be maintained?

Information is reported to NYSDOH via a secure web site. All matters reported to the DOH Nursing Home Hotline are considered confidential and sensitive.

6 b. If an abuse, mistreatment, neglect or misappropriation allegation is investigated by the facility and not substantiated; does it have to be reported to NYSDOH?

If at any time during the facility investigation the reasonable cause threshold is met, the facility must immediately report the incident to the Department.

6 c. When are initial incident reports due?

Initial reports are to be submitted online within 24 hours after the incident is identified or if abuse, mistreatment or neglect appears to have occurred, once the reasonable cause threshold is met via the web reporting system. All facilities must assure that internal reporting systems are in place to meet these requirements.

6 d. What is the time frame for a completed written report after the initial report is made?

If the DOH requires more information, beyond the initial report, follow-up written reports should be completed and submitted upon request, within **5 working days** of the incident. While the initial report is submitted via the HCS, the written report will be sent through conventional mail or fax.

6 e. Do facilities need to call the hotline in addition to reporting via the web site?

A call is not necessary if the facility submitted the reportable incident to the Department via the web site. In the event you cannot access the web site, you can call the toll-free line at 1-888-201-4563 or e-mail to nhintake@health.state.ny.us. Additional information the facility wishes to submit after the initial report should be called to the toll-free hotline or e-mailed.

6 f. Will a series of events reported as incidents trigger a survey?

A series of events reported as incidents may trigger a survey. When the incidents are related to a specific area or standard of care, a survey may be indicated. The critical factors that NYSDOH considers are: whether the facility is doing all that it reasonably can to prevent incidents, and whether the facility is completing appropriate investigations and follow-up when an incident is determined to be unavoidable.

6 g. What constitutes *verbal abuse*?

This includes any action that creates fear or psychological harm for the resident. Examples may include a threatening tone of voice, angry gesture, or any other action that creates fear, intimidation or humiliation.

6 h. How can a facility be sure that it is conducting an acceptable investigation?

Please refer to the educational PowerPoint that can be found on the Health Commerce System and in the Dear Administrator Letter web page. In addition, NYSDOH expects that all of the questions on the Incident Reporting Form are thoroughly completed. If additional information is required, you will be contacted by an investigator.

6 i. An assessment of a resident is completed after an incident, but there is no physical injury. If the resident was involved in a physical altercation, and indicates by action or interview(s) that he/she experiences pain, is this considered an injury?

Yes. Pain is considered injury. Even if a resident with cognitive impairment cannot express pain, any action that would normally be considered painful by a reasonable person should be considered an injury. For example, a slap that leaves no mark would

normally be painful and should be considered reportable as an injury even if the resident cannot verbalize pain.

6 j. How can I find out if a staff person has been excluded from working in a nursing facility?

The general public can access this information for anyone who ever received status as a certified nurse aide. Federal and State regulations (42 CFR 483.75(e)(5) and 10 NYCRR 415.13(c)(2)(i)) require facilities to verify each nurse aide's certification status, as well as the status of all potential staff, with the New York State Nurse Aide Registry prior to employment or use in the facility. The Registry is available 24 hours a day, seven days a week at: <https://registry.prometric.com/registry/public>.

The Registry is not the only resident protection tool employed by the Department of Health. A Criminal History Record Check (CHRC) is conducted on any unlicensed staff that has access to a resident or a resident's belongings. Licensed personnel are not subject to the Department's CHRC program.

CHRC results are not available to the general public. However, if the Department, as a result of the CHRC process, has determined that an individual is not allowed to work in a nursing home in a job that gives that person access to a resident or the resident's belongings, the determination is communicated to the authorized person(s) (AP) who submitted the fingerprint request (CHRC 103) to the Department of Health.

II. INCIDENT CATEGORY STATUTES AND EXAMPLES

Section II of this manual provides the federal statute for reporting incidents for all relevant reporting categories. Reporting categories are displayed, with the required elements that trigger reporting of an incident to the NYSDOH. In addition, a list of items that should be collected during the facility investigative process is included. These investigative items should be retained by the facility to provide proof that a thorough investigation was conducted. Examples are provided for each category of determining whether the reasonable cause threshold was reached for incident reporting; it should be noted that these examples are not all inclusive due to the multitude of incident scenarios that may occur during the daily operations of a nursing home.

A. PHYSICAL ABUSE/ MISTREATMENT/ NEGLECT/ MISAPPROPRIATION

42 CFR 483.13 Resident behavior and facility practices.

- (1) The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
- (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the NYSDOH).
- (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
- (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with federal and State laws (including the NYSDOH) within **5 working days** of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

DEFINITIONS of abuse, mistreatment, neglect and misappropriation:

Abuse

- **NYS - Inappropriate physical contact with a resident of a residential health care facility, while the resident is under the supervision of the facility, which harms or is likely to harm the resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping, and sexual molestation.**
- **Federal - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.**

Mistreatment

- **NYS - The inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on a resident of a residential health care facility, while the resident is under the supervision of the facility.**

- **Federal** – No federal definition at this time.

Neglect

- **NYS** - The failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident of a residential health care facility while the resident is under the supervision of the facility, including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living.
- **Federal** - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Misappropriation

- **NYS** - The theft, unauthorized use or removal, embezzlement or intentional destruction of the resident's personal property including but not limited to money, clothing, furniture, appliances, jewelry, works of art, and such other possessions and articles belonging to the resident regardless of monetary value.
- **Federal** - The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

1. PHYSICAL ABUSE

TYPES OF PHYSICAL ABUSE

- Resident to resident
- Staff to resident
- Family / visitor to resident

If the following element exists, a report must be made to the DOH:

- **Inappropriate physical contact resulting in bodily injury, or likely to harm a resident.**

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

1a. RESIDENT TO RESIDENT ABUSE:

Q&A

- **If a resident with Alzheimer's hits another resident and causes an injury (bruise, skin tear etc.) or pain, is it reportable?**

Yes, the facility has a responsibility to protect all residents from abuse. The Department would be reviewing the facility response to the incident in terms of care planning.

- **Two residents, each with a diagnosis of dementia and residing in a nursing home are involved in an altercation. Staff heard the residents yelling and found resident A standing over resident B. Resident A was shouting, "I told you to stay out of my room". Resident B was lying on the floor of resident A's room. He had sustained a 1 cm laceration to his left arm. When questioned, resident B was unable to relate what had happened. Resident A stated that he had struck resident B when he failed to leave the room. Resident B has a history of wandering and resident A has a history of being very territorial. Is this reportable?**

Yes, this would be reportable. The resident had an altercation resulting in an injury.

- **Two residents have a physical altercation. No injury results. Is this reportable?**

This is reportable since the behaviors may result in harm.

1b. STAFF TO RESIDENT ABUSE

Q&A

- **A resident, who is cognitively intact, is combative with care. He is acting out and staff is unable to provide care to him. The resident exhibits bruising to both lower arms. The resident alleges that staff intentionally hurt him. Is this reportable?**

Yes, it would be reportable. There was an allegation of inappropriate physical contact resulting in harm.

- **A cognitively impaired resident claims that a staff member pushed her. This resident has a history of making false allegations against staff. There are no injuries and no witnesses. Her story changes each time she tells it. Is this reportable?**

The facility would be required to show that they investigated this allegation and retain a record of the investigation report. If the facility determines that abuse did not occur, and the reasonable cause threshold was not reached, based on observation, interviews and record review, and absence of injury, the facility would not be required to report this.

- **One staff member reports that another staff member punched the resident. The resident is unable to give a version. Is this reportable?**

Yes, this is reportable. The existence of even one witness meets the reasonable cause threshold that abuse occurred.

1c. FAMILY TO RESIDENT ABUSE

Q&A

- **If a family member hits a resident, is this reportable?**

Yes, it is considered abuse and should be reported and investigated, with the goal of protecting the resident from further abuse by this individual.

2. NEGLECT

If one of the following elements exists for an incident of neglect, then the incident needs to be reported to DOH:

- Failure to follow the care plan resulting in injury; or
- Failure to follow the care plan on more than one occasion with or without injury; or
- Failure to provide timely, consistent, safe, adequate and appropriate services.

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

Q&A

- **A resident falls on the evening shift. Staff witnessed the fall. The resident is assessed and no injury is noted. The resident does not complain of pain. Staff does not document the fall and does not pass the information on to the next shift. No increased monitoring is performed, as other staff members are unaware of the fall. For the next two days the resident complains of pain. After two days, the physician is notified and x-rays are taken which confirm a fracture. Is this reportable as neglect?**

Yes, this is reportable. Staff was aware of the fall and potential for injury and failed to provide timely and appropriate services.

- **A resident requires a Hoyer lift for transfers. Two staff members transfer the resident without the lift. The resident falls and sustains a fracture. The Hoyer lift was available but the staff members were in a hurry and chose not to use it. Is this reportable as neglect?**

Yes, this is reportable. The staff members should have been knowledgeable of the resident's care plan indicating that they were supposed to use the Hoyer lift. This failure resulted in an injury to the resident.

- **Night staff failed to assure that a resident's bed alarm was working properly. The resident attempted to get out of bed and fell, fracturing her hip. The staff had looked at the light near the resident's bed that was "red". This usually indicated the alarm was functioning; however, this resident had a different type of alarm than any other resident in the facility. Is this reportable?**

Yes, this is reportable as neglect. The staff failed to assure that the safety device was in proper working order. If staff had not been trained on this device, the facility could incur culpability for failure to appropriately train staff.

- **A resident was on a 2-hour toileting schedule. A staff person failed to toilet the resident once during that shift. The resident was incontinent but did not suffer any skin breakdown. The resident did not have a history of skin breakdown. Is this reportable as neglect? The staff person had no history of failure to provide care. Is this reportable?**

No, this is not reportable. There was no evidence to support a pattern of poor care and there was no injury to the resident. However, it is a resident care concern and the facility needs to address it. If the same staff person had a similar issue after being retrained then it would be considered neglect. The facility should evaluate the resident for any outcomes related to dignity, including mental anguish.

- **Morning staff discovered a resident's call light unplugged. Interview with the resident and other staff determined that a CNA unplugged the call light because the resident had been using it frequently during the night. The resident was not harmed. Is this reportable as neglect?**

Yes, this is reportable. Such conduct constitutes neglect because the resident is being deprived of the call light to which she is entitled and needs in order for her to obtain assistance with activities of daily living. This conduct also constitutes reportable mistreatment in that the resident is now being inappropriately isolated.

3. MISTREATMENT

One (1) element is needed for an incident to be reported to DOH:

- **The inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on a resident of a residential health care facility, while the resident is under the supervision of the facility.**

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

Q&A

- **Resident is found by a CNA tied to the bed with a sheet. It was determined that another CNA used a sheet to restrain the resident, in order to limit activity. Is this reportable?**

Yes, this is reportable because it involved the inappropriate use of a physical or chemical restraint on a resident.

4. SEXUAL ABUSE

- Resident to resident
- Staff to resident
- Family / visitor to resident

If the element below exists, a report must be filed with DOH:

- **Non-Consensual sexual intrusion or penetration or, touching intimate parts or the clothing covering the intimate parts or, examines or treats resident/patient for other than bona fide medical purposes or, observes or photographs another person's intimate parts or, physical force/threat.**

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

4a. RESIDENT TO RESIDENT SEXUAL ABUSE

Q&A

- **A staff member observed a male resident fondling the breasts of a female resident. The female resident was interviewed but has severe dementia and could not relate what happened. The male resident has a psychiatric diagnosis but is cognitively aware and was able to be interviewed. He denied fondling the resident. Is this reportable?**

Yes, this would be reportable. This is an example of non-consensual sexual contact.

- **A staff member reported finding a cognitively intact male resident in a cognitively intact female resident's room. He was stroking her breast and leg. When questioned by the staff member to determine whether this activity was consensual, the female resident voiced no complaint. Both residents had been on friendly terms with each other and continued to be for the next several days, when the female resident reported that she considered this to have been inappropriate behavior by the male resident. The male resident was**

interviewed and stated that the female had encouraged his behavior. Is this reportable?

Yes, this is reportable. Once a resident states that the act was not consensual or otherwise inappropriate, this should be reported.

Two cognitively impaired residents, a male and a female, were sitting on a couch in the lounge. The male resident had his hand on the female resident's breast. Neither resident seems fearful or distressed, and it appears that that the residents enjoy each other's company and have some kind of relationship. Is this reportable?

The facility must determine if both residents are consenting in this situation. If the facility determines that the residents are consenting, this would not be reportable, as all the sexual abuse elements are not met. Care planning is essential.

4b. STAFF TO RESIDENT SEXUAL ABUSE

Q&A

- **A certified nursing assistant (CNA) stated that she had observed a male nurse fondling a female resident (his hand was between the resident's legs). This occurred on the Alzheimer's Unit, during the night shift. No other staff was present. The male nurse denied the allegation. He stated that he had spoken with the CNA earlier on the shift regarding her unsatisfactory job performance and believed she was accusing him of retaliation. The female resident could not be interviewed, nor were any other residents on the unit interviewed, due to their levels of cognitive impairment.**

Yes, this would be reportable. An allegation was made that contained the element of non-consensual sexual contact. Further, if the staffer is a "health care provider" or "mental health care provider" as defined in section 130.00 of the Penal Law, the resident is deemed to be incapable of consent. (PL 130.05(3) (h)).

- **A staff member reported that another staff member had been observed with his arms around a female resident, kissing her on the cheek. The resident was interviewed and stated that the staff member had hugged and kissed her but she did not perceive his actions as inappropriate or sexual in nature. The male staff member was interviewed and acknowledged hugging and kissing the resident. He stated that she seemed to be having a bad day and he gave her a hug and kiss as a supportive gesture. Is this reportable?**

No, this is not reportable. The act was not sexually inappropriate and the resident consented. Before determining that it was not reportable, the facility should assure that the resident was comfortable with the staff member's action. In constructing

policies and procedures, the facility should ensure that residents are not compromised in any way by personal contact or relationships.

- **A cognitively intact female resident complained to a staff member that while she was in Physical Therapy, a male staff member had touched her breast. This was unrelated to any treatment modality. She reported that she believed that this was a purposeful act.**

Yes, this would be reportable. The element of non-consensual sexual contact was present. The facility must still complete a thorough investigation to determine if the staff person was providing legitimate medical assessment or care, as opposed to inappropriate touching.

4c. FAMILY/VISITOR TO RESIDENT SEXUAL ABUSE

Q&A

- **If a family member has sexual contact with a resident, is this reportable?**

Yes it is reportable and considered abuse if the element is evident and should be investigated, with a goal in mind of protecting the resident from further abuse by this individual. Sexual relations between consenting adults are not reportable.

5. VERBAL ABUSE/ DIGNITY CONCERNS

42 CFR 483.13 (b) and (c) Resident behavior and facility practices. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

“Verbal abuse” is defined as 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 their age, ability to comprehend, or disability. Examples of verbal abuse may include, but are not limited to, threats of harm or saying things to frighten a resident.

TYPES OF VERBAL ABUSE/DIGNITY CONCERNS:

- Resident to resident
- Staff to resident
- Family / visitor to resident

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for the incident to be reported to DOH:

- **Threat OR Physical Action (includes threatening gesture, intimidation).**
- **Fear of imminent, serious bodily injury.**
- **Use of foul, humiliating or threatening language.**

5a. RESIDENT TO RESIDENT VERBAL ABUSE

Q&A

- **Staff overheard resident #1, who is alert and oriented, shout at his roommate, resident #2, “Shut the hell up. You moan all the time. Shut up or I’ll shut you up.” Staff intervened immediately. Resident #2 is demented. Immediately following this incident resident #2 stopped talking which staff thought might be related to the incident. Is this reportable?**

Yes, it is reportable because it would meet all the elements for verbal abuse. Resident #1 directly threatened resident #2, and did so with foul language, and fear of imminent bodily injury. Although resident #2 could not verbalize that he was afraid, his behavior indicated that he was fearful. The staff did a good job of noting the non-verbal reaction of the resident which is very important in determining whether an incident is reportable when it involves residents who are not able to tell you how they feel or residents who have short-term memory loss.

5b. STAFF TO RESIDENT VERBAL ABUSE

Q&A

- **Staff member A overheard staff member B talking to a resident in a harsh tone of voice. Staff member B was in the resident's room responding to a call light. She was heard to say in a loud, rough voice, "I'm getting tired of having to come in here all the time to clean you up". Staff member A reported the incident to the charge nurse who attempted to assess the resident. The resident, who has some dementia, was unable to tell staff what had happened. Later, staff member A was assisting staff member B in caring for the same resident. When staff member B attempted to assist the resident with dressing, the resident kept pulling back as though she was afraid or humiliated. She became somewhat agitated. Staff member A asked staff member B to leave the room. As soon as staff member B left, the resident became calm and staff member A was able to finish dressing the resident. Was this reportable as verbal abuse?**

Yes, this is reportable. It meets the elements of threat (by the rough tone of voice and the nature of the remarks – "I'm tired of having to take care of you") and of fear or humiliation (following the incident, the resident appeared fearful of the staff member, and humiliated). Staff knew the resident and was able to identify a change in her behavior that indicated she was fearful of the staff member.

- **A resident met with the facility social worker and stated that one staff member has continually insulted residents during the course of daily care. Is this reportable as verbal abuse?**

Yes, this is reportable because it meets the definition of verbal abuse.

- **A staff member was showering an alert and oriented 75-year-old female resident. The resident shouted that the water was too cold and shouted, "Damn it, warm it up." The staff member replied, "Shut the hell up and let's get this over with", and shook her fist. Another staff member cleaning the floor in the hall heard the exchange. Is this reportable?**

Yes, this is reportable because it contained the necessary elements of physical action and foul language.

5c. FAMILY/VISITOR TO RESIDENT VERBAL ABUSE

Q&A

- **Staff overheard the husband of resident #1 yelling at his wife and her roommate, resident #2. (Both residents reside on an Alzheimer's Unit) The husband was angry that his wife had called him and then could not remember why she had called. He was angry with resident #2 because he thought she had damaged an item that belonged to his wife. He was shouting and shaking his finger in resident #2's face. Staff entered the room and told him he would have to leave if he didn't calm down. His wife was upset but not afraid of him. Resident #2 did express fear of the husband. Is this reportable as verbal abuse?**

Yes, it is reportable. Shaking his finger in resident #2's face meets the element of a "physical action" resulting in a threat. The element of fear was also met because resident #2 stated that she was afraid of the individual.

If resident #1 had been the only resident in the room; this would not have been reportable because she stated she was not afraid of her husband. Therefore one of the necessary elements, "causing fear" would not have been present.

- **If a family member verbally abuses a resident, is this reportable?**

Yes, it is reportable as the facility has knowledge that the family member verbally abused the resident. In addition, the facility must take action to protect the resident from further abuse by this individual.

6. MISAPPROPRIATION OF PROPERTY

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement
 - Plan to prevent reoccurrence

One (1) element needed to report to DOH:

- **Deliberate misplacing, exploiting, or wrongful use of a resident's property.**
- **A pattern of misplacing, exploiting, or wrongful use of a resident's property.**
- **Resident consent not given.**

If the allegation is made against a staff member, and the facility has reasonable cause to believe that misappropriation occurred, then it is reportable.

If the resident reports misappropriation by a family member to the facility, it would not be reportable to the DOH, unless the family member was an employee of the agency or staff under contract with the facility.

Q&A

- **The resident's daughter reported that her mother's ruby ring, which she last saw two days ago, was missing. The resident has mild dementia, but the daughter insisted the resident did not misplace it. The daughter implied a staff member was responsible. Is this reportable?**

At this point this is not reportable because the facility has no evidence of deliberate misplacing or wrongful use of the ring. The facility needs to conduct an investigation and a search. The ring could be lost.

Following the search, the ring had not been found. The daughter observed a staff member wearing what she believes to be her mother's ring. The daughter notified the police. Is this reportable?

Yes, this is reportable because there is reasonable cause to believe a staff member may have taken the ring.

- **The facility was given \$25.00 by three different families on Wednesday, so their family members could go to an outing on Friday. The person at the desk took the money and gave it to the nurse, who locked it in the medicine room drawer. On Friday morning, the Social Worker asked the nurse for the money for the three residents to go on the outing. There was no money in the medicine drawer. Is this reportable?**

Yes, this is reportable. Deliberateness was implied because the money was in a locked drawer and only staff had a key to the drawer. Additionally, valuables are not to be stored in the medication drawers or narcotic box.

- **A resident reported that the night shift was using her personal cell phone for other residents without her permission. Is this reportable?**

Yes, this is reportable because the resident did not give permission for the use of her personal property by others in the facility.

B. QUALITY OF CARE CONCERNS

Sec. 483.25 Quality of care: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Reportable incidents:

- Medication error / drug diversion
- Injury of unknown origin
- Burns
- Death related to suicide / restraints/ equipment
- CPR concerns
- Accidents related to choking, or equipment misuse or failure

1. MEDICATION ERROR / DRUG DIVERSION

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Accused statement(s)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for report to DOH:

- **Medication or treatment error with harm.**
- **Repeated medication or treatment errors by a nurse.**
- **Missing controlled drugs, that is not a documentation error.**
- **Multiple occurrences of not administering medications or treatments as ordered.**

Q&A

- **A nurse makes an error on a dose of Coumadin over a few days. The resident exhibits excessive bruising and a very high INR. The resident was hospitalized and required vitamin K treatment. Is this reportable?**

Yes, it is reportable. Harm occurred in the form of bruises and low INR which required hospitalization and additional medical intervention.

- **A unit dose package of Oxycontin is missing. Staff report that only one nurse had the keys and the count was correct at shift change, but incorrect at the next shift. Is this reportable?**

Yes, it is reportable as the nurse may have diverted the medication. This could possibly be considered misappropriation in addition to a medication concern. In addition to reporting this incident to the Department of Health, reports should also be made to the New York State Education Department, Office of Professional Discipline, Medicaid Fraud Control Unit and the Department of Health's Bureau of Narcotic Enforcement.

- **A nurse administered one dose of antibiotic to the wrong resident. There was no negative outcome to the resident and the nurse has no history of errors. Is this reportable?**

No, this is not reportable, as there was no history of medication errors and no harm. This matter should be investigated and handled internally by the facility.

- **A nurse fails to administer treatments on the unit to which she is assigned. Is this reportable?**

Yes, this is reportable as it affects many residents and there is a potential for harm. In addition, MD orders and the plans of care were not followed. Signing for medications and /or treatments not administered is considered falsification of records and is reportable.

2. INJURY OF UNKNOWN ORIGIN

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

Two (2) elements are needed for report to the DOH:

- **Injury without known incident.**
- **Facility unable to rule out abuse or care plan violation.**

Q&A

- **A resident is found with bruising to both upper extremities. The resident is not interviewable. Is this reportable?**

Injuries of unknown origin are reportable. The facility must conduct a preliminary investigation to determine if the elements of abuse, neglect or mistreatment are present. The facility should focus on root cause analysis and determine through investigation if abuse, neglect or mistreatment occurred.

- **A resident is found with a fractured hip of unknown origin. Is this reportable?**

The facility must investigate this occurrence. If it determined that there was no care plan violation, and abuse, neglect and mistreatment were ruled out, the facility is not required to report this. The facility should seek guidance from the physician to determine the origin of the fracture. If the facility is **unable** to determine cause and abuse is not ruled out, it is reportable.

3. BURNS

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for report to the DOH:

- **Second or third degree burns.**
- **Accident resulting in burn to body surface.**

Q&A

- **An 80-year-old male resident was outside smoking. He had his oxygen on via nasal cannula. When staff returned, they discovered that the resident was red and blistered around the mouth and nose. The resident's beard was burned. Is this reportable?**

Yes, this is reportable because the resident sustained a burn related to an accident. The blisters are classified as second degree burns.

- **An aide put a 30-year-old female patient with Multiple Sclerosis in the tub. The resident added hot water to the tub when the aide left the room. Upon return, the aide discovered that the patient was red and had blisters from the waist down, when she took the patient out of the tub. Is this reportable?**

Yes, this is reportable because the resident sustained a burn related to an accident.

- **A resident spills hot coffee onto his lap and sustains a blistered area. Is this reportable?**

Yes, this is reportable because the resident sustained a burn related to an accident.

- **A resident developed a red blistered area after application of a hot pack. Is this reportable?**

Yes, this is reportable because the resident sustained a burn related to an accident.

4. ATTEMPTED SUICIDE OR DEATH RELATED TO SUICIDE, RESTRAINTS, EQUIPMENT

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed to report to DOH:

- **Incident resulting in death.**
- **Resident attempt at suicide.**
- **Death reportable to law enforcement as unexplained or suspicious.**

➤ **Are unexpected deaths reportable?**

Yes, they are reportable if the death resulted from an incident (event).

➤ **Is a suicide occurring on the premises of a residential facility reportable?**

It is reportable if the death occurred while the resident is under the supervision of the facility, regardless of where or when the death occurred.

➤ **A resident is injured during a Hoyer lift transfer, and sustains a subdural hematoma. A few days later, she expires. Is this reportable?**

Yes this is reportable. The injury is related to the use of equipment. If equipment failure is identified, the facility must complete and forward a report according to the Safe Medical Devices reporting guidelines.

➤ **What if a resident attempts to take their own life? Is this reportable?**

Yes, this is reportable. The facility investigation should document mental status and the facility's planned intervention.

5. CPR CONCERNS

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Facility investigation
 - Advanced directive documents
 - DNR /CPR policy
 - Care plan(s)
 - Resident cognition evaluation
 - Employee personnel and training records
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for report to the DOH:

- **CPR not provided when it was required.**
- **CPR provided against resident's wishes.**

Q&A

- **A resident with a DNR order was found without breath and pulse. Staff responded by providing CPR. Is this reportable?**

Yes, this is reportable because the provision of CPR was in direct opposition to the resident's wishes. This may indicate that the facility plan to make resident wishes known to all may have failed.

- **A resident with no DNR order is found without breath and pulse and staff decides not to provide CPR. Is this reportable?**

Yes, this is reportable because the decision by staff is incorrect and in direct opposition to the resident's wishes.

- **CPR was performed as required, but the resident expired. Is this reportable?**

No, this is not a reportable incident.

6. ACCIDENTS RELATED TO CHOKING OR EQUIPMENT HAZARD; RESIDENT FOUND IN NON-RESIDENT AREA

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for report to the DOH:

- **Accident related to choking; or**
- **Accident related to entrapment in equipment; or**
- **Resident found in potentially hazardous non-resident area.**

Q&A

- **If a resident is served, or manages to obtain, food of incorrect consistency, is this reportable?**

Yes, this is reportable if the resident choked and required staff interventions. If the staff prevented ingestion of the item, and the resident was not negatively affected, this would not be reportable.

- **If the resident required thickened liquids, and was served or managed to obtain incorrect consistency, is this reportable?**

Yes, this is reportable if the resident choked and required staff intervention(s). If the staff prevented ingestion of the item, and the resident was not negatively affected, this is not reportable.

- **A resident uses upper side rails for positioning, turns in bed, and gets a body part wedged in between the side rail and mattress. Is this reportable?**

Yes, this is reportable regardless of outcome.

- **A resident stands from his chair, loses balance and falls, sustaining a fractured hip. Is this reportable?**

The facility must investigate this incident. If it is determined that the care plan was not violated and there is no evidence of abuse, neglect or mistreatment, it is not reportable.

- **A resident is ambulatory and found unattended in a non-resident area in the nursing home. The area has machinery, equipment and toxic supplies. Is this reportable?**

Yes, this is reportable as a resident should not be unattended in non-resident areas, including but not limited to: equipment rooms, stairwells, kitchen areas, janitor areas, utility areas or utility basements. If this occurs, it is reportable, regardless of the presence of actual injury.

7. ELOPEMENT FROM THE BUILDING

Elopement occurs when a resident leaves the Nursing Home building undetected or fails to return from a **(preauthorized)** pass.

What should the facility have readily available?

- Complete electronic incident form
- Have available
 - Witness statement(s)
 - Resident statement(s)
 - Photographic evidence (if available)
 - Facility investigation
 - Care plan(s)
 - Resident cognition evaluation
 - Elopement Risk Assessment
 - Report /case ID number from law enforcement, if reported
 - Plan to prevent reoccurrence

One (1) of the following elements is needed for report to the DOH:

- Resident is at risk for elopement and remains missing after search of building conducted; or
- Resident with cognitive impairment leaves facility undetected; or
- Resident on outing or appointment with staff and elopes from staff oversight; or
- Resident fails to return from outing, with pass.

Q&A

- **A facility receives a call from the local hospital, informing the facility that one of their residents was brought to the hospital after being found by the police. The facility did not know the at-risk resident was missing, so they did not initiate a search. The resident was found within 8 hours. Is this reportable?**

Yes, this is reportable. The fact that the facility did not search because they did not know the resident was missing does not exclude the facility from reporting. If a resident is missing from the building, it is reportable.

- **A resident with impaired cognition was sent to the physician's office via a mobility van as ordered by the MD. His daughter planned to meet him at the physician's office. The appointment date was miscommunicated and the office was closed. The resident did not return at the expected time. The facility called the physician's office and discovered that the office was closed. The resident is mildly confused. He had been missing for four hours. Is this reportable?**

Yes, this is reportable. The resident was sent to the MD appointment by the facility. The facility is responsible to assure safe arrival and return. He was at high risk due to his mental status and inability to make his needs known, his age and medical condition.

- **If a patient leaves the Nursing Home AMA (against medical advice), is this a reportable incident?**

No, as long as there is no dementia involved, this is not reportable as the resident has announced his/her intention to leave and is therefore, not considered to be a missing person.

- **A security guard was at the front desk, when a resident who appears healthy and looks like a visitor approaches the desk and asks to leave. The guard allows him to leave and then discovers that the man was a resident. Is this reportable?**

Yes, this is reportable, as having a security guard is part of the facility elopement prevention policy and the system failed.

- **A confused resident approaches an alarmed door. The alarm sounds and staff responded. The resident is safe and returned to her unit. Is this reportable?**

No, this is not reportable as the system worked and the resident never left the building or staff line of vision. If the resident was able to exit the building and staff was unaware, the incident is reportable.

C. PHYSICAL ENVIRONMENT

1. MALFUNCTION OR MISUSE OF EQUIPMENT

If misuse of equipment or faulty equipment results in resident accident, this is reportable under quality of care.

Investigation materials:

- Complete electronic incident form
- Have ready:
 - Facility investigation
 - Staff interviews
 - Facility policy and plan for monitoring equipment
 - Preventive maintenance plan and PM records
 - Staff in-service records / personnel records
 - Resident interviews

Safe Medical Device Act

What is Medical Device Reporting (MDR)?

Medical Device Reporting (MDR) is the mechanism for the federal Food and Drug Administration (FDA) to receive significant medical device adverse event reports from **manufacturers, importers and user facilities**, so they can be detected and corrected quickly.

User Facilities and MDR

User Facilities (e.g., hospitals, nursing homes) are required to report suspected medical device-related deaths to both the FDA and the manufacturers. User facilities report medical device-related serious injuries only to the manufacturer. If the medical device manufacturer is unknown, the serious injury is reported by the facility to the FDA. Health professionals within a user facility should familiarize themselves with their institution's procedures for reporting adverse events to the FDA and medical device manufacturers.

Two (2) of the following elements is needed for report to the DOH:

- **Malfunction or intentional or unintentional misuse of equipment.**
- **Adverse effects related to use of equipment.**

Q & A

- **A nursing home resident was being removed from an Apollo bathtub by a portable chair. The chair stand failed to lock in place and the resident sustained a laceration to the right ear lobe and an abrasion to the right shoulder. The chair armrest had warped causing the locking mechanism to fail. Is this reportable?**

Yes, this is reportable. The equipment clearly malfunctioned and although staff was able to intervene in this instance, there was an injury.

- **In the subacute unit, the wall oxygen delivery system failed and an alarm sounded. The nurses immediately attached the patients to the portable oxygen tanks. Is this reportable?**

No, this is not reportable. The backup system functioned appropriately; thus, there was lack of potential for serious injury. If the alarm failed, it would be reportable.

2. PHYSICAL PLANT ISSUES and LOSS OF SERVICES

The facility must report planned and unintentional loss of service for telephones, electricity, heat, air conditioning, water, and concerns effecting kitchen sanitation.

One (1) of the following elements is needed for report to the DOH:

- **Loss of service lasting or expected to last 4 or more hours.**
- **There is no back-up system in place; or**
- **The back-up system fails to work.**

Investigation materials:

- Complete electronic incident form
- Have ready:
 - Facility plan to maintain services
 - Facility policy and plan for monitoring equipment

3. PHYSICAL ENVIRONMENT ISSUES

The facility must report occurrences of smoke or fire requiring evacuation or resulting in injury to resident(s), including serious injury or death related to a fire or smoke inhalation.

The facility must report building issues that affect resident care or safety, such as, but not limited to, bomb threats, storm damage and flooded areas.