



COMMISSIONER
Adelaide Horn

January 3, 2007

To: Licensed Nursing Facilities, Medicare/Medicaid-certified Nursing Facilities, and Skilled Nursing Facilities

Subject: **Provider Letter #06-43** – Guidelines for Reporting Incidents (Replaces PL 06-32)

The purpose of this letter is to provide guidance for reporting incidents to the Department of Aging and Disability Services (DADS). These revised guidelines supersede those dated October 3, 2006.

Health and Safety Code §242.122 and 40 Texas Administrative Code (TAC) §19.602(a) require any facility staff member who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect, or exploitation. Facilities are required at 40 TAC §19.601(c)(2) to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to DADS. Facilities are also required to report certain other incidents, which may or may not constitute abuse, neglect, or exploitation. Certified facilities are required by 42 Code of Federal Regulations (CFR) §483.13(c)(2) and (4) to report alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, and the results of the investigation conducted by the facility to the state survey and certification agency.

Incidents are reported to DADS Consumer Rights and Services Section at (800) 458-9858.

The facility or facility staff member must report the following incidents (1-10) to the Consumer Rights and Services Section, DADS State Office, Austin, Texas, immediately (within 24 hours) upon learning of the incident and send a written investigation report to the Consumer Rights and Services Section no later than the fifth working day after the oral report. The facility must use the Provider Investigation Report (Attachment 1) to document facility investigations. The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. If the alleged violation is substantiated, appropriate corrective action must be taken.

REPORTING ABUSE, NEGLECT, EXPLOITATION, AND OTHER INCIDENTS

1. ABUSE [as defined in 40 TAC §19.101(1)]

- For allegations of resident-to-resident abuse, refer to Attachment 2 and the accompanying flowchart.
- For all other allegations of abuse, report to DADS.

For certified facilities, abuse is also defined at 42 CFR §488.301 and prohibited at §483.13(b) and (c).

2. NEGLECT [as defined in 40 TAC §19.101(81)]

The facility must determine if an injury, harm, or death of a resident was due to a facility failure to provide services, treatment, or care to a resident. The following examples of reportable neglect are not all-inclusive.

- A resident with a doctor's order for close supervision due to unsteady gait is left unsupervised or inadequately supervised, resulting in his falling and fracturing his hip.
- A resident, according to his care plan, requires a two-person transfer from bed to chair. Only one staff assists the resident in transferring from a bed to a chair, and the resident falls, resulting in extensive bruising to his thigh.
- A resident with a known history of physical abuse (that has not been addressed by the facility) punches another resident in the eye, causing a black eye. Note: This is a reportable incident of neglect because staff inaction resulted in injury to a resident.
- A resident slips in urine left in the hallway for an extended period of time and breaks his arm. Staff was aware that the urine was on the floor but failed to remove it. The injury was accidental but due to neglect because staff inaction (failure to clean the urine from the floor) resulted in the injury.

For certified facilities, neglect is also defined at 42 CFR §488.301 and prohibited at §483.13(b) and (c).

3. EXPLOITATION [as defined in 40 TAC §19.101(38)]

Exploitation is defined as "the illegal or improper act or process of a caretaker using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain."

4. DEATH

If the death of a resident involves unusual circumstances that cast doubt upon the death being from natural causes, the death must be reported. Examples include, but are not limited to:

- Death due to medication overdose, administration of wrong medication, or failure to administer a medication;
- Accidental death caused by exposure to weather, being struck by a motor vehicle, drowning, strangulation (by ligature or aspiration), burns (fire or water), electrical shock, falls, etc.;
- Suicide; or
- Death following a resident-to-resident altercation.

5. MISSING RESIDENT

If a resident is not located during a search of the facility, facility grounds, and immediate vicinity, and there are circumstances that place the resident's health, safety, and/or welfare at risk, the report must be made as soon as the facility becomes aware the resident is missing and cannot be located. Examples include, but are not limited to:

- A resident requires medications that, if not taken as scheduled, place the resident at risk of serious illness or death or both;
- Extreme weather conditions expose the resident to potential freezing, heat prostration, or drowning from flooding;
- A resident is confused or otherwise incapable of assessing potential danger; or
- There is suspicion of foul play.

Regardless of the circumstances, any resident missing for eight hours and not yet located must be reported at that time. In addition, the facility must contact the DADS Consumer Rights and Services Section daily until the resident is found.

6. MISAPPROPRIATION OF FUNDS [as defined in 40 TAC §19.101(79)]

Misappropriation of resident property is defined in 40 TAC §19.101(79) as “the taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real, or personal, or anything of value belonging to or under the legal control of a resident, without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of property of a resident.”

For certified facilities, misappropriation of resident property, as defined in 42 CFR §488.301, is “. . . the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident’s belongings or money without the resident’s consent.”

7. DRUG DIVERSIONS

Facility staff must make a report to DADS if the facility has reason to believe that drugs were stolen. Staff must also notify the local police department.

8. INJURIES OF UNKNOWN SOURCE

An injury must be classified as an “injury of unknown source” when both of the following conditions are met:

- No one saw the incident that resulted in the injury **or** the source of the injury could not be explained by the resident; **and**,
- The injury is suspicious because of the extent of the injury **or** 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 number of the injuries over time.

9. FIRES

Fires of any nature, including those requiring notification of the local fire department are to be reported to DADS as incidents according to 40 TAC §19.326(b). The facility must report all fires on the "Fire Report for Long Term Care Facilities," Form 3707, within 15 days after the fire. The form can be viewed at <http://www.dads.state.tx.us/handbooks/mpm-ltcf/forms/index.asp?HB=MPM-LTCF&Form=3707>. The completed form must be mailed to the Consumer Rights and Services Section, Complaint Intake Unit, Mail Code E-249, with the completed Provider Investigation Report.

Additionally, the facility must immediately notify DADS by phone of any fires that caused death or serious injury. Telephone reports must be followed by written reports. [40 TAC §19.326(b)]

10. CONDITIONS THAT POSE A THREAT TO RESIDENT HEALTH AND SAFETY

Any situation that poses a threat to residents, staff, or the public must be reported, including situations for which police or the local fire authority must be notified or summoned in order to maintain safety. Examples include:

- Bomb threat
- Tornado hits building
- Flood
- Generator or emergency power failure
- Failure of the sprinkler system
- Failure of the fire alarm
- Environmental conditions that compromise the facility's structure
- Air conditioning failure when outdoor temperature is or will be 90 degrees or above
- Heating failure if outdoor temperature is 65 degrees or below
- Firearms in building

PROCEDURES FOR TELEPHONE REPORTS

When reporting an incident by telephone at 1-800-458-9858, provide the following information: facility name, vendor/ID number, resident name(s), time and date of incident, what occurred, condition of resident(s), person(s) involved (other than resident), and action taken by facility authority to date.

Within five working days of making the oral report, send the written investigation report, with statements and other relevant documentation, to DADS using the Provider Investigation Report form. Always include your Medicaid or DADS-assigned vendor number on the report. If the Provider Investigation Report form, with statements and other relevant documentation, is 15 pages or fewer, you may fax them toll-free to DADS at 1-877-438-5827. Otherwise, mail the report and attachments to:

Department of Aging and Disability Services
Consumer Rights and Services Section, E-249
ATTN: Intake Coordinator
P.O. Box 149030
Austin, TX 78714-9030

DO NOT REPORT THE FOLLOWING INCIDENTS

- Burglary of nursing facility property – notify the local police department.
- Theft of any property not belonging to a resident – notify the local police department.

If you have questions about these guidelines, please contact Vella Salazar, Nursing Facility Program Specialist, Policy, Rules, and Curriculum Development Unit, at 512-438-3334.

Sincerely,

[signature on file]

Veronda L. Durden
Assistant Commissioner
Regulatory Services

VLD:ca:mdv:vs

c: Chris Adams, E-353
Anthony Chapple, E-335
Susan E. Davis, E-341
Regional Directors

Attachments:

Attachment 1, Provider Investigation Report Form Instructions

<http://www.dads.state.tx.us/handbooks/instr/3000/F3613-A/>

Provider Investigation Report Form

<http://www.dads.state.tx.us/forms/3613-A/3613-A.pdf>

<http://www.dads.state.tx.us/forms/3613-A/3613-A.doc>

Attachment 2, Resident-to-Resident Incidents

Attachment 3, Flowchart (in pdf format) Note: Set the printer's orientation to landscape.

Attachment 2 Resident-to-Resident Incidents

The purpose of this attachment is to provide guidance to facilities concerning appropriate nursing facility practice regarding reporting resident-to-resident alleged abuse.

Abuse versus Inappropriate Behavior

DADS has developed a flowchart (Attachment 3) to assist facilities in determining when to report resident-to-resident incidents.

The flowchart makes the same distinction as the Centers for Medicare & Medicaid Services (CMS) Regional Survey and Certification Letter No: 00-03 regarding abusive behaviors by demented residents. The letter states, "a determination of abuse requires that the incident under investigation must have been willful and/or deliberate." Similarly, the flowchart's first decision box asks whether the resident has the capacity to act willfully, knowingly, or recklessly. If the answer is "no," then abuse has not occurred.

Although abuse has not occurred, further assessment is required to determine if neglect occurred. Did the facility exercise reasonable judgment in managing the resident and minimizing the threat to the resident or other residents? Does the facility have appropriate policies and procedures in place to address the behaviors, as well as to protect the resident and others? If the answer to these or other similar questions is "no," neglect may have occurred and should be reported to DADS.

Instances of resident-to-resident inappropriate behavior that do not constitute either abuse or neglect may not need to be reported; however, such behavior still must be addressed (see Facility Responsibility). Additionally, please note, as detailed in the flowchart, that some incidents must be reported, regardless of whether they constitute abuse or neglect.

Reportable incidents are those that result in:

- physical injury requiring medical attention for evaluation or treatment, excluding minor skin tears, a threat to health or safety;
- resident psychological distress (related to the incident) that does not resolve within 8 hours; and
- a change in condition related to the incident.

Reporting Incidents and Abuse

When either a reportable incident or actual abuse occurs, the facility must:

- report the incident or abuse;
- conduct and document a thorough investigation of each incident;
- complete an appropriate assessment of the residents involved; and
- implement a plan of action designed to prevent recurrence.

Facility Investigation

Facility actions when conducting an investigation must be documented and include:

- observations, interviews, and record reviews of all residents involved;
- interviews of all witnesses, including residents, staff, and family members;
- notification of the physicians and, where appropriate, the families or responsible parties of the involved residents; and
- recording of all relevant physical findings.

Deficient Practice

A deficiency is defined as failure to meet a requirement. DADS may identify a deficient practice when a facility fails to:

- report all reportable incidents and allegations of abuse;
- thoroughly investigate and document all incidents and allegations of abuse;

- properly assess residents upon initial and annual assessments, as well as after a significant change in condition; or
- implement a plan of action to prevent recurrence of incidents or abuse.

The occurrence of problem behaviors or reportable incidents does not in itself constitute evidence of deficient practice. However, the facility's failure to address important early warning signs (see Attention to Early Warning Signs) may constitute a deficient practice, even in incidents that otherwise appear to be unprecedented.

Attention to Early Warning Signs

If a resident begins to exhibit inappropriate behavior, the facility must assess the resident and promptly intervene, taking appropriate action to protect other residents, even if no allegation of abuse is made. Failure to do so is a deficient practice that may constitute neglect. Appropriate actions include steps such as additional supervision for aggressive residents and appropriate medical/psychiatric evaluation and treatment.

Inappropriate behavior may first be directed toward staff or may be minor in nature. It is important that facilities assess and intervene at this point, rather than after inappropriate behavior is directed toward other residents or the inappropriate behavior escalates.

Facility Responsibility

When any resident's behavior constitutes a threat to the health and safety of other residents, the facility must report the behavior and must protect other residents from that threat. Minimum evidence of protection must include both assessment and prompt intervention. The facility must reassess the inappropriate behavior and adjust the care plan accordingly. The facility must take specific steps to control the inappropriate behavior and to protect other residents. The facility's plan of action may include steps such as:

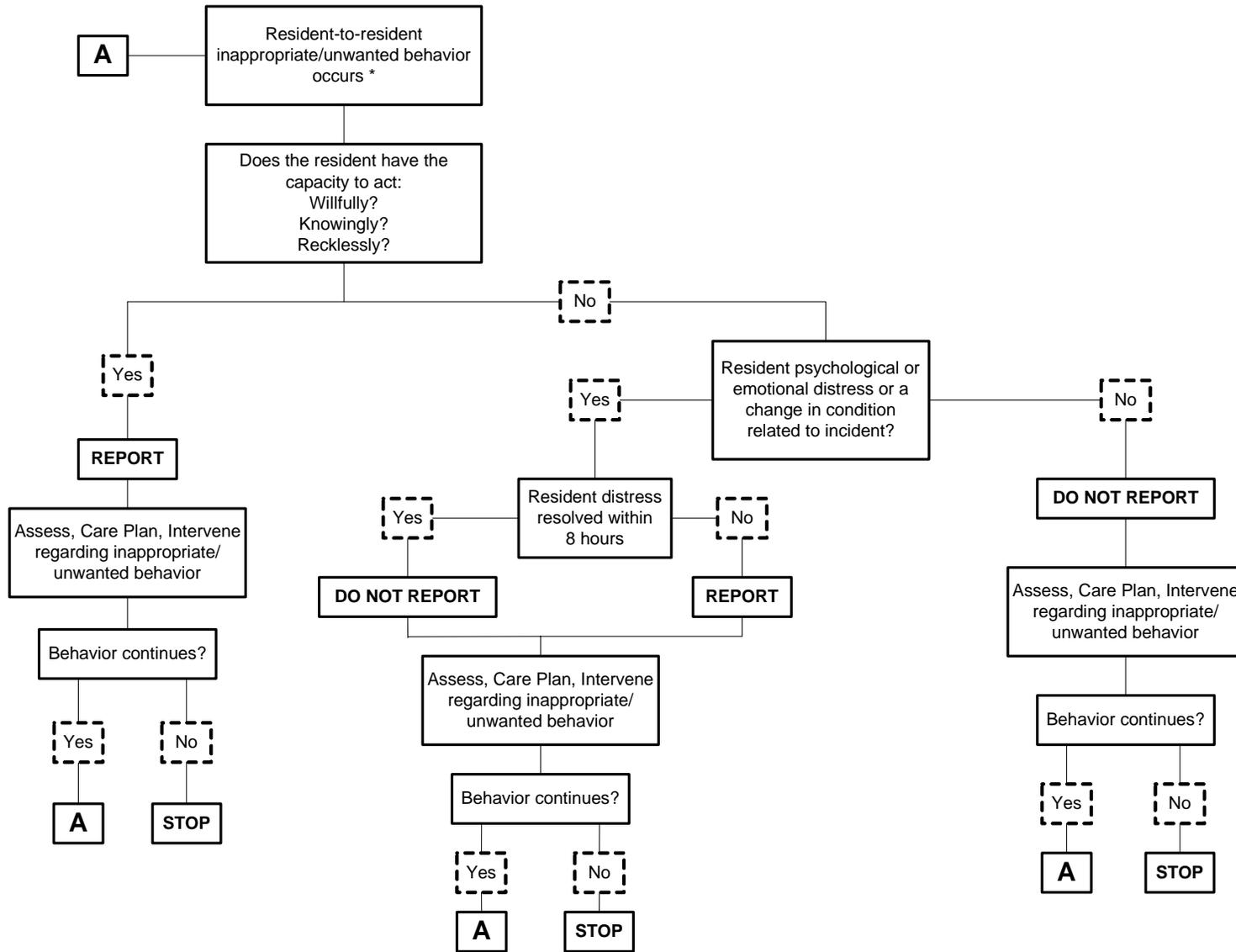
- specific psychiatric or medical therapy for the resident with aggressive behavior;
- additional supervision of residents;
- adjustment of facility practices to minimize the risk of occurrences;
- activities and other interventions that redirect the energies of the resident with aggressive behavior; and
- care plan changes to minimize the risk of recurrent incidents.

Sexual Activity

When a third party (other than the participants) makes an allegation of sexual abuse, it is necessary to determine whether the sexual activity was consensual. In the case of a resident who has been adjudicated incompetent, the guardian must have provided consent. A resident may have decision-making capacity over sexual matters, even though he or she lacks the ability to handle the entirety of his or her life affairs. In all other cases, consent must come from the resident.

In the absence of allegations of abuse, consensual sexual activity between residents having specific decision-making capacity over sexual matters is not a reportable incident. Sexual activity involving a resident without specific decision-making capacity over sexual matters is a reportable incident and must be addressed.

Inappropriate sexual behavior not directed toward a particular individual that does not result in an allegation and does not constitute cause to believe sexual abuse has occurred does not need to be reported but must be addressed. The facility must document the behavior, conduct a resident assessment, as necessary, and incorporate in the care plan procedures to address the behavior and protect other residents from the inappropriate behavior.



* Persistent behaviors must be documented