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January 26, 1999

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To: All Licensed Nursing Facilities and Skilled Nursing Facilities

Re: Provider Letter 99 – 04: Q&A's Regarding Nursing Facility Reporting Requirements

Attached are the Q&A's generated by the department as a result of the Incident Reporting Requirements training sessions that were conducted in December, 1998.

If you have any questions, please contact Elva Longoria, Professional Services Section, at (512) 438-2345.

Sincerely,

- Original Signature on File -

Jim Lehrman  
Associate Commissioner  
Long Term Care - Regulatory

JL:mg

Attachment

## Incident Reporting Questions and Answers

- Q1.** *If a family member complains about the call light not being answered as quickly as they want, or that a patient was not bathed to the satisfaction of the family member, are these "complaints" reportable as neglect? If the facility receives a letter of complaint regarding ADL's, etc., are these reportable as well? If these are reportable, then would we call DHS with every complaint received?*
- A1.** No. Although the family may call in a complaint directly to DHS, these are care/training issues that the facility should address. However, if these issues resulted in a negative outcome for the resident, and met the criteria for "reportable (according to Provider Letter 98-29)", then the facility should report the incident to DHS. We would expect the facility to report such things as a staff leaving a resident on a heating pad too long, resulting in burns, or a staff attempting to transfer a resident unassisted (when a two-person transfer was required), resulting in a fall and injury.
- Q2.** *What is the policy for when a surveyor is in your building on an investigation and then asks for "anything else you have called in", when these were not the basis for the original investigation?*
- A2.** The surveyor's focus should be on the investigation of the allegation(s). However, if the surveyor becomes aware of evidence that the facility may be out of compliance in an unrelated area, the surveyor may request information from the facility to determine the degree of noncompliance.
- Q3.** *If a facility has done a thorough and complete investigation, and abuse or neglect is substantiated, does the facility make the referral or will DHS have to do another investigation to make the referral?*
- A3.** DHS will conduct an investigation even if the facility has already done so, and will make referrals as appropriate. The facility is also free to report staff to the appropriate licensing board.
- Q4.** *A resident's family (guardian) and physician do not want the resident restrained with side rails or any other type of restraint. The resident is placed in a low bed with a soft foam mattress placed on the floor beside the bed. The resident falls out of bed and lacerates his head and is taken to the hospital. Is this reportable to DHS?*
- A4.** The issue is whether the facility suspects that neglect occurred. If the resident has a history of falling, and the facility knows that side rails (or any other type of restraint) are the only method to ensure the resident does not fall, then the incident is reportable under neglect.

However, if the resident has no history of falling, and falls out of bed and hurts himself (for the first time), the facility must address this issue to protect the resident from injury. This incident

would not be reportable, as there would be no evidence of neglect. The facility is responsible for protecting the resident and addressing any disagreements with the IDT, which includes the physician and guardian.

**Q5. Define "serious" accidental injury. According to the letter (Provider Letter 98-29), it is determined by a physician, nurse practitioner (NP) or physician assistant (PA). Can a DHS surveyor decide an injury is "serious" without having the credentials of MD, NP or PA?**

**A5.** Although the surveyor may not have these credentials, he/she will investigate an injury by observations, interviews and record reviews to determine whether the facility responded appropriately and the resident received adequate assessment and treatment. **Generally**, an injury is considered "serious" if:

- a. the resident is transported to a hospital or emergency care facility for evaluation and/or treatment, regardless of whether treatment is rendered;
- b. the resident is admitted to a hospital as an inpatient or retained overnight for observation;
- c. the physician has ordered treatment other than observation (orders for neurological checks are considered treatment, not observation).

**Q6. How does the definition of "theft" differ from "misappropriation"?**

**A6.** Theft is defined as stealing someone's property. Misappropriation of resident property, as defined in Section 19.101 of the Nursing Facility Requirements for Licensing and Medicaid Certification, is "the taking, secretion, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive the 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."

**Q7. How can a facility substantiate an abuse allegation which is based on "rudeness" or "heavy handedness" as seen on a video camera placed in a resident's room? What can the facility do to get the camera (placed there by a family member) removed?**

**A7.** Assuming that "substantiate" an allegation of abuse means complete the facility's mandatory investigation of the allegation of abuse, the facility should attempt to complete this investigation just like any other investigation of possible abuse. Abuse which has been captured on videotape would not seem to be difficult to substantiate.

Under 40 TAC §19.401(b), a resident has the right to keep and use personal property. A resident's rights may be restricted only to the extent necessary to protect the resident or another person from danger or harm, or to protect the rights of another resident, particularly those relating to privacy and confidentiality.

**Q8.** *A resident slaps, shakes or scratches another resident. There are no injuries. Is this reportable?*

**A8.** No. However, the facility is responsible for intervening and taking the necessary steps to protect residents from all forms of abuse and to reduce the chance of recurrence. A pattern of minor injuries may trigger a DHS investigation for resident to resident abuse or facility neglect.

**Q9.** *Are witness statements (handwritten) that were done when a notary was not available considered valid when attached to the investigation report?*

**A9.** They are valid for our purposes.

**Q10.** *Under what circumstances should the police also be notified? The provider letter specifies burglary, theft and drug diversion, but what about abuse, etc.?*

**A10.** The police should be notified whenever a crime is committed. Certain types of abuse (sexual or physical) are crimes. If a resident wishes to press charges when a crime is committed against him/her, it is the resident's right to contact the police, or be assisted in making the call if he/she is unable to do this independently.

**Q11.** *Should investigation reports be placed under "Facility CQI" under the Texas Medical Act?*

**A11.** Assuming "Facility CQI" stands for Facility Care Quality Improvement, this question appears to stem from some continuing confusion between two separate federal requirements: accident and incident reports and quality assessment and assurance. Facilities must meet both requirements.

Accident and incident reports are covered in 42 CFR §483.13(c)(2), (3)&(4). The purpose of this regulation is to assure that the facility has in place an effective system that, regardless of the source, prevents mistreatment, neglect and abuse of residents and misappropriation of residents' property. According to guidance provided in the SOM, one of the items survey staff should ask the administrator to provide within one hour of the conclusion of the entrance conference is evidence that the facility, on a routine basis, monitors accidents and other incidents, records these in the clinical or other record, and has in place a system to prevent and/or minimize further accidents or incidents. The SOM specifically states, "This evidence could be a record of accident and injury reports."

Quality assessment and assurance is covered in 42 CFR §483.74(o); it requires the facility to maintain a quality assessment and assurance committee that performs certain duties. Once again, the SOM provides guidance on how to survey for these requirements. Even the timing is specified - review of a facility's compliance with this federal requirement is postponed until after the Phase 2 sampling meeting to ensure that facility quality deficiencies are not identified by the survey team through the use of records of the facility's quality assessment and assurance activities. The department may not require

disclosure of the records of the quality assessment and assurance committee, but this does not relieve the facility of the requirement to document compliance with federal standards.

If a facility places its investigation reports under "Facility CQI" and therefore refuses to provide state surveyors with these documents, it is up to survey staff to determine if the facility is in compliance with federal requirements, including 42 CFR §483.13(c)(2),(3)&(4). If survey staff cannot make this determination without access to records the facility refuses to release, then survey staff must find the facility out of compliance.

**Q12. *Regarding resident to resident abuse - does "treatment" include skin tears or minor scratches?***

**A12.** Yes, **if** the incident was serious enough that the physician ordered evaluation or treatment.

**Q13. *If female and male residents are found "fondling" each other with exposed anatomy and both residents are "incompetent" - is this reportable to the state?***

**A13.** Yes. If the residents are adjudicated incompetent by a court of law, they would not be able to give consent. Therefore, the sexual activity would not be consensual and is reportable to DHS, as referenced in 19.101(D) of the "Nursing Facility Requirements for Licensure and Medicaid Certification".

**Q14. *Give some examples of incidents that are not reportable as a result of actions/inactions of facility or staff.***

**A14.** A staff places a box on the floor in front of an office in order to unlock a door. A resident walks by and trips over the box, but sustains no injury. The staff action (placing the box on the floor) caused the resident to trip, however, the staff could not have predicted that the resident would walk into the box. Neglect was not a factor, therefore, the incident is not reportable.

A resident walks down the hall, and collides with a staff (or resident) who happens to be walking out of a room into the hall. The resident suffers a laceration and is taken to the hospital, where he receives sutures. This accidental injury did not appear to result from abuse or neglect, and therefore, is not reportable.

**Q15. *Regarding statement of conduct or conditions language "...circumstances within the facility..." , please explain what this means, what serious injuries are not reportable and give examples.***

**A15.** "Conduct or conditions", as defined in Provider Letter 98-29, is "a facility practice, actions/inactions by staff or circumstances within a facility that have resulted in serious accidental injury or hospitalization of residents." This means that an injury or hospitalization was related to or caused by a facility practice, such as, for example,

stacking boxes of supplies very high to preserve more floor space. If a resident walks by and the boxes fall on him, causing a serious accidental injury, this would be reportable, because the facility practice of stacking boxes high caused a serious injury to a resident. Actions/inactions by staff refer to something staff did (e.g., abuse) or did not do (e.g., neglect), and circumstances within the facility refers to a situation or occurrence within a facility that is directly or indirectly associated with a negative outcome for the resident (e.g., an injury).

As stated in Provider Letter 98-29, "Serious injuries that are NOT the result of a facility practice, actions/inactions by staff or circumstances within the facility, are NOT reportable incidents."

**Q16. *Can the facility be notified of what priority the incident receives?***

**A16.** No. That would be tantamount to announcing an investigation.

**Q17. *How should an administrator or D.O.A. handle this? If staff knows of physical or verbal abuse, but does not report it to the D.O.A. or administrator until two to three days later because staff felt that resident did not receive any injury and the person was not an employee of the facility.***

**A17.** The facility should report the incident immediately. The facility is responsible and will be held accountable when staff members fail to report allegations of abuse. Staff should be inserviced regarding reporting requirements.

**Q18. *The MD, NP and PA are not in the facility and never see the residents except on regular rounds for monthly visits. What would prevent a facility from never contacting these people and "hiding" the fact that it (reportable incident) ever occurred? For example, DHS surveyors frequently find residents with fractured fingers, arms, hips, etc. that the facility never followed up on.***

**A18.** During surveys or incident/complaint investigations, surveyors would probably either observe injuries, discover that injuries have occurred during interviews with residents, or become aware of injuries during review of facility documentation. The facility would then be held accountable for failing to report.

**Q19. *What is "immediate" - regarding reporting an incident?***

**A19.** "Immediately" is defined as "instantly". Once it is determined that an incident is reportable, staff should report the incident to DHS without delay.

**Q20.** *If a resident needs "close supervision", is this an Interdisciplinary Team decision, a nurse's judgement, or does there need to be a doctor's order? How is "close" defined? How is "extended period of time" defined (as in "close supervision for an extended period of time")?*

**A20.** Any decision affecting resident care should be a team decision. "Close" is defined by the IDT, taking into account the frequency and severity of the maladaptive behavior. One facility may define "close" as "within eyesight at all times", whereas another facility may define it as "knowing the resident's whereabouts at all times". Either of these definitions may be "correct", depending on the resident's needs at the time.

**Q21.** *If the facility has a policy to use restraints, but they are not used and the resident is injured, would this be an example of an injury resulting from facility practice? Would not using restraints per facility policy be injury resulting from facility practice?*

**A21.** If a resident requires restraints for medical necessity per physician's order, and the resident receives an injury because the restraints were not used, then staff inaction, or neglect resulted in injury.

**Q22.** *How much preliminary investigation should be done prior to reporting by phone?*

**A22.** None. The facility immediately reports the incident based upon the incident reporting criteria and then follows up with an investigation per the requirements.

**Q23.** *Nurses' and administrators' licenses can be revoked, suspended, etc. But it seems that even with convictions, a CNA's certification is rarely affected. Why?*

**A23.** A nurse aide will be listed on the Nurse Aide Registry for a findings of abuse, neglect or misappropriation of a resident's property. According to §94.3(g) of the "Licensing Standards for Nurse Aides", "A facility must not employ individuals who have had a finding entered into the registry concerning abuse, neglect or misappropriation of a resident's property."

**Q24.** *During the night shift a resident is found during rounds with a small skin tear. Is this reportable?*

**A24.** Only if abuse (other than resident to resident) or neglect is suspected. The criteria for reporting resident to resident abuse is outlined in Provider Letter 98-29.

**Q25.** *Can you fax in a report to DHS immediately upon learning of the incident rather than calling?*

**A25.** No, Section 19.602(b)(1) of the "Nursing Facility Requirements" states that the person reporting must make a telephone report. DHS is developing guidelines to allow facilities the option of reporting incidents to DHS by fax or by telephone. However, continue to make telephone reports until you receive written notice of a change in procedure.

**Q26.** *"Burden of proof" bears repeating. It is not necessary to prove an allegation beyond a shadow of a doubt. Preponderance of the evidence is sufficient. Both facility and DHS investigators need to be reminded of this. Our cases do not go to the supreme court.*

**A26.** This statement relates to facility as well as DHS investigations of allegations. Allegations should be substantiated (or unsubstantiated) based on the preponderance of evidence.

**Q27.** *Who do you recommend the investigator to be? Or should it be a committee?*

**A27.** The facility has some flexibility in this area. DHS has no specific requirements, but the investigator should possess skills in the areas of organizing and conducting an investigation, as well as gathering and analyzing evidence in an impartial manner.

**Q28.** *Why is DHS interested in knowing all of this information on incidents and accidents?*

**A28.** To ensure protection of resident health and safety. Health and Safety Code Chapter 242 and 40 TAC 19.602 require that the facility report abuse, neglect and exploitation of residents as well as the other items listed in Provider Letter 98-29, dated September 11, 1998. Report accidental injuries only when they result from a facility practice, actions/inactions by staff or circumstances within the facility.

**Q29.** *Why do state surveyors ask facility staff or witnesses to write new statements many months after the alleged incident occurred? They do not seem to want the staff to copy or review statements previously written and submitted as part of the facility's investigation.*

**A29.** When allegations are re-investigated, this is treated as a new investigation. Therefore, new statements may be taken.

**Q30.** *We have a special care unit. All of our residents push or hit. If one pushes another, and the other falls and fractures a hip, do we report this?*

**A30.** Yes, because the resident sustained a hip fracture. See Provider Letter 98-29, which states that resident to resident abuse is to be reported only when a resident is killed, has to be taken to a hospital or emergency care facility, is admitted to a hospital or when the physician orders treatment other than observation. See Section 3 of the letter for a detailed explanation.

**Q31.** *We do neurological checks for all falls, even when not ordered by a doctor. Do we report these even if they are not ordered?*

**A31.** No.

**Q32.** *Will you define sexual harassment (resident to resident) as it relates to residents with dementia, especially when the resident talks about sex.*

**A32.** The definition of sexual abuse is found at 40 TAC §19.101 of the "Nursing Facility Requirements" and includes sexual harassment. If the IDT determines that a resident with dementia is incompetent, and that resident "sexually abuses (as defined in 40 TAC §19.101)" or is sexually abused by another resident, these are reportable incidents. If it is determined that the resident in question is directing comments to another resident in an attempt to arouse or gratify the sexual desire of any person, it is considered sexual abuse if the recipient is incompetent or does not want this behavior to occur.

**Q33.** *If a nurse aide or medication aide reports a family's concern for a resident's health to the charge nurse and the D.O.A. does not respond, is the nurse/medication aide responsible for neglect?*

**A33.** Yes, and a referral would be made to the Board of Nurse Examiners as well.

**Q34.** *If a nurse does not give a number of ordered medications, throws them in the trash and exits the facility never to return, is this reportable?*

**A34.** Yes, if the missed medications caused or could have caused harm to the resident. According to the "Nursing Facility Requirements", 40 TAC §19.101, neglect is defined as the failure of an individual to provide services, treatment or care to an resident which causes or could cause physical injury, harm or death to the resident. The department would make a referral to the Board of Nurse Examiners as well.

**Q35.** *If during the process of investigation to identify if an incident is reportable, the state comes to investigate the same incident due to a family complaint. Does the facility still report the incident?*

**A35.** Yes. The facility is responsible for investigating all allegations of abuse, neglect or exploitation.

**Q36.** *Re: Provider letter 98-29, page 5 states that the facility report must be sent to DHS no later than the fifth working day after the oral report. Does this mean that Saturday and Sunday do not count when figuring five working days?*

**A36.** Correct.

- Q37.** *When will Texas follow other states and not take anonymous complaints?*
- A37.** According to 40 TAC §19.2006(c) of the "Nursing Home Requirements", anonymous complaints of abuse and neglect will be treated in the same manner as acknowledged reports. It is not known at this time if this requirement will change.
- Q38.** *I called in an incident and sent in an investigation report to TDHS, but TDHS lost the report. Who do I call to find out what happened to the report?*
- A38.** You may contact the "Customer Service Section" of DHS LTC-R at 512-438-2633 to discuss the issue.
- Q39.** *Who determines if serious accidental injuries did or did not result from a facility practice? There would probably be a difference in opinion.*
- A39.** Facility staff would have to make this determination, in order to decide whether the incident is reportable. During a complaint investigation, DHS investigators would make this determination.
- Q40.** *A resident was put to bed per his/her request at 7:00 p.m. The resident's bed rails were in place per Dr.'s order and request of resident. In between rounds, the resident wakes up and climbs over the bed rails, falls and lacerates his head, resulting in the need for stitches. He is sent to the ER and returned to the facility. Is this reportable?*
- A40.** If the resident had no history of climbing over the bed rails, and there is no reason for staff to believe that he would climb over the bed rails (change in medication, medical condition, etc.), then neglect does not appear to be a factor. In this case, the incident would not be reportable. See Section III of Provider Letter 98-29 for incidents that are not reportable.
- Q41.** *If a resident gets a skin tear and the Dr. orders a treatment, is this reportable?*
- A41.** If another resident caused the skin tear, the incident would be reportable (see Section I(3)(D) of Provider Letter 98-29). If it is an unknown or accidental injury, and the tear is a "minor" injury, it would not be reportable unless the facility suspected abuse or neglect.