310 INCIDENT REPORTING

The facility must develop and implement written policies and procedures to ensure that incidents, including:

- **alleged or suspected abuse or neglect of residents;**
- **accidents, including accidents resulting in death;**
- **unusual deaths or deaths from violence;**
- **unusual occurrences; and,**
- **exploitation of residents or any misappropriation of resident property,**

are prohibited, reported, investigated and documented as required by these regulations.

A facility is not required under this regulation to report death by natural causes. However, nothing in this regulation negates, waives or alters the reporting requirements of a facility under other regulations or statutes.

Facility policies and procedures regarding reporting, as addressed in these regulations, must be included in orientation training for all **new** employees, and must be addressed at least **annually** during in-service training for **all** facility staff.

310.1 NEXT-BUSINESS-DAY REPORTING OF INCIDENTS

The following events shall be reported to the Office of Long Term Care by facsimile transmission to telephone number 501-682-8551 of the completed Incident & Accident Intake Form (Form DMS-7734) no later than 11:00 a.m. on the next business day following discovery by the facility.

a. Any alleged, suspected or witnessed occurrences of abuse or neglect to residents.

b. Any alleged, suspected or witnessed occurrence of misappropriation of resident property, or exploitation of a resident.

c. Any alleged, suspected or witnessed occurrences of verbal abuse. For purposes of this regulation, "verbal abuse" means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he or she will never be able to see his or her family again.

d. Any alleged, suspected or witnessed occurrences of sexual abuse to residents by any individual.

In addition to the requirement of a facsimile report by the next business day on Form DMS-7734, the facility shall complete a Form DMS-762 in accordance with Section 310.2.

310.2 INCIDENTS OR OCCURRENCES THAT REQUIRE INTERNAL REPORTING ONLY - FACSIMILE REPORT OR FORM DMS-762 NOT REQUIRED.

The following incidents or occurrences shall require the facility to prepare an internal report **only** and **does not require** a facsimile report, or form DMS-762 to be made to the Office of Long Term Care. The internal report shall include all content specified in Section 310.3, as applicable. Facilities must maintain these incident record files in a manner that allows verification of compliance with this provision.

a. Incidents where a resident attempts to cause physical injury to another resident without resultant injury. The facility shall maintain written reports on these types of incidents to document "patterns" of behavior for subsequent actions.

b. All cases of reportable disease, as required by the Arkansas Department of Health.

c. Loss of heating, air conditioning or fire alarm system of greater than two (2) hours duration.

310.3 INTERNAL-ONLY REPORTING PROCEDURE

Written reports of all incidents and accidents included in section 310.2 shall be completed within five (5) days after discovery. The written incident and accident reports shall be comprised of all information specified in forms DMS-7734 and 762 as applicable.

All written reports will be reviewed, initialed and dated by the facility administrator or designee within five (5) days after discovery. All reports involving accident or injury to residents will also be reviewed, initialed and dated by the Director of Nursing Services or other facility R.N, if any.

Reports of incidents specified in Section 310.2 will be maintained in the facility **only** and are not required to be submitted to the Office of Long Term Care.

All written incident and accident reports shall be maintained on file in the facility for a period of three (3) years.

310.4 OTHER REPORTING REQUIREMENTS

The facility's administrator is also required to make any other reports of incidents, accidents, suspected abuse or neglect, actual or suspected criminal conduct, etc. as required by state and federal laws and regulations.

310.5 ABUSE INVESTIGATION REPORT

The facility must ensure that all alleged or suspected incidents involving resident abuse, exploitation, neglect or misappropriations of resident property are thoroughly investigated. The facility's investigation must be in conformance with the process and documentation requirements specified on the form designated by the Office of Long Term Care, Form DMS-762, and must prevent further potential incidents while the investigation is in progress.

The results of all investigations must be reported to the facility's administrator, or designated representative, and to other officials in accordance with state law, including the Office of Long Term Care. Reports to the Office of Long Term Care shall be made via facsimile transmission by 11:00 a.m. the next business day following discovery by the facility, on form DMS-7734. The follow-up investigation report, made on form DMS-762, shall be submitted to the Office of Long Term Care within 5 working days of the date of the submission of the DMS-7734 to the Office of Long Term Care. If the alleged violation is verified, appropriate corrective action must be taken.

The DMS-762 may be amended and re-submitted at any time circumstances require.

310.6 REPORTING SUSPECTED ABUSE OR NEGLECT

The facility's written policies and procedures shall include, at a minimum, requirements specified in this section.

310.6.l The requirement that the facility's administrator or his or her designated agent immediately reports all cases of suspected abuse or neglect of residents of a long-term care facility as specified below:

a. Suspected abuse or neglect of an adult (18 years old or older) shall be reported to the local law enforcement agency in which the facility is located, as required by Arkansas Code Annotated 5-28-203(b).

b. Suspected abuse or neglect of a child (under 18 years of age) shall be reported to the local law enforcement agency and to the central intake unit of the Department of Human Services, as required by Act 1208 of 1991. Central intake may be notified by telephone at 1-800-482-5964.

310.6.2 The requirement that the facility's administrator or his or her designated agent report suspected abuse or neglect to the Office of Long Term Care as specified in this regulation.

310.6.3 The requirement that facility personnel, including but not limited to, licensed nurses, nursing assistants, physicians, social workers, mental health professionals and other employees in the facility

who have reasonable cause to suspect that a resident has been subjected to conditions or circumstances which have or could have resulted in abuse or neglect are required to immediately notify the facility administrator or his or her designated agent.

310.6.4 The requirement that, upon hiring, each facility employee be given a copy of the abuse or neglect reporting and prevention policies and procedures and sign a statement that the policies and procedures have been received and read. The statement shall be filed in the employee's personnel file.

310.6.5 The requirement that all facility personnel receive annual, in-service training in identifying, reporting and preventing suspected abuse/neglect, and that the facility develops and maintains policies and procedures for the prevention of abuse and neglect, and accidents.

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE
DMS-7734

Incident & Accident Next Day Reporting Form

Purpose/Process

This form is designed to standardize and facilitate the process for the reporting allegations of resident abuse, neglect, misappropriation of property or injuries of an unknown source by individuals providing services to residents in Arkansas long term care facilities for next day reporting pursuant to LTC 310.2.

The purpose of this process is for the facility to compile the information required in the form DMS-7734, so that next day reporting of the incident or accident can be made to the Office of Long Term Care.

Completion/Routing

This form, with the exception of hand written witness statements, MUST BE TYPED!

The following sections are **not** to be completed by the facility; the Office of Long Term Care completes them:

1. The top section entitled **COPIES FOR:**
2. The **FOR OLTC USE ONLY** section found at the bottom of the form.

All remaining spaces **must** be completed. If the information can not be obtained, please provide an explanation, such as "moved/address unknown", "unlisted phone", etc.

If a requested attachment can not be provided please provide an explanation why it can not be furnished or when it will be forwarded to OLTC.

The original of this form **must be faxed to the Office of Long Term Care the next business day following discover by the facility.** Any material submitted as copies or attachments must be legible and of such quality to allow recopying.

OLTC INCIDENT AND ACCIDENT REPORT (I&A)

Date & Time Submitted (if known): _____ Date & Time of Discovery: _____

Facility Name: _____

Facility Area Code and telephone # (_____) _____

Facility Address: _____

_____

Staff reporting I & A: _____ Title: _____

Date of I & A _____ Time:_____ AM or PM

Name of Injured Resident:_____ Age:_____ Sex:_____ Race: _____

Status of Alleged Perpetrator: ___ Facility Employee ___ Family ___ Visitor ___ Other ___ Unknown

Type of Incident: **Neglect**_____
Abuse: Verbal_____
Sexual_____
Physical_____
Emotional/Mental_____

Misappropriation of Property: Drugs_____
Personal Property_____
Resident Trust Fund_____

NOTIFICATIONS: FAMILY: Yes _____ No _____ DOCTOR: Yes _____ No _____

LAW ENFORCEMENT: Yes _____ No _____ ADMINISTRATOR: Yes _____ No ____

Summary of Incident:_____

_____

_____

_____ (cont. on page 2)

Steps taken to prevent continued abuse or neglect during the investigation:_____

_____

_____

_____ (cont. on page 3)

SUMMARY OF INCIDENT – CONTINUED

STEPS TAKEN TO PREVENT CONTINUED ABUSE OR NEGLECT DURING THE INVESTIGATION– CONTINUED

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE
DMS-762

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

Purpose/Process

This form is designed to standardize and facilitate the process for the reporting allegations of resident abuse, neglect, or misappropriation of property or exploitation of residents by individuals providing services to residents in Arkansas long term care facilities. This investigative format complies with the current regulations requiring an internal investigation of such incidents and submittal of the written findings to the Office of Long Term Care (OLTC) within five (5) working days.

The purpose of this process is for the facility to compile a substantial body of credible information to enable the Office of Long Term Care to determine if additional information is required by the facility, or if an allegation against an individual(s) can be validated based on the contents of the report.

Completion/Routing

This form, with the exception of hand written witness statements, MUST BE TYPED!

Complete **all** spaces! If the information can not be obtained, please provide an explanation, such as "moved/address unknown", "unlisted phone", etc. Required information includes the actions taken to prevent continued abuse or neglect during the investigation.

If a requested attachment can not be provided please provide an explanation why it can not be furnished or when it will be forwarded to OLTC.

This form, and all witness and accused party statements, **must be originals**. Other material submitted as copies must be legible and of such quality to allow re-copying.

The facility's investigation and this form must be completed and submitted to OLTC within five (5) working days from when the incident became known to the facility.

Upon completion, send the form by certified mail to:
Office of Long Term Care, P.O. Box 8059, Slot 404, Little Rock, AR 72203-8059.

Any other routing or disclosure of the contents of this report, except as provided for in LTC 310.3 and 310.4, may violate state and federal law.

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

Section I-Reporting Information

Name of Facility:_____

Phone #:__(_____)_____

Address:_____

City _____ State _____ Zip Code _____

Facility Staff Member Completing DMS 762:_____

Title:_____

Date Incident Reported/Faxed to OLTC: _____ Time:_____AM/PM

Date & Time of Incident (if known):_____
Time & Time of Discovery:_____

Type of Incident: **Neglect**_____ **Misappropriation of Property**: Drugs_____
Abuse: Verbal_____ Personal Property_____
Sexual_____ Resident's Trust Fund_____
Physical_____
Emotional/Mental_____

Name of Involved Resident:_____ Room # :_____

Social Security #:_____ DOB: _____

Height_____Weight_____Physician_____

Is Resident still Living:_____ If not, Date of Death:_____

Ambulatory? YES_____ NO_____ Oriented Time, Place, Person, Events (Circle one or all).

Physical Functional Level/Impairment_____

_____

_____

Mental Functional Level_____

_____

_____

Primary Diagnosis_____

_____

Section II-Complete Description of Incident

"See Attached Is Not Acceptable!"

(Attach Additional Pages as Necessary)

Section III- Findings and Actions Taken

Please include Resident's current medical condition

Facility Administrator's Signature

Date

Section IV- Notification/ Status

Administrator/Written Designee Must Be Notified!

Name of Administrator_____

Date:_____ Time:_____AM / PM

Family Notified: YES_____ NO _____ NONE _____ Date:_____ Time:_____AM/PM

Name of Family Member:_____

Relationship:_____ Phone #: _____

Doctor Notified: YES _____ NO____ Date:_____Time:_____AM/PM

Doctor's Name:_____ Phone #:_____

Resident Sent to Hospital: YES_____ NO_____Date:_____Time:_____AM/PM

Admitted to Hospital: YES_____ NO_____

Name/ Address/ Phone of Hospital: _____

_____

_____

Law Enforcement Must Be Notified for abuse and neglect

Date:_____ Time:_____AM/PM

Name of Law Enforcement Agency:_____

Phone #:_____

Address:_____

City/Zip: _____

Was an Investigation Made by the Law Enforcement Agency?: YES_____ NO_____

Date of Investigation:_____ Time:_____

Name of Officer:_____

Section VI-Accused Party Information

Name of Accused Party:_____

Job Title (if any):_____ Phone #: _____

Home Address:_____

City/State/Zip:_____

Social Security #: _____ DOB: _____

Dates of Current Employment: From_____ To _____

Certified Nursing Assistant: YES_____ NO_____

Registration # :_____ Date Issued: _____

Date Criminal Background Check Completed: _____

Licensed by State Board of Nursing: YES_____ NO_____

Type of License: RN #_____ LPN #_____

Date Issued:_____

Section VII- Attachments

Attach the following information to the back of this form. If you do not have one of the specified attachments, please provide an explanation why it can not be obtained or if it will be forwarded in the future.

1. Statement from the accused party.

2. All witness statements. Use the attached OLTC Witness Statement Form for all witness statements submitted. If the statement is a typed copy of a handwritten statement, the handwritten statement must accompany the typed statement.

3. Law enforcement incident report. This can be mailed at a later date if necessary.

4. Other pertinent reports/information, such as Ombudsmen, autopsy, reports, etc. These can be mailed at a later date if necessary.

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form

Date:_____ Time:_____AM/ PM

Witness Full Name:_____

Job Title:_____ Shift:_____

Home Address:_____ City/Zip_____

Home Phone #:_____ Work Phone #:_____

Relation to Resident (If Any?)_____

State in your own words what you witnessed (be very descriptive) and sign below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ (Continue on Back as Necessary)

The information provided above is true to the best of my knowledge:

Signature of Witness:_____ Date:_____