LONG TERM CARE FAX REPORTING
OF INCIDENTS AND ABUSE

GENERAL INSTRUCTIONS:

1. These instructions apply to reporting all incidents, and suspected abuse, neglect, mistreatment and misappropriation of resident property under the Patient Abuse Law.

2. Complete a separate blank form for each occurrence following the instructions below.

3. Use the attached tables to enter a description for those items that are marked "see table."

4. Submit your completed report by fax to the Department immediately for (1) suspected abuse, neglect or misappropriation; (2) epidemic disease; (3) fires; and (4) death resulting from incidents. **Notify the Department immediately by phone at 617-753-8150 of any deaths resulting from incidents, medication errors, abuse or neglect; and full or partial evacuation of the facility for any reason**. Submit other completed reports within seven days of the date of the occurrence of an incident resulting in serious harm.

5. Fax your completed report to the Department at **617-753-8165**.

LINE-BY LINE INSTRUCTIONS

PAGE 1 OF REPORT FORM:

FROM: Please provide the name and address of the facility making the report.

DATE OF REPORT: Enter the date that you are submitting your report to the Department.

GENERAL INFORMATION: Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information, and the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

RESIDENT INFORMATION: Please provide information here regarding the resident involved. The information reported here should reflect the resident's condition prior to the occurrence. If more than one resident was injured, or one resident has injured another resident, provide additional resident information under the narrative portion of the report or on an additional page. Please indicate:

NAME: The resident's first and last name.

AGE; SEX; ADMISSION DATE: Enter each for the named resident.

AMBULATORY STATUS: Select the term from Table #1, "Ambulatory Status", that most closely describes the resident's ability to walk.

LINE BY LINE INSTRUCTIONS - CONTINUED

ADL STATUS: Activities of Daily Living (ADLs) such as eating, dressing or personal grooming. Select the term from Table #2, "Resident ADL Status", that most closely describes the resident's ability to perform these functions.

COGNITIVE LEVEL: Select the term from Table #3, "Resident Cognitive Status", that best describes the resident's cognitive status at the time of the occurrence.

DEVELOPMENTALLY DISABLED: Indicate whether or not the resident is developmentally disabled. If so, indicate the name of the Case Manager assigned to the patient, if known.

REPORT DETAIL:

OCCURRENCE TYPE: Select the term from Table #4, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

TYPE OF HARM: Select the term from Table #5, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.

BODY PART AFFECTED: Use terms such as "arm", "foot", etc.; indicate left or right when it applies.

RESIDENT'S ACTIVITY AT TIME OF OCCURRENCE: Select the term from Table #6, "Resident's Activity", that best describes the resident's activity at the time of the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

PLACE OF OCCURRENCE: Specify where the event occurred. Examples would include: "resident's room", "dining room", "shower room", or any other short phrase that specifies the type of setting in which the occurrence took place.

WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE: Specify if any equipment was in use, such as "Hoyer lift", or "walker".

ANY SAFETY PRECAUTIONS IN PLACE: Check the "yes" or "no". If "yes", describe the precautions that were in place.

PAGE 2 OF REPORT FORM:

NARRATIVE: Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

CORRECTIVE MEASURES NARRATIVE: Describe what actions have been taken in response to the occurrence. Note that in the case of abuse, neglect, mistreatment and misappropriation, or injuries of an unknown cause in Medicaid and Medicare certified facilities, federal regulations require that you have evidence that an investigation occurred and the resident was protected from future injury.

NOTIFICATION: Indicate whether or not the resident's family and physician, and police were notified. Provide the name of the physician notified. Indicate whether any person injured was brought to the hospital, and if so, the hospital they were brought to.

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE: Indicate who was in present and charge at the facility (not on the unit) when the occurrence reported happened.

WITNESS INFORMATION: List the name and title for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in what occurred. Other residents, visitors and volunteers should be listed as witnesses if they have direct knowledge of what occurred.

ACCUSED INFORMATION: When reporting suspected abuse, neglect or misappropriation, indicate the name of the accused, a phone number at which the accused can be contacted, if the accused is a nurse, nurse aide or other licensed professional please indicate the individual's license or registration number. Check the appropriate block if you are not reporting abuse, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a resident's money or belongings is unknown. If more than one individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide.

LINE BY LINE INSTRUCTIONS - CONTINUED

REPORTING TABLES**:**

Table #1: Ambulatory Status:

Independent
Supervised
Dependent/Assist
Wheels Self
Wheelchair
Bedfast
Unknown

Table #2: Resident ADL Status:

Independent
Supervised
Dependent
Unknown
Other

Table #3: Resident's Cognitive Status:

Alert/Oriented
Dementia
Developmentally Disabled
Confused
Alzheimer's
Comatose
Unknown
Other

Table #4: Occurrence Type:

Fall
Abuse
Neglect
Misappropriation
Resident to Resident
Injury of Unknown Origin
Epidemic Disease
Food Poisoning
Death
Suicide
Missing Person
Criminal Act
Fire
Pending Strike
Choking
Other (Describe)
Equipment Malfunction

Table #5: Type of Harm:

Fracture
Laceration
Bruise/Hematoma
Reddened Area
Dislocation
Burn
Unwelcome Sexual Contact/Advance
Emotional Harm/Upset
Care Not Provided
Quality of Care
Decline in Condition
Infection
Confinement
Property
Funds
Death
No Harm
Other(Describe)
Unknown

Table #6: Resident's Activity

Ambulating
Toileting
Transfer/Assist
Getting Out of Bed
Getting Up From Chair
Reaching
Standing/Sitting Still
Crowded Area
Unknown
Other(Describe)

LONG TERM CARE FAX REPORT FORM

TO: INTAKE STAFF
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE FACILITY LICENSURE AND CERTIFICATION
FAX NUMBER (617) 753-8165

FROM: Facility Name: _____
Address (Street): _____
Address (City/Town) _____

DATE OF REPORT: _____ NUMBER OF PAGES: _____

GENERAL INFORMATION:
Report prepared by: _____
Title: _____
Phone Number: (_____)_____-_____Ext:_____
Date of Occurrence: Month_____ Date_____ Year_____
Time of Occurrence: _____ am_____ pm_____

RESIDENT INFORMATION:
Name: First_____Last_____
Age: _____
Sex: Male _____ Female _____
Admission Date: Month_____ Date_____ Year_____
Ambulatory Status (See table #1):_____
ADL Status (See table #2): _____
Cognitive Level (See table #3):_____
Developmentally Disabled: ____ Yes ____No
If yes, Service Coordinator or Case Manager (if known): _____

REPORT DETAIL:
Occurrence Type (See table #4):_____
Type of Harm (See table #5):_____
Body Part Affected: _____ L:____ R: ____
Resident's activity at time of occurrence (See table #6): _____
Place of Occurrence: _____
What equipment, if any, was being used at time of occurrence? _____
Any safety precautions in place?Yes_____ No_____
If yes, describe what preventive measures were in place:

[Form continues to page 2.]

FACILITY NAME: _____ DATE OF OCCURRENCE: _____

NARRATIVE: (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated? [Attach additional pages as needed.])

Were there any unusual circumstances involved? Yes_____ No_____ If yes, please describe. [Attach additional pages as needed.]

CORRECTIVE MEASURES NARRATIVE: (Please address the following: Was there an internal investigation: Yes_____ No_____. If No - why? If yes - What are the investigation findings? What action was taken with regard to: Resident?; Staff?; Facility practice? What is the resident's current status? What corrective action taken regarding equipment involved, if applicable? [Attach additional pages as needed.])

NOTIFICATION:
Was family notified: Yes_____ No_____
Was MD notified: Yes_____ No_____
Name of MD if notified: _____
Was resident brought to hospital: Yes_____(Hospital:_____) No _____
Were police notified: Yes_____ No_____

STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:
Name: Title: Directly Involved:
_____YES_____NO_____

WITNESS INFORMATION: (Check here if unwitnessed: _____)
Name: Title: Directly Involved:
_____YES_____NO_____
_____YES_____NO_____

ACCUSED INFORMATION: (Check here if unknown or not applicable: _____)
Name: Telephone #:
_____(_____)_____-_____ CNA ___; RN/LPN ____
If CNA, RN/LPN or other licensed individual, indicate license #:_____
FILENAME=FAX LTC 9-2002.doc