DELAWARE HEALTH & SOCIAL SERVICES

Incidents and Investigations

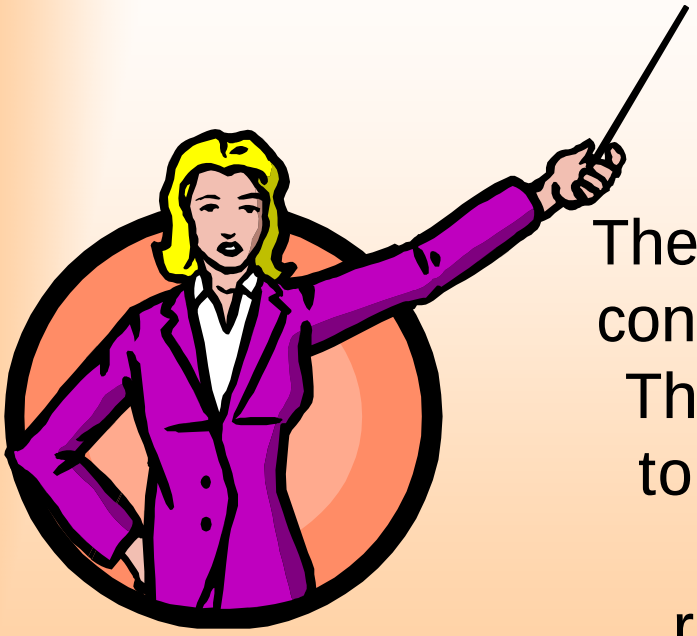
DIVISION OF LONG TERM CARE RESIDENTS PROTECTION

Presentation Date: January 7, 2014

Licensing Section

History - Basis for the State Agency Certification Functions

Section 1864 and Section 1902 of the Social Security Act



The State Agency functions under a contract with the federal government. This contract pays the State Agency to determine a facility's compliance with Medicare and Medicaid regulations by way of the survey process.

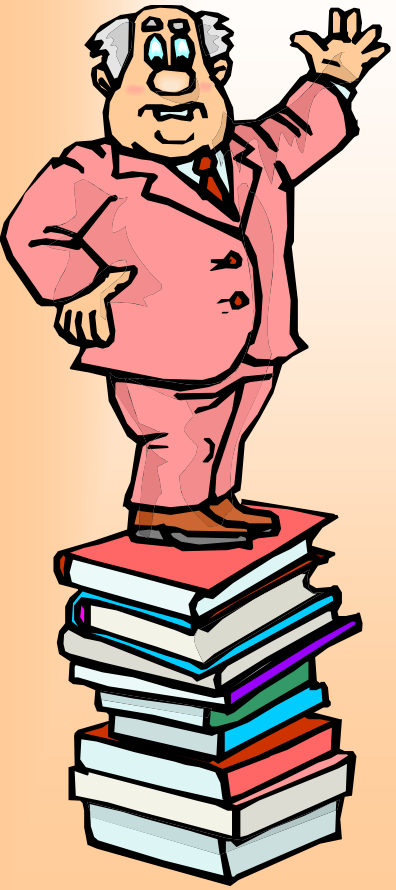
Functions

The Licensing Section functions under a specific survey process Methodology outlined by the federal government in the State Operations Manual.

Mandated Functions

- Conduct annual **surprise** surveys (full survey to determine compliance with all the regulations every 9-15 months).
- Abbreviated standard surveys (focus survey to investigate complaints, or determine compliance after prior deficiencies were identified).
- In order to meet the criteria set forth in the grant the annual surveys must be conducted every 9-15 months and the complaint surveys must be conducted according to the triage criteria (2, 10, 45 days). Licensing is presently dependent upon the Investigation section to open cases and assist us in assigning the priority depending upon the information found on site.

Mandated Functions



- Five percent (5%) of our annual surveys must be conducted during evening, night or weekend hours.
- Maintains the CNA registry.
- Additionally the State Agency also evaluates a facility's compliance with State laws such as Eagle's law.
- Issues state licenses to facilities either annually or on a provisional basis.

Harm

- No actual harm with a potential for minimal harm a deficiency that has the potential for causing no more than a minor negative impact on the resident.
- No actual harm with potential for more than minimal harm noncompliance that results in minimal physical, mental and/or psychosocial discomfort to the resident.
- Actual Harm is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his or her highest practicable physical, mental and psychosocial well being.
- Immediate jeopardy a situation in which immediate corrective action is necessary because the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Scope and Severity Matrix

SEVERITY	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F Substandard Quality of Care
	No actual harm with potential for minimal harm	A Substantial Compliance	B Substantial Compliance	C Substantial Compliance
		Isolated (1)	Pattern (2)	Widespread (3)
		Scope		

Scope and Severity Matrix (Cont.)

SEVERITY				
	Immediate jeopardy to resident health or safety	**J** Immediate Jeopardy	**K** Immediate Jeopardy	**L** Immediate Jeopardy
	Actual harm that is not immediate jeopardy	**G**	**H** Substandard Quality of Care	**I** Substandard Quality of Care
		Isolated (1)	Pattern (2)	Widespread (3)
		Scope		

Investigative Section

Authority for the State Agency Investigatory Functions

- Created by State Statute in 1999.
- The purpose of the Investigative Section is to ensure that individuals receiving long term care services are safe, secure and free from abuse, neglect, mistreatment and financial exploitation and to promote the quality of care and quality of life for individuals receiving long term care services.

Investigative Section Functions

Incident Referral Center

Receives incident reports and complaints regarding long term care, prioritizes them and if appropriate assigns them for follow-up.

Investigative Unit

Investigates abuse, neglect, mistreatment and financial exploitation of long term care residents & conducts preliminary investigations to assist licensing in triaging complaints.

Investigative Section Functions

Criminal Background Unit

Receives, investigates and maintains criminal history record and drug test results. Determines eligibility for employment in the long term care field.

Adult Abuse Registry

A listing of all persons in the state who have substantiated judgments of abuse, neglect, mistreatment or financial exploitation against them. The unit manages the placement and removal of persons on the registry and processes all inquiries from potential employers.

Definitions

State of Delaware Definitions of Abuse, Neglect, Mistreatment

Abuse shall mean:

- **"Physical abuse"** by unnecessarily inflicting pain or injury to an infirm adult. This includes, but is not limited to hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.

- **"Emotional abuse"** which includes, but is not limited to ridiculing or demeaning an infirm adult, making derogatory remarks to an infirm adult or cursing directed towards an infirm adult, or threatening to inflict physical or emotional harm on an infirm adult.

Sexual Abuse: 16 *Del. C.* §1131 (1) (b)

- **Sexual abuse** which includes, but is not limited to, any sexual contact, sexual penetration, or sexual intercourse, as those terms are defined in § 761 of Title 11, with a patient or resident by an employee or volunteer working at a facility. It shall be no defense that the sexual contact, sexual penetration, or sexual intercourse was consensual.

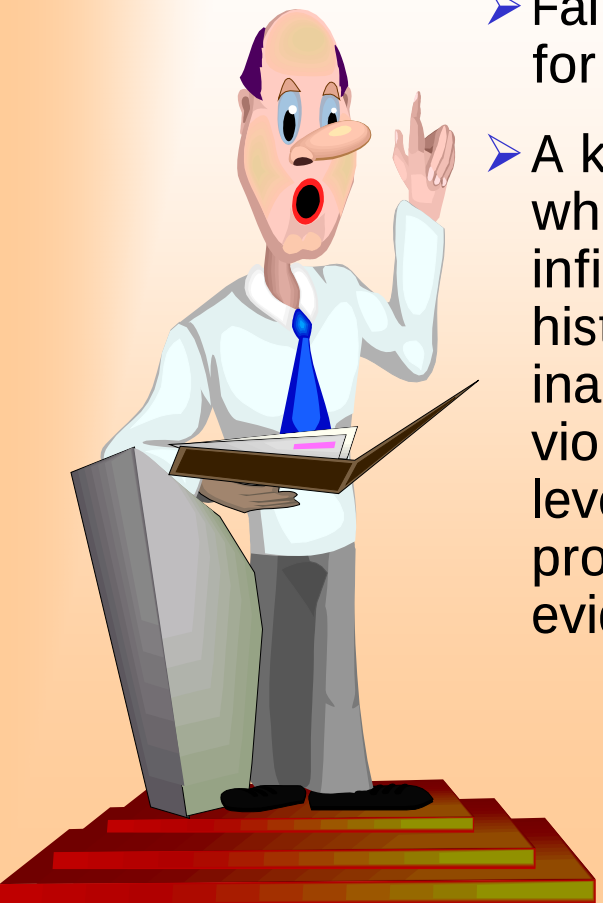
State of Delaware Definitions of Abuse, Neglect & Mistreatment (cont.)

- **"Mistreatment"** shall include the inappropriate use of medications, isolation, or physical or chemical restraints on or of an infirm adult.
- **"Neglect"** shall mean:

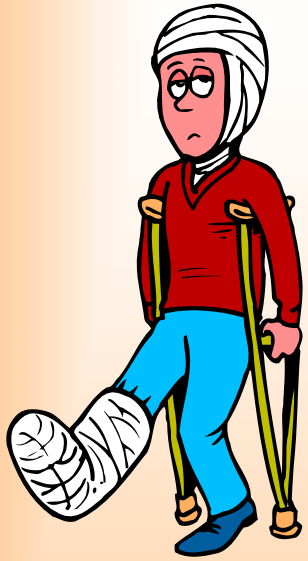
  - Lack of attention to physical needs of an infirm adult including, but not limited to toileting, bathing, meals and safety.
  - Failure to report the health problems or changes in health problems or changes in health condition of an infirm adult to an immediate supervisor or nurse.

State of Delaware Definitions of Abuse, Neglect & Mistreatment (cont.)

- **"Neglect"** (cont.) shall mean:
  - Failure to carry out a prescribed treatment plan for an infirm adult.
  - A knowing failure to provide adequate staffing which results in a medical emergency to any infirm adult where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the Department, all so as to evidence a willful pattern of neglect.



Code of Federal Regulations Definitions of Abuse, Neglect & Misappropriation of Resident Property (Medicare & Medicaid Certified Facilities)



- **Abuse** means the **willful** infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
- **Misappropriation of property** means the ***deliberate*** misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
- **Neglect** means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Injuries of Unknown Source

- An injury should be classified as an "injury of unknown source" when ***both*** of the following conditions are met:
- The source of the injury was not observed by any person ***or*** the source of the injury could not be explained by the resident ***and***

Injuries of unknown source con't

- 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 incidence of injuries over time.

Code of Federal Regulations Definition of "Reportable Incident"

- A **"reportable incident"** is an allegation of mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property.

State of Delaware Definition of "Incident"

- An **'incident"** is an occurrence or event, a record of which must be maintained in facility files, that results or might result in harm to a resident. Incident includes alleged abuse, neglect, mistreatment and financial exploitation; incidents of unknown source which might be attributable to abuse, neglect or mistreatment; all deaths; falls and errors or omissions in medication/treatment.

State of Delaware Definition of Reportable Incident”

- A **“Reportable Incident”** is an occurrence or event which must be reported at once to the Division and for which there is reasonable cause to believe that a resident has been abused, neglected, mistreated or subjected to financial exploitation. **“Reportable Incident”** also includes an ***incident of unknown source*** which might be attributable to abuse, neglect or mistreatment; all deaths; falls with injuries; and significant errors or omissions in medication/treatment which cause the resident discomfort or jeopardize the resident’s health and safety.

DE Regulations – Incidents

- Changes to Delaware LTC regulations have affected what must be documented in facility files and reported to DLTCRP. These changes have resulted in a reduction of the number of incidents reported to DLTCRP.
- Delaware nursing home regulations incorporate the provisions of 42 CFR Ch. IV Part 483, Subpart B.

3201 Skilled and Intermediate Care Nursing Facilities – Delaware State Regulations

- 2.9 Incident - An occurrence or event, a record of which must be maintained in facility files, which includes all reportable incidents and the additional occurrences or events listed in Section 9.7 of these regulations.

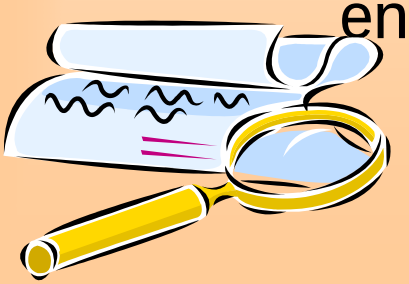
Reportable Incidents

- 2.15 Reportable Incident –

  An occurrence or event which must be reported immediately to the Division and for which there is reasonable cause to believe that a resident has been abused, neglected, mistreated or subjected to financial exploitation/misappropriation of their property as those terms are defined in 16 Delaware Code, §1131 and/or 42 CFR 483.13(c). Reportable incident also includes an occurrence or event listed in Section 9.8 of these regulations.

3201 Skilled and Intermediate Care Nursing Facilities – Delaware State Regulations

- 9.5 Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.



3201 Skilled and Intermediate Care Nursing Facilities – Delaware State Regulations

9.6 All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. **The method of reporting shall be as directed by the Division**.

9.7 Incident reports which shall be retained in facility files are as follows:

- 9.7.1 All reportable incidents as detailed below.
- 9.7.2 Falls without injury and falls with minor injuries that do not require transfer to an acute care facility or neurological reassessment of the resident.
- 9.7.3 Errors or omissions in treatment or medication.
- 9.7.4 Injuries of unknown source.
- 9.7.5 Lost items which are not subject to financial exploitation.
- 9.7.6 Skin tears.
- 9.7.7 Bruises of unknown origin.

9.8 Reportable incidents are as follows:

- 9.8.1 Abuse as defined in 16 Delaware Code, §1131.
- 9.8.1.1 Physical abuse with injury if resident to resident and physical abuse with or without injury if staff to resident or any other person to resident.
- 9.8.1.2 Any sexual act between staff and a resident and any non-consensual sexual act between residents or between a resident and any other person such as a visitor.
- 9.8.1.3 Emotional abuse whether staff to resident, resident to resident or any other person to resident.

Reportable Incidents (continued)

- 9.8.2 Neglect, mistreatment or financial exploitation as defined in 16 Delaware Code, §1131.
- 9.8.3 Resident elopement under the following circumstances:
- 9.8.3.1 A resident's whereabouts on or off the premises are unknown to staff and the resident suffers harm.
- 9.8.3.2 A cognitively impaired resident's whereabouts are unknown to staff and the resident leaves the facility premises.
- 9.8.3.3 A resident cannot be found inside or outside a facility and the police are summoned.

Reportable Incidents (continued)

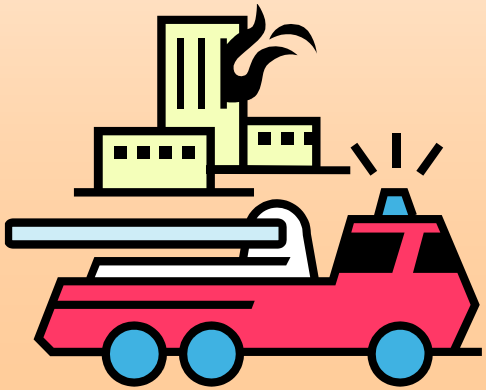
- 9.8.4 Significant injuries.
- 9.8.4.1 Injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time.
- 9.8.4.2 Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.
- 9.8.4.3 Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing.

Reportable Incidents (continued)

- 9.8.4.4 Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.
- 9.8.4.5 A burn greater than first degree.
- 9.8.4.6 Any serious unusual and/or life-threatening injury.

Reportable Incidents (continued)

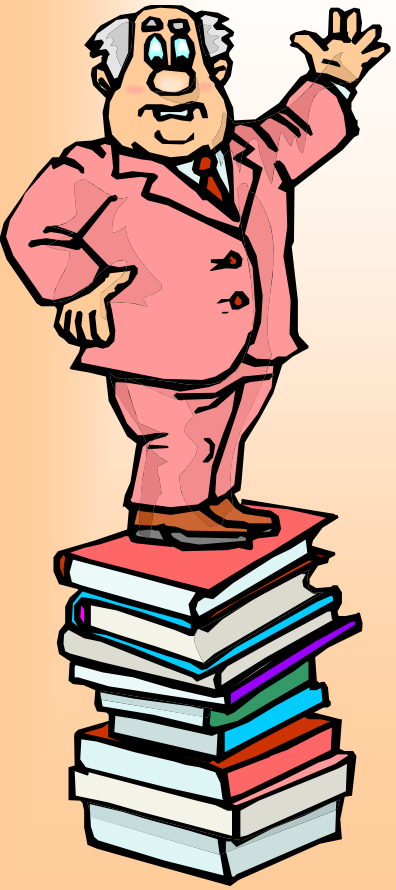
- 9.8.5 Entrapment which causes the resident injury or immobility of body or limb or which requires assistance from another person for the resident to secure release.
- 9.8.6 Suicide or attempted suicide.
- 9.8.7 Poisoning.
- 9.8.8 Fire within a facility.



Reportable Incidents (continued)

- 9.8.9 Utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones.
- 9.8.10 Structural damage or unsafe structural conditions.
- 9.8.11 Water damage which impacts resident health, safety or comfort.

3225 Assisted Living Facilities



- 3.0 Glossary of Terms
- “Incident” - An occurrence or event, a record of which must be maintained in facility files, which includes all reportable incidents and the additional occurrences or events listed in Section 19.5 of these regulations. (Also see Reportable Incident, 19.6 and 19.7)

- Reportable Incident” - An occurrence or event which must be reported immediately to the Division and for which there is reasonable cause to believe that a resident has been abused, neglected, mistreated or subjected to financial exploitation as those terms are defined in 16 Del. C. §1131. Reportable incident also includes an occurrence or event listed in Sections 19.6 and 19.7 of these regulations. (Also see Incident, 19.5.)

Assisted Living Regulations (cont.)

- 19.5 Incident reports, with adequate documentation, shall be completed for each incident. Records of incident reports shall be retained in facility files for the following:

Assisted Living Regulations (Incidents, cont.)

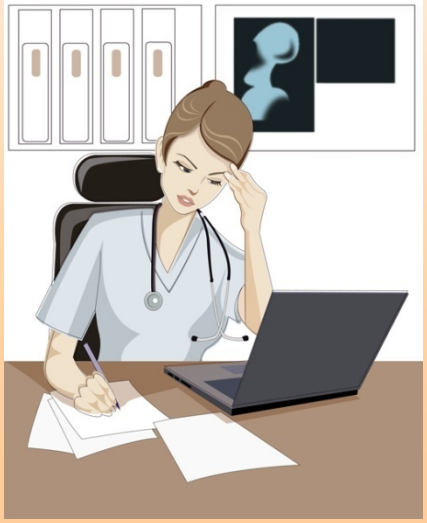
- 19.5.1 All reportable incidents.
- 19.5.2 Falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident.
- 19.5.3 Errors or omissions in treatment or medication.
- 19.5.4 Injuries of unknown source.

Assisted Living Regulations (incidents cont.)

- 19.5.5 Lost items, in accordance with facility policy, which are not subject to financial exploitation. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses and any accused persons; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities when appropriate.

3225 Assisted Living Facilities

- 19.6 Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. **The method of reporting shall be as directed by the Division.**



Assisted Living Regulations (incidents cont.)

- 19.7 Reportable incidents include:
- 19.7.1 Abuse as defined in 16 Del.C. §1131.
- 19.7.1.1 Physical abuse.
- 19.7.1.1.1 Staff to resident with or without injury.
- 19.7.1.1.2 Resident to resident with or without injury.
- 19.7.1.1.3 Other (e.g., visitor, relative) to resident with or without injury.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.1.2 Sexual abuse.
- 19.7.1.2.1 Staff to resident sexual acts.
- 19.7.1.2.2 Resident to resident non-consensual sexual acts.
- 19.7.1.2.3 Other (e.g., visitor, relative) to resident non-consensual sexual acts.
- 19.7.1.3 Emotional abuse.
  - 19.7.1.3.1 Staff to resident.
  - 19.7.1.3.2 Resident to resident.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.1.3 Emotional abuse. (cont.)
  - 19.7.1.3.3 Other (e.g., visitor, relative) to resident.
- 19.7.2 Neglect as defined in 16 Del. C. §1131.
- 19.7.3 Mistreatment as defined in 16 Del. C. §1131.
- 19.7.4 Financial exploitation as defined in 16 Del. C. §1131.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.5 Resident elopement.
- 19.7.5.1 Any circumstance in which a resident's whereabouts are unknown to staff and the resident suffers harm.
- 19.7.5.2 Any circumstance in which a cognitively impaired resident, whose whereabouts are unknown to staff, exits the facility.
- 19.7.5.3 Any circumstance in which a resident cannot be found inside or outside a facility and the police are summoned.
- 19.7.6 Death of a resident in a facility or within 5 days of transfer to an acute care facility.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.7 Significant injuries.
- 19.7.7.1 Injury from an incident of unknown source in which the initial investigation concludes that there is reasonable basis to suspect that the injury is suspicious. An injury is suspicious based on; the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time or the incidence of injuries over time.

Assisted Living Regulations (significant injuries, cont.)

- 19.7.7.2 Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.
- 19.7.7.3 Injury sustained while a resident is physically restrained.
- 19.7.7.4 Injury sustained by a resident dependent on staff for toileting, mobility, transfer and/or bathing.

Assisted Living Regulations (significant injuries, cont.)

- 19.7.7.5 Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires extensive monitoring for up to 48 hours.
- 19.7.7.6 A burn greater than first degree.
- 19.7.7.7 Choking resulting in transfer to an acute care facility.
- 19.7.7.8 Areas of contusions or lacerations which may be attributable to abuse or neglect.
- 19.7.7.9 Serious unusual and/or life-threatening injury.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.8 Attempted suicide.
- 19.7.9 Poisoning.
- 19.7.10 Epidemic outbreak or quarantine.
- 19.7.11 Fire within a facility due to any cause.

Assisted Living Regulations (reportable incidents cont.)

- 19.7.12 Utility interruption lasting more than 8 hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephone system.
- 19.7.13 Structural damage or unsafe structural conditions.
- 19.7.13.1 Structural damage to a facility due to natural disasters such as hurricanes, tornadoes, flooding or earthquakes.
- 19.7.13.2 Water damage which impacts resident health, safety or comfort.

Web-Based Incident Reporting

- DLTCRP now requires that facilities report incidents using an incident reporting system that has its own dedicated web site. Users access the site, which contains an incident report screen. Certain demographic information, such as facility name, address, phone, etc. will auto-fill.

Web-Based Incident Reporting (cont.)

- 1.) Each facility has its own identifying code for auto-filling of their Facility name
- 2.) Pertinent information elements that must be entered by the reporting person include:
- **Reporting Person:**
- **Resident:**
- **Involved Staff:**
- **Incident Description:**
- 3.) After report completion on the screen, it is then sent to DLTCRP. The facility may print a copy (paper or electronic) for its records.

Delaware Code – Title 16

- § 1132. Reporting requirements.
- (a) Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A written report shall be filed by the employee or service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation.

16 Del. C., Section 1135, (b)

No facility shall discharge, or in any manner discriminate or retaliate against any person, by any means whatsoever, who in good faith makes or causes to be made, a report under this subchapter, or who testifies or who is about to testify in any proceeding concerning abuse, mistreatment, or neglect of patients or residents in said facility".

Protecting Those Who Report

- Establish and enforce an environment of protection from retaliation, during and after the investigation of an event.
- Offer assurances that the reporter will not be looked upon negatively or receive any form of treatment that may be considered punishment.
- Delaware law includes protection of reporters from retaliation. (16 Del. C., Section 1135)

Federal Requirements

F225

Employment

- The Facility must not employ individuals who have been:
  - Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
  - Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
  - Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness of service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

State Timeframes for Reporting

A reportable incident must be reported to The Division of Long Term Care Residents Protection immediately, which shall be within eight hours of the occurrence of the incident. The method of reporting shall be as directed by the Division.

The results of all investigations shall be reported to the Division within five working days of the incident. If the alleged violation is verified appropriate corrective action must be taken.

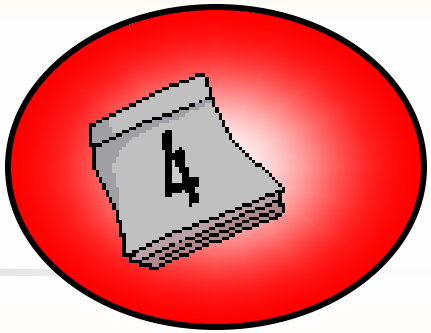
If the investigation is still in progress, the Division shall be notified of the status of the investigation on the fifth day. Upon completion of the investigation the Division shall be notified.

Reporting

- 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 to the State survey and certification agency).

Federal Requirement for Facility Investigations (F 225)

Facility Investigation



- The facility must have evidence that all alleged violations are **thoroughly** investigated, and must prevent further potential abuse while the investigation is in progress.
- The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Potential Barriers to Investigations

- Lack of individualized planning to prevent further harm.
- The providers of service are directly responsible for conducting their own investigations of abuse and neglect.
- Internal investigations are generally impacted by:
  - Conflict of interest
  - Lack of investigative skills
  - Low priority
  - Lack of staff cooperation

Components of an Internal Investigation

A provider's internal investigation may include:

1. An interview of the victim or reporting person
2. An evaluation of the victim
3. A clinical history (if needed)
4. A physical examination (if needed)
5. A psychosocial evaluation (if needed)
6. Documentation of interviews with **all** involved parties or written statements
7. Pertinent records and documentation
8. Photographs and physical evidence

The Aim of Internal Investigations is to Determine:

- If abuse and neglect have occurred
- The causative factors
- Interventions to prevent further injury
- The level of planning and support required to prevent further harm
- Utilize findings and conclusions to ensure future safety and compliance

Collecting Information

- Improves the likelihood that the investigation will yield a satisfactory resolution.
- Thorough documentation of every step along the way.
- The following need to be considered:
  - Information should be systematically presented, well-organized, and legible.

Collecting Information (Cont.)

- Behaviors should be described rather than interpreted and facts reported objectively.
- It is useful to document the actual words of the alleged victim and others interviewed, and all sources of information should be included.

- For a document to withstand legal scrutiny, it must contain no changes, omissions, or time gaps.

Interviews

Setting

- Conducted in private
- Free of any intimidating factors
- Accurately documented

Interviews (continued)

Techniques

- Initial questions should be general, such as, “Tell me what happened?”
- Prompt the witness to describe the incident chronologically.
- Use open ended questions to elicit information they may have omitted in the general questioning.
- Use direct questions to clarify the sequence of events.
- Direct questions can also be used to probe inconsistencies in previous interviews or statements.

Interviews (continued)

Important points to cover:

- Who was present?
- What happened?
- When did it happen?
- Where did it happen?
- How did it happen?
- Why the incident may have occurred?

Interviews (continued)

Other Points to cover:

- Timeframe of their contact with or observation of the alleged victim
- Their activity and/or interaction with the alleged victim
- Observation of other person's activity and/or interaction with the alleged victim (including staff, family, or others)
- Reason this incident may have occurred

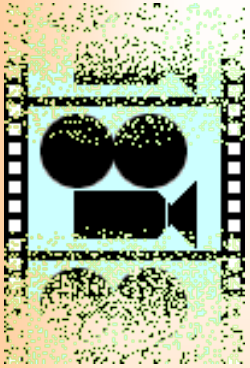
Evidence that an incident has been thoroughly reported, investigated and documented is determined by the presence of an investigative report, file or other documentation that includes:

- A copy of the LTCRP Incident Report that was submitted to the Division. (To include the steps taken to prevent further potential abuse).
- If the facility completed a facility incident form that form should also be reviewed.
- A copy of the 5-day follow-up report submitted to the Division.

Evidence Supporting a Thorough Investigation (continued)

- Interviews, in order of preference: tape recorded interviews, handwritten interviews with questions and responses written and signed by the interviewee and interviewer, summaries of the interviews by the interviewer or a written statement by the interviewee.
- Copies of records or documents that are pertinent to the investigation. (If the records or documents are internal and readily accessible they do not have to be re-copied but may simply be referenced in the investigative packet.)

Evidence Supporting a Thorough Investigation (continued)



- Photos, videos or written descriptions of other items pertinent to the investigation. For example, wounds, bruises, unopened blister packs, wound dressings with expired or incorrect dates, any item that impacted the investigation.
- A conclusion clearly detailing whether or not the allegation is verified, including direct references to the facts that led to the conclusion.
- Documentation of corrective action taken if the allegation is verified.

Investigative Findings

- Conclusions must be based on facts and evidence.
- Take appropriate follow up action based on your conclusions.
- Submit the results of the investigation to DLTCRP.

Guidelines for Complaint Investigation and Record Review

Verbal Abuse, Physical Abuse, Neglect/Mistreatment, Theft/Financial Exploitation, Weight Loss/ Nutrition/ Hydration, Falls and Restraints

Guidelines for Complaint Investigation

Concern:

Observation:

Sample Selection:

Interview:

Record Review:

Analysis:

Record Review

- Minimum Data Set (MDS)
- Care Plan (All Plans)
- Skin Assessment (Braden/Horton)
- Delaware Functional / Care Summary
- Nursing Admission Assessment
- Physician Orders
- Doctor's / Progress Notes
- Assignment Sheet
- Physicians Consultation
- Family Complaint Record
- Behavior Chart
- Nurse's / Progress Notes
- Treatment Administration Record (TAR)
- Medication Chart (MAR)
- X-ray Report
- Lab (Values) Reports
- Hospital Reports
- C.N.A. Flow Chart

Record Review

- Weight Chart / I & O's Flow Sheet Section E4
- Meal %
- Resident Assessment Sheet (RAP)
- 24 hour Report
- Facility Incident Reports
- Facility Policy Pertaining to the Incident
- Maintenance Log
- Physical / Occupational Therapy Notes
- Staffing Sheets
- Personnel File of Identified Staff
- CBC
- Performance Evaluations
- AAR
- Disciplinary Action
- Clothing / Personal Belonging List
- Resident Council Notes &/or Complaint Log
- Registered Dietician's Note

Complaint Investigation

- Investigation of a complaint, that is something other than an incident reported by a facility, should start with interview of the complainant.
- Investigator should enumerate the complainant's allegations. An **allegation** is an assertion of improper care or treatment by a facility that could result in a deficiency. Investigation and resolution of complaints is a critical activity of this department.

Monitoring Facility's Reporting Performance

- Prior to survey review facility reports in IRC.
- For facilities who under report for example 39 reports for a 300 bed facility.
- Review clinical record for documentation of injuries to dependent population. If no notations are in the clinical record we need to in-service that facility regarding reporting requirements.

Allegations

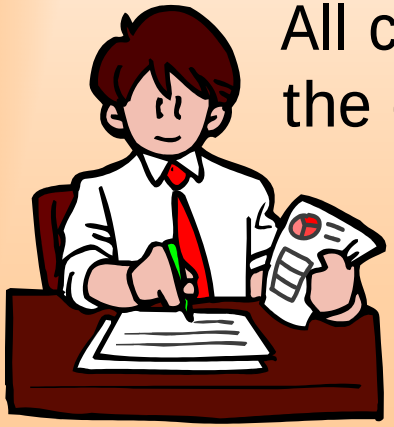
- Allegations can be weight loss, dehydration, elopement, abuse, neglect, fractures, falls, etc.
- In the triage process licensing has grouped these allegations into the regulatory areas to be evaluated on cite in the facility i.e. activities, quality of care, abuse, neglect or misappropriation.

Complaint Findings

- Substantiated with deficiencies
- Substantiated with no deficiencies
- Unsubstantiated with unrelated deficiencies
- Unsubstantiated with no deficiencies

The Complaint Summary

- Written at the conclusion of the investigation should clearly outline each allegation of the complaint and the corresponding finding, such as substantiated with deficiency in F309. Complaint summary should use the exit date of the survey and reflect all the numbers in ACTS, IRC, and LCS. All complaints from the same survey should be in the one complaints summary.



THE END