



Adult Care Facility Incident Reporting Manual

**Division of Adult Care Facility and Assisted Living Surveillance
Center for Health Care Provider Services and Oversight
Office of Primary Care and Health Systems Management
New York State Department of Health**

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Section I: General Information about Incident Reporting

A. Introduction

As required by 18 NYCRR 487.7(d)(11); 488.7(b)(11); and 490.7(d)(9) adult homes, enriched housing programs, and assisted living residences (hereinafter referred to as Adult Care Facilities or ACFs) must convey reportable incidents to the New York State Department of Health (Department).

This manual is available to all ACF staff responsible for reporting alleged violations of mistreatment, neglect and abuse, including injuries of unknown source and misappropriation of resident property, and potential felony crimes, to the Department. The manual is intended to provide clarification and guidance on what incidents are reportable and how they should be reported.

Nothing in this manual affects the requirement for ACFs to report to the New York State Justice Center for the Protection of People with Special Needs and/or to the appropriate regional office of the Department.

B. Reporting Requirements

Adult care facilities are required to report various occurrences to the Department within specific timeframes. The purpose of this correspondence is to remind you of various reporting requirements applicable to situations you may encounter. **Operators who fail to adhere to prescribed timeframes are subject to civil penalties.**

1. Resident Deaths

Upon the death of a resident, the operator must **immediately** report the death to the appropriate regional office of the Department via telephone **and** submit an Incident Report (DOH-5175), which must be received by the Regional Office within twenty-four hours of the death.

Additionally, per DAL 18-19, Social Services Law §461-m requires that a resident death involving any resident who, at any time, received mental hygiene services, must also be referred to the Justice Center for the Protection of People with Special Needs. DOH regulations further provide that, if the resident received services from a mental hygiene service provider within the 24 months preceding the date of the death, such reporting to the Justice Center must be both immediately reported orally or electronically (as required by the Justice Center), as well as through submitting a written report to the Justice Center within 24 hours of the discovery of the death.

2. Resident Attempted Suicide

If a resident attempts suicide, the operator must immediately report the attempt to the appropriate regional office of the Department via telephone **and** submit a copy of the applicable Incident Report (DOH-5175), which must be received by the Regional Office within twenty-four hours of the attempt.

Additionally, per DAL 18-19, Social Services Law §461-m requires that attempted suicide by any resident who, at any time, received mental hygiene services, must be referred to the Justice Center for the Protection of People with Special Needs. DOH regulations

further provide that, if the resident received services from a mental hygiene service provider within the 24 months preceding the date of the incident, such reporting to the Justice Center must be both immediately reported orally or electronically (as required by the Justice Center), as well as through submitting a written report to the Justice Center within 24 hours of the discovery of the attempted suicide.

3. Felony Crime Against a Resident

If it is believed a felony crime may have been committed by or against a resident, the operator must immediately report the occurrence to the appropriate regional office of the Department via telephone **and** submit an Incident Report (DOH-5175), which must be received by the Regional Office within twenty-four hours of the occurrence.

Additionally, per DAL 18-19, Social Services Law §461-m requires that, if it is believed a felony crime may have been committed by or against a resident who, at any time, received mental hygiene services, such information must be referred to the Justice Center for the Protection of People with Special Needs. Department regulations further require that such incidents be reported to an appropriate law enforcement authority as soon as possible but at least within twenty-four hours.

C. Additional Reportable Incidents

In addition to the situations described above, the following are considered reportable incidents, wherein an Incident Report (DOH-5175) must be submitted to the appropriate regional office of the Department:

- Resident's whereabouts were unknown for more than 24 hours;
- Complaint or evidence of resident abuse;
- Resident assaults or injures, or is assaulted or injured by another resident, staff, or others;
- Resident behaved in a manner that directly impaired the well-being, care, or safety of the resident or any other resident, or which substantially interferes with the orderly operation of the facility; and/or
- Resident was involved in an accident on or off the facility grounds which resulted in such resident requiring medical care, medical attention, or services.

During normal business hours Monday through Friday. Please contact the appropriate Regional Office of the Department.

Capital District Regional Office (CDRO)	Central New York Regional Office (CNYRO)	Metropolitan Area Regional Office – New York City (MARO)	Metropolitan Area Regional Office – Long Island (MARO)	Western Regional Office (WRO)
875 Central Avenue Albany, NY 12206	217 S. Salina Street 4 th Floor Syracuse, NY 13202	90 Church Street 15 th Floor New York, NY 10007	320 Carleton Avenue Suite 5000 Ctr. Islip, NY 11722	335 E. Main Street 1 st Floor Rochester, NY 14604
Phone: (518) 408-5287	Phone: (315) 477-8472	Phone: (212) 417-4440	Phone: (631) 851-3098	Phone: (585) 423-8185

1. Night, Weekend, Holiday Reporting

It is unnecessary to report a resident’s natural death to the after-hours Administrator on Duty (AOD). It is appropriate for a natural death to be reported via voicemail message to the appropriate regional office of the Department. However, in cases of after-hours total facility evacuation, resident endangerment, and/or suspicious death or death of unusual circumstances of a resident occurring after-hours, the facility representative **must** contact the after-hours AOD at (866) 881-2809.

Facilities subject to the Justice Center, and any individuals associated with such facility, or performing work for it, who fall within the definition of *mandated reporter* under section **487 or 488** of the Social Services Law, shall report any occurrence constituting a reportable incident immediately to the Justice Center upon having *reasonable cause* to suspect that a reportable incident has occurred.

- Circumstances to be reviewed that may lead to a *reasonable cause* to suspect conclusion might include, but are not limited to:
 - A statement that a reportable incident has occurred;
 - The presence of a physical condition (e.g. a bruise) which is inconsistent with the history or course or treatment of the resident; or
 - A visual or aural observation of an act or condition indicating the occurrence of a reportable incident.
- Such facilities must report to the Justice Center reportable incidents, including injuries of unknown origin, if and when the *reasonable cause* to suspect threshold has been achieved. This might occur before the facility investigation into the incident has begun or at any time during the investigation.

- If the *reasonable cause* to suspect threshold has not been achieved, notification to the Justice Center is not required.
- When an alleged reportable incident occurs, the facility is required to initiate an investigation. The Justice Center, and/or the department, may also investigate the incident.
- Such reporting obligations are in addition to those otherwise provided for under this Part.

Reports to the Justice Center must be made by calling the Vulnerable Persons Central Register Hotline at (855) 373-2122.

2. Justice Center Reportable Incidents

Facilities subject to the Justice Center [487.2(d)(8) & 488.2(c)(8)] shall mean adult homes having a capacity of eighty (80) or more beds, and in which at least 25% (twenty-five percent) of the residents are persons with serious mental illness as defined by section 1.03(52) of the mental hygiene law

Significant Incident [487.2(d)(9) & 488.2(c)(9)] shall mean an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety or welfare of a person receiving services and shall include but shall not be limited to:

- conduct between persons receiving services, or between such persons and third parties other than a custodian, that would constitute abuse if committed by a custodian; or
- conduct on the part of a custodian, which is inconsistent with a service recipient's individual treatment plan or individualized educational program, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies and which impairs or creates a reasonably foreseeable potential to impair the health, safety or welfare of a person receiving services, including but not limited to:
 - unauthorized seclusion, which shall mean the placement of a person receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will;
 - unauthorized use of time-out, which shall mean the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming but shall not include the use of a time-out as an emergency intervention to protect the health or safety of the individual or other persons;
 - except for the unlawful use or administration of a controlled substance, the administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order issued for a service recipient by a licensed, qualified health care practitioner, and which has an adverse effect

on a service recipient. For purposes of this paragraph, "adverse effect" shall mean the unanticipated and undesirable side effect from the administration of a particular medication which unfavorably affects the well-being of a service recipient;

- inappropriate use of restraints, which shall mean any use of a restraint; or
- any other conduct identified in regulations of the department, pursuant to guidelines or standards established by the Justice Center.

Misappropriation of Property [487.2(d)(9)(iii) & 488.2(c)(9)(iii)] shall mean the theft, unauthorized use or removal, embezzlement or intentional destruction of the resident's personal property, including but not limited to money, clothing, furniture, appliances, jewelry, works of art and such other possessions and articles belonging to the resident, regardless of monetary value.

Mistreatment [487.2(d)(9)(iv) & 488.2(c)(9)(iv)] shall mean confinement, isolation, intimidation, abandonment or use of physical restraints on a resident of an adult care facility while the resident is under the supervision of staff.

3. Investigation

The facility must begin an investigation immediately upon discovery of an incident. The investigation must be complete and thorough, and further potential abuse must be prevented while the investigation is in progress. Documents associated with the facility investigation include, but are not limited to:

Complete electronic incident form on Drupal and have available:

- Witness statement(s);
- Resident statement(s);
- Accused statement(s);
- Facility investigation report;
- Resident(s) medical record;
- Care plan(s) and diagnoses;
- Resident cognition evaluation;
- Employee personnel and training records;
- Report/case ID number from law enforcement, if reported;
- Pictures, if taken;
- Video surveillance;
- Police or other public safety reports; and
- Plan to prevent reoccurrence.

Section II: Incident Categories and Reporting Scenarios with Questions and Answers

Section II of this manual will outline relevant incident categories. Each category is presented, along with the required element(s) that trigger reporting of an incident to the Department.

Reporting scenarios, in the form of questions and answers, are provided for each category to assist in determining whether the reasonable cause threshold for incident reporting was met.

The facility is responsible to investigate all incidents and maintain records of each investigation.

 **The reporting scenarios include examples but are not all-inclusive.**

Incident Categories

- **Abuse, Mistreatment, Neglect, Misappropriation of Property (487.2 & 488.2)**
- **Resident Services (487.7 & 488.7)**
 - Medication Error/Drug Diversion (resulting in impairment to well-being, care, or safety of resident or other residents or staff)*
 - Injury of Unknown Origin*
 - Burns*
 - Attempted Suicide or Death or Injury Related to Suicide, Restraints, Equipment, or Falls*
 - Accidents Related to Choking Resident*
 - CPR Concerns*
 - Elopement for more than 24 hours*
- **Disaster and Emergency Preparedness (487.12(j) & 488.12(l))**
 - Loss of Service*
 - Fire*
 - Evacuation*

A. Abuse, Mistreatment, Neglect, Misappropriation

1. Abuse

Abuse [487.2(d)(1) & 488.2(c)(1)] shall mean inappropriate physical contact with a resident of an adult care facility while the resident is under the supervision of the facility, which harms or is likely to harm the resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, and bumping. "Abuse" shall, in addition, include those actions incorporated within the definitions "inappropriate use of restraints" as defined in 10 NYCRR Parts 487 and 488, and the definitions of physical abuse, sexual abuse, psychological abuse, deliberate inappropriate use of restraints, use of aversive conditioning, obstruction of reports of reportable incidents, and unlawful use or administration of a controlled substance all as defined in section 488 of the Social Services Law. However, for purposes of reporting, psychological abuse need not be supported by a clinical assessment in order to be reported, so long as there is reasonable cause to suspect that such abuse has occurred.

Freedom from Abuse: Each resident has the right to be free from all types of abuse, including psychological abuse (as defined in Social Services Law section 488).

The facility must not only report the alleged violation to the Department, the Administrator and appropriate officials, but must initiate an immediate investigation and take steps to prevent further potential abuse and based upon findings, the facility must implement corrective actions to prevent reoccurrence.

If the Department receives an allegation of mental abuse related to unauthorized transmission of photographs or video recordings of a resident(s), any humiliation or demeaning of a resident(s), the Department will conduct an investigation and will evaluate whether the allegation may require additional referrals.

Abuse can be:

- Resident to resident abuse (*for example, an aggressive act, including inappropriate physical contact that is harmful or likely to cause harm. Incidental touching or non-aggressive contact is generally not considered to be physical abuse*).
- Staff to resident
- Family/visitor to resident

Generally, one of the following elements must be present for an incident to be reportable to the Department:

- Inappropriate physical contact resulting in injury or likely to harm a resident.
- Non-consensual sexual intrusion or penetration.
- Touching intimate body parts or the clothing covering intimate body parts.
- Examination or treatment of the resident for other than bona fide medical purposes.
- Observation or photographs of another person's intimate body parts.
- Threat or physical action (including threatening gesture or intimidation).

- Fear of imminent, serious bodily injury.
- Use of foul, threatening, disparaging, derogatory, or discriminatory language.
- Evidence of psychological harm.
- Taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment (e.g., cameras, smart phones, and other electronic devices) and/or keeping or distributing them through multimedia messages or on social media networks
(See regulatory definition of “abuse” for complete information.)

Reporting Scenarios Frequently Asked Questions

Resident to Resident

Q. A resident with Dementia hits another resident and causes an injury (bruise, skin tear, etc.) and/or pain. Is this reportable?

A. *Yes, this is reportable. The facility has a responsibility to protect all residents from abuse. The Department would review the facility response to the incident in terms of care planning.*

Q. Two residents are involved in an altercation. Staff hear the residents yelling and find Resident #1 standing over Resident #2 in Resident #1’s room. Resident #1 is shouting, “I told you to stay out of my room.” Resident #2 is lying on the floor. Resident #2 sustains a 1 cm laceration to his left arm. When questioned, Resident #1 states that he struck Resident #2 when he failed to leave the room. Resident #2 has a history of wandering and Resident #2 has a history of being very territorial. Is this reportable?

A. *Yes, this is reportable. Resident #1 had an altercation with Resident #2, which resulted in injury.*

Q. Two residents bump into each other's wheelchair and move the chairs to open a path of egress. Is this reportable?

A. *This is reportable if aggression occurred. If the incident was accidental and no aggression occurred, this is an example of incidental touching or contact and is not reportable.*

Q. Two residents are seated near one another. Resident #1 attempts to remove food from Resident #2’s tray or slaps Resident #2’s hand. Is this reportable?

A. *Yes, this is reportable if aggression occurred. If no aggression occurred, this is an example of incidental touching or contact that is not reportable.*

Q. It is observed that Resident #1 frequently enters Resident #2’s room and rearranges personal items or touches Resident #1 on the arm to say hello. Is this reportable?

A. *No, this is not reportable. Abuse did not occur; however, there is a concern for Resident #1's right to private space and a dignified existence. The facility has a responsibility to care plan, including accounting for such occurrences and patterns of behavior and to evaluate that plan periodically, with the intent of preserving resident rights.*

Q. A staff member observes a male resident fondling the breasts of a female resident. The female resident is interviewed but has severe dementia and cannot convey what happened. The male resident has a psychiatric diagnosis but is cognitively aware and able to be interviewed. The male resident denies fondling the resident. Is this reportable?

A. *Yes, this is reportable. This is an example of non-consensual sexual contact.*

Q. A staff member reports finding a male resident in a female resident's room stroking the female resident's breast and leg. When questioned by the staff member to determine whether this activity was consensual, the female resident voiced no complaint. Both residents are on friendly terms and continue to be for the next several days. The female resident then reports that she considers the male resident's behavior to be inappropriate. The male resident is interviewed and states that the female encouraged the behavior. Is this reportable?

A. *Yes, this is reportable. Once a resident states that a sexual act is not consensual or is otherwise inappropriate, it is reportable.*

Q. Staff overhears Resident #1, who is alert and oriented, shout at his roommate (Resident #2), "Shut the hell up. You moan all the time. Shut up or I'll shut you up." Staff intervenes immediately. Resident #2 is demented. Immediately following the incident, Resident #2 stops talking, which staff believe might be related to the incident. Is this reportable?

A. *Yes, this is reportable. The scenario meets all of the elements for verbal abuse. Resident #1 directly threatened Resident #2 and did so with foul language and fear of imminent bodily injury. Although Resident #2 could not verbalize that he was afraid, his behavior indicated that he was fearful.*

Staff to Resident

Q. Employee #1 states that she observed Employee #2 fondling a female resident (his hand was between the resident's legs) during the night shift. No other staff was present. Employee #2 denies the allegation. The female resident could not be interviewed, nor were any other residents on the unit interviewed due to their levels of cognitive impairment.

A. *Yes, this is reportable. An allegation was made that contained the element of non-consensual sexual contact.*

Q. A female resident complains to a staff member that while she was in physical therapy, a staff member touched her breast. This is unrelated to any treatment modality. The resident reports that she believes this was a purposeful act.

A. *Yes, this is reportable. The element of non-consensual sexual contact was present. The facility must conduct a complete and thorough investigation to determine if the staff person was providing legitimate medical assessment or care, as opposed to inappropriate touching.*

Q. A cognitively impaired resident exhibits inappropriate behavior toward staff. Is this reportable?

A. *No, this is not reportable. The facility must conduct a complete and thorough investigation to determine the possible causes for behavior, including a medical exam, if applicable. Care planning is essential to determine if the resident needs a higher level of care.*

Q. A staff member overhears another staff member say to a resident “I’m getting tired of having to come here all the time to clean you up. You are a pain.” Resident appears fearful of the staff member and this is reported to the charge nursing. Is this reportable?

A. *Yes, this is reportable. The resident was spoken to in a derogatory manner and is fearful.*

Q. A resident meets with the facility social worker and states that one staff member has continually spoken to the resident in a derogatory way during the course of daily care and remains upset. Is this reportable?

A. *Yes, this is reportable. The scenario meets the definition of verbal abuse.*

Q. A staff member is showering an alert and oriented 75-year-old female resident. The resident shouts that the water is too cold and yells, “Damn it, warm it up!” The staff member replies, “Shut the hell up and let’s get this over with,” shaking her fist. Is this reportable?

A. *Yes, this is reportable. The scenario contains elements of foul language and physical gesture.*

Q. A staff member is found taking pictures of residents eating in the dining room. Is this reportable?

A. *Yes, this is reportable if this is unauthorized and there is no written consent by each resident or the resident’s designee.*

Q. It has come to your attention that an LPN posted a picture of herself and a demented resident on the LPN’s social media account. You see the post and note both the LPN and resident are smiling. Is this reportable?

A. *Yes, this is reportable if the nurse does not have written authorization from the resident designee giving her permission to take the picture and post it on Facebook.*

Family/Visitor to Resident

Q. A family member hits a resident or handles the resident roughly (poking, shaking, force feeding, etc.). Is this reportable?

A. *Yes, this is reportable. The actions of the family member are considered abuse and should be reported and investigated with the goal of protecting the resident from further abuse by the family member.*

Q. A family member has sexual contact with a resident. Is this reportable?

A. *Yes, this is reportable if the element of non-consensual sexual contact was present. Sexual relations between consenting adults (who are capable of consent) are not reportable. If the facility determines non-consensual activity occurred, the facility must conduct a thorough investigation and protect the resident from further abuse by the family member.*

Q. Staff overhear a visiting husband yelling at his wife's roommate (resident #2) and accusing her of breaking his wife's belongings. He is shaking his finger at her. Resident #2 appears fearful. Is this reportable?

A. *Yes, this is reportable. The facility has knowledge that a family member verbally abused the resident.*

2. Mistreatment

Mistreatment [487.2(d)(9)(iv) & 488.2(c)(9)(iv)] shall mean confinement, isolation, intimidation, abandonment or use of physical restraints on a resident of an adult care facility while the resident is under the supervision of staff.

Reporting Scenarios Frequently Asked Questions

Q. Staff finds a resident tied to the bed with a sheet. It is determined that another staff member used the sheet to restrain the resident in order to limit activity. Is this reportable?

A. *Yes, this is reportable. The example demonstrates inappropriate use of a physical or chemical restraint on a resident.*

3. Neglect

Neglect [487.2(d)(2) & 488.2(c)(2)] shall mean the failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident of an adult care facility while the resident is under the supervision of the facility, including but not limited to: personal care, nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living.

Neglect also includes those actions incorporated within the definition of neglect set forth in Social Services Law section 488(1)(h).

Neglect may include, but is not limited to:

- Failure to carry out physician orders, medication omission, treatment omission or failure to follow the care plan or provide emergency services.
- Failure to adequately supervise whereabouts and activities of residents.
- Failure to provide adequate hydration and nutrition.

Generally, at least one of the following elements must be present for an incident to be reportable to the Department:

- Failure to follow the care plan, which results in unsafe, inadequate, or inappropriate services being rendered.
- Failure to follow the care plan on more than one occasion, with or without injury.
- Failure to provide timely, consistent, safe, adequate and appropriate services.

Reporting Scenarios Frequently Asked Questions

Q. Staff on the evening shift witness a resident fall. The resident is assessed, and no injury is noted. The resident does not complain of pain. Staff does not document the fall and does not pass the information on to the next shift. For the next two days, the resident complains of pain. After two days, a physician is notified and x-rays are taken, which confirm a fracture. Is this reportable?

A. *Yes, this is reportable. Staff was aware of the fall and potential injury but failed to provide timely and appropriate services.*

Q. A resident requires an assistive device for lift for transfers. Two staff members transfer the resident without the lift. The resident falls and sustains a fracture. The Hoyer lift was available, but the staff were in a hurry and chose not to use it. Is this reportable?

A. *Yes, this is reportable. The staff should have been knowledgeable about, and followed, the resident's care plan indicating that the resident requires a Hoyer for transfers. This failure resulted in an injury to the resident.*

4. Misappropriation of Property

Misappropriation of Property [§487.2(d)(9)(ii)(d)(iii) and 488.2(c)(9)(ii)(d)(iii)] shall mean the theft, unauthorized use or removal, embezzlement or intentional destruction of the resident's personal property including, but not limited to, money; clothing; furniture; appliances; jewelry; works of art; and such other possessions and articles belonging to the resident regardless of monetary value.

At least one of the following elements generally must be present for an incident to be reportable to the Department:

- Deliberate misplacing, theft, exploiting, destruction, or wrongful use of a resident's property.
- A pattern of misplacing, theft, exploiting, destroying, or wrongful use of a resident's property.

If an allegation is made against a staff member and the facility has reasonable cause to believe that misappropriation occurred, it is reportable. If the resident reports misappropriation by a family member to the facility, it is not reportable to the Department unless the family member is an employee of or staff under contract with the facility.

Reporting Scenarios Frequently Asked Questions

Q. A resident's daughter reports that her mother's ruby ring, which she last saw two days ago, is missing. The resident has mild dementia, but the daughter insists that the resident did not misplace it. The daughter implies that a staff member is responsible. Is this reportable?

A. *No, this is not reportable at this point. The facility has no evidence of deliberate misplacing, theft, destruction, or wrongful use of the ring. The ring could be lost. The facility must conduct a complete and thorough investigation and search.*

Q. In the above scenario, following a search, the ring has not been found. The daughter observes a staff member wearing what she believes to be her mother's ring. The daughter notifies the police. Is this reportable?

A. *Yes, this is reportable. There is reasonable cause to believe a staff member may have taken the ring.*

Q. A facility receives \$25 from three different families on Wednesday for its family members to go on a resident outing on Friday. The staff person at the desk takes the money and gives it to the nurse, who locks it in the business office. On Friday morning, the facility social worker asks the nurse for the money for the three residents to go on the outing. There is no money in the business office. Is this reportable?

A. *Yes this is reportable. Deliberateness is implied because the money was given to staff and secured, and only staff have a key to the business office.*

Q. A resident reports that night shift staff is using her personal cell phone for other residents without her permission. Is this reportable?

A. *Yes, this is reportable. The resident did not give permission for use of his/her personal property by others in the facility.*

B. Resident Services

1. Medication Error/Drug Diversion

Generally, at least one of the following elements must be present for an incident to be reportable to the Department:

- Medication or treatment error with harm.
- A deliberate decision made by a nurse not to administer medication or a treatment, or a pattern of omission of medications or treatment and/or including falsification of records.
- Missing controlled substances that are not a documentation error and have potential for (or result in) a negative resident outcome.



Facilities must report any diversion of controlled substances to the Department's [Bureau of Narcotic Enforcement](#) and the [New York State Education Department's Office of the Professions](#), if applicable.

Reporting Scenarios Frequently Asked Questions

Q. How do I notify the Bureau of Narcotic Enforcement of an incident or alleged incident of theft, loss or possible diversion of a controlled substance?

A. *Submit form DOH-2094, which is found on the BNE web site at: <https://www.health.ny.gov/professionals/narcotic/forms.htm>*

Q. What if the incident is not recent, but was just discovered?

A. *Submit form DOH-2094, within 1 business day from the date the incident was discovered.*

Q. Should I contact my local police department?

A. *If you suspect an incident of theft or diversion, yes, you should contact them. This information will also be contained within the DOH-2094*

Q. Should we wait to send in the DOH-2094 until we complete an investigation internally?

A. *No. You should send in the DOH-2094 as soon as you are aware of an incident and continue your internal investigation while awaiting a response from BNE.*

Q. If I have questions or need additional information, who should I contact?

A. *You can email BNE at narcotic@health.ny.gov with your questions.*

2. Injury of Unknown Origin

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.
- The injury is suspicious because the extent or location 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 incidences of injuries over time.

The following two elements generally must be present for an incident to be reportable to the Department:

- Injury without known incident.
- Facility unable to rule out abuse or care plan violation.



The facility should seek guidance from the physician to determine if there is any underlying medical condition that may explain an injury of unknown origin.

Reporting Scenarios Frequently Asked Questions

Q. A resident is found with bruising to both upper extremities. The resident is not able to be interviewed. Is this reportable?

A. *Yes, this is reportable if the facility’s preliminary investigation determined that elements of abuse, mistreatment or neglect were present.*

Q. A resident is found with a fractured hip of unknown origin. Is this reportable?

A. *Yes, if the facility is unable to determine the cause of the fracture; there is a care plan violation; and/or abuse, neglect or mistreatment is not ruled out, this is reportable.*

3. Burns

Any instance resulting in a burn to the body surface, must be reported to the Department.

Reporting Scenarios Frequently Asked Questions
<p>Q. An 80-year old male resident is outside smoking. He has oxygen on via nasal cannula. When staff returns, they discover that the resident is red and blistered around the mouth and nose. The resident's beard is burned. Is this reportable?</p> <p>A. <i>Yes, this is reportable. The resident sustained a superficial partial thickness (superficial second-degree) burn related to an accident.</i></p> <p>Q. A resident spills hot coffee on his lap, which results in a blistered area. Is this reportable?</p> <p>A. <i>Yes, this is reportable. The resident sustained a burn related to an accident.</i></p> <p>Q. A resident develops a red blistered area after application of a hot pack or curling iron. Is this reportable?</p> <p>A. <i>Yes, this is reportable. The resident sustained a burn related to an accident.</i></p>

4. Attempted Suicide or Death or Injury Related to Suicide, Restraints, Equipment or Death Related to Fall

At least one of the following elements must be present for an incident to be reportable to the Department:

- Resident attempt at suicide.
- A death occurred that is reportable to law enforcement as unexplained or suspicious.
- A death related to an accident.
- An incident or accident related to entrapment or use of equipment.

Reporting Scenarios Frequently Asked Questions
<p>Q. Resident A identifies they tried to commit suicide or witnessed another resident try to commit suicide, but there is no evidence of such. Is this reportable?</p> <p>A. <i>Yes, this is reportable. All suicides and suicide attempts are reportable. Resident's report of a suicide attempt with/without evidence of a suicide attempt is reportable.</i></p> <p>Q. A resident was stopped in the act of attempting to commit suicide and all injuries were avoided. Is this reportable?</p> <p>A. <i>Yes, all suicides and suicide attempts must be reported.</i></p> <p>Q. Staff are observed using a restraint on a resident, but the resident is not injured. Is this reportable?</p>

A. *Yes, this is reportable with or without injury. Restraints are considered abuse. See Regulation referring to restraints [487.2(d)(1) and 488.2(c)(1)].*

Q. A resident falls but does not appear to be injured. A few days later, the resident complains of pain in the area of the body affected by the fall. , is this reportable?

A. *Yes, this is reportable, even if the injury or pain was not evident at the time of the fall.*

Q. A resident, with an approved enabling device on their bed, becomes entrapped. Staff safely assist the resident and no injuries are sustained. Is this reportable?

A. *Yes, the entrapment must be reported.*

Q. A resident using a chair equipped with an enabling device falls and is injured. Is this reportable?

A. *Yes, any injury related to the use of equipment is reportable.*

Q. Resident A falls while walking to communal dining and EMS is called and assesses the resident. They find no injuries and allow the resident to continue to the dining room. Should this be reported?

A. *Yes, this is reportable because EMS has completed an assessment, even if the resident is not transported to the hospital this must still be reported.*

5. Elopement (absent from the facility)

When a resident is absent from a facility and the resident's whereabouts are unknown for more than 24 hours, the facility must:

- Immediately notify the resident's next of kin or representative;
- Immediately notify the appropriate law enforcement agency;
- **Notify the appropriate regional office of the department on the first available working day;** and
- **Send a copy of the Incident Report to the appropriate regional office of the department within five working days.**

Reporting Scenarios Frequently Asked Questions

Q. A facility receives a call from the local hospital stating that one of the facility's residents was brought to the hospital after being found by the police. A review of the facility's records shows that the resident was last observed during the nightly medical pass (5 p.m.). The facility did not know the resident was missing until notification from the hospital at 7:00 p.m. the following day. Is this reportable?

A. *Yes, this is reportable. The fact that the facility did not initiate a search because they did not know the resident was missing does not relieve the facility of its responsibility to report. If a resident is missing from the building for more than 24*

hours, it is reportable.

Q. A resident is sent to an outside physician's office with staff. While there, the resident leaves the office building, undetected by staff but is found unharmed at the facility approximately 4 hours later. Is this reportable?

A. *No, this is not reportable. While staff had a responsibility to assure that the resident was supervised and safely returned to the facility, the resident was not absent from the facility, with their whereabouts unknown, for more than 24 hours.*

Q. A resident leaves the facility at 9:00 a.m. to spend the day with family. The facility identifies that the resident is not in their room at 8:00 p.m. and confirms that the resident has not returned to the facility. Calls to the resident's family go unanswered. The resident is still not back by 9:00 a.m. the following day and attempts to reach the family are still unsuccessful. Is this reportable?

A. Yes, although the facility knows that the resident left to spend the day with family, the residents whereabouts have been unknown for more than 24 hours. This is reportable.

C. Disaster and Emergency Planning

Pursuant to 487.12(j) and 488.12(l) Any time there is a work stoppage, a fire within the facility, failure of any one of the fire prevention or detection systems, lack of hot water, interruption or shut-off of essential services or any circumstances necessitating the implementation of the disaster and emergency plan, the department shall be notified by the next business day.

1. Loss of Essential Services

The facility must report any interruption or shut-off of essential services, which may include services for telephones, electricity, heat, air conditioning, and hot water, to the appropriate regional office by the next business day.

2. Fire

The facility must report a fire within the facility, or a failure of any fire prevention or detection system, to the appropriate regional office by the next business day.

3. Circumstances Necessitating the Disaster and Emergency Plan

The facility must report any circumstances that require the facility to implement its disaster and emergency plan, which may include, for example, responses to bomb threats, emergency evacuations, storm damage and flooded areas. Such information must be reported to the appropriate regional office by the next business day.



Please see Page 4 of this manual for directions on additional reporting requirements in an emergency and/or disaster that occurs on nights, weekends, or holidays.

Section III: Drupal Incident Reporting Instructions

ACF incidents must be reported through Drupal Survey. Incidents may be reported 24 hours a day, seven days a week. All incidents reported are considered confidential. If the facility loses internet access, the incident may be reported through the Adult Care Facility Complaint/Intake Program at 866-893-6772. If a report is taken by phone, it is not necessary to report again via the Drupal. However, the ACF will be required to ensure inclusion of such report in the chronological listing of ACF incidents.

Introduced March 29, 2023 and effective by May 1, 2023, ACFs are required to submit such reports via the Secure Drupal Link: [Adult Care Facility Incident Report | Survey Builder \(ny.gov\)](#).

A. Completing and Submitting a Report:

Reports may be completed by an Operator, Administrator, or Incident Report Designee. Incident Report Designee(s) may be a person(s) and/or role(s) designated by the Operator and/or Administrator and thereby authorized to, in their absence and on their behalf, complete the Attestation and submit the report to the Department. This does not exempt the Administrator from reviewing, addressing and being familiar with all reports submitted to the Department.

To complete a report, the Incident Reporter, Operator, Administrator must:

1. Utilize the secure Drupal Survey Link: [Adult Care Facility Incident Report | Survey Builder \(ny.gov\)](#)
2. When entering a new incident please complete all applicable fields. All fields with a red asterisk* are required.
3. Prior to submitting, review all fields for accuracy as survey cannot be edited once submitted, then sign attestation and submit.
4. Upon submitting, a summary will appear. Please save and/or print for records retention purposes.

B. Resident Comment

Operators are required to include a Resident Comment providing the resident's description of the incident for all incidents reported, unless the resident objects or declines. If the Resident has objected/declined to provide a Resident Comment, this can be reported in the electronic Incident Reporting Process described above by selecting "no". The ACF must obtain a signed notification from the resident documenting their objection/declination on the Resident Comment Form (DOH-5789). This does not need to be submitted to the Department but must be maintained at the ACF.

If the resident does provide a Resident Comment, as indicated by selecting "yes" in the electronic Incident Report, the ACF must use the Resident Comment Form (DOH-5789).

If the resident is unavailable by time of submission, Resident Comment Form (DOH-5789) may be collected on their return and maintained on file accordingly.

C. Records Retention

ACFs must maintain a copy of all Incident Reports and Resident Comments in the appropriate resident's file. Additionally, the ACF must maintain a chronological listing of all Incident Reports.

In the event an ACF loses internet access, and a report is submitted through the Adult Care Facility Complaint Intake Program at 866-893-6772, it is not necessary to report again via Drupal Survey. However, the ACF will be required to ensure inclusion of such report in the chronological listing of ACF incidents.

Need Help?

Questions about the Adult Care Facility Incident Reporting Manual can be directed to:

New York State Department of Health Division
of Adult Care Facility & Assisted Living
Surveillance

875 Central Avenue Albany,
New York 12206 (518) 408-1133

acinfo@health.ny.gov