



*"These bed sheets are filthy."*

# Reportable Incidents

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# Reportable Incidents

- **5 types of incidents that must be reported to the Bureau**
- **Call Hotline (208) 364-1883**
- **Fax report (208) 364-1888**

# Injuries of Unknown Origin

- **Not observed**
- **Resident can not explain where it came from;**
- **Bruising, laceration, sprain, broken bone**
- **Minor bruising and skin tears on the extremities need not be reported.**
- or**
- **Severe bruising on the head, neck, or trunk, fingerprint bruises, regardless of explanation**

# Facility Vehicle

- Facility-sponsored transportation.
  - Falling from the facility's van lift,
  - Wheel chair belt coming loose during transport
  - Accident with another vehicle.

# Elopement

- Unable to make sound decisions
- Physically leaves the facility premises
- Facility's staff unaware resident left

# Resident to Resident

- Physical
- Causes an injury



# Serious Incident

- Incident: An event that can cause injury
- Hospital Treatment
- fractured bones, IV treatment, dialysis, or death.
- (Falls, scooter accident, over-medicating, neglect, inappropriate transfer, ingestion of toxic substance, etc.)

# Hotline Information

- Name and Location of Facility
- Name and Title of Person Reporting
- Date and Time of the Incident
- Resident Name ( Include Spelling)
- Social Security Number of the Resident
- Outline of What Happened (Brief Description of the Incident)
- A Description of Injuries That Occurred
- Corrective actions or preventative plan

# Fax to BFS

- **Fax a copy of the Facility's Incident Report and the plan to prevent further incidents to (208) 364-1888.**

# Protecting Residents

- **IDAPA 16.03.22.350.03. Resident Protection.** Any resident involved must be protected during the course of the investigation.
- Administrative leave until investigation complete

# Police and AP

- **IDAPA 16.03.22.350.05. Facility Notification to Appropriate Agencies.**  
The facility must notify the Idaho Commission on Aging or it's Area Agencies on Aging, and law enforcement in accordance with Section 39-5303, Idaho Code.

# AP Statute

- (Title 39 Chapter 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT. 39-5303. DUTY TO REPORT CASES OF ABUSE, NEGLECT OR EXPLOITATION OF VULNERABLE ADULTS. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency.)

# Examples of things that did not need to be reported

- Resident was complaining that she was feeling sick and weak, she had her daughter and one of the caregivers call the home health nurse who came and checked her out. Daughter decided to call 911 to transport to hospital to be checked out. She was seen at St. Luke's ER and sent back home after a few hours with discharge diagnosis of viral (?) syndrome. Family has scheduled follow up appointment. 919-1217.

# Examples of things that did not need to be reported

- Yesterday morning resident got up. She was not feeling well, said she hurt and could not move. We called her son and 911. She was taken to St. Luke's Hospital by paramedics. She was brought back around noon for a prescription for Norco for pain. They had done a cat scan and ex-rays and found nothing to cause her pain.

# Examples of things that did not need to be reported

- This resident was walking back to her room after breakfast and fell forward in the hallway and skinned the bridge of her nose. Upon further investigation this morning the injuries received appear to be a bruised bridge of her nose as well as an abrasion that is small on the bridge of her nose, both eyes are bruised and her right breast is bruised. Faxing completed report.  
208-237-6866

# Examples of things that did not need to be reported

- There was no noticeable injuries. One resident tried to hurt the other but no injuries. Faxing report as soon as possible. (She did not state what had occurred)

# Examples of not enough info shared

- “No injuries at this time. Has another doctor’s appointment on the 27th follow up.”
- Patient lost her balance and fell over backwards. Has two small lacerations to the back of her head. The nurse took care of her and she is fine.

# Examples of Thorough Reporting

- Yesterday morning she got up, was confused about being with her daughter out on the tractor and she went out the front of the building about 7:00 a.m. She was found in the street right in front of the facility, dressed in her pajamas, she had no shoes on. A car came by and managed to stop and then we also had an aide who happened to be out front that got resident, put her sweater and shoes on her, brought her inside, warmed her up, got her dressed. There were no injuries. This is an isolated incident with her. We transferred her to our Expressions unit which is secure yesterday at least for the next few days to monitor her and see how she is doing. We did a UA on her to see if there was anything going on, that was clear, we are scheduling her for a doctor's appointment for a medical follow up to see if there is anything else going on. There were no injuries and she was doing well yesterday morning after the incident.

# Examples of Thorough Reporting

- Resident was being transferred in our company van, she was riding in her wheelchair, it turned a corner and the resident's wheelchair tipped over, wheelchair brakes were locked, however wheelchair did tip over. Injuries: She complained of chest discomfort, was taken to the Kootenai Medical Center and we had two ex-ray reports. The ex-ray report on the chest was unremarkable from the previous one – she has severe lung problems already, nothing significant new from the fall. She may have some impression on the spine thoracic showed a t-9 fracture since CT scan of 3/22/06. It is large bulky osteofite which suggests it is remote but age is indeterminate. So it is unclear to the ER physician and to the radiologist and to us if there is a t-9 fracture secondary to this in the fall in the van. Resident has returned to us and she is back to her baseline up in the wheelchair however she does have pain which is being controlled as always and previous to fall with her morphine. She is a hospice resident. The follow up to prevent further occurrences, the van driver has been suspended and I have suggested that we have a van inspection to assure that the strapping device meets state regulations. Other than that I don't know of any other follow ups we will be implementing other than the van inspection to make sure that is being taken care of. No further information at this time.

# Technical Assistance

- Website: [www.facilitystandards.idaho.gov](http://www.facilitystandards.idaho.gov)
- Email questions to:  
[FSB@dhw.idaho.gov](mailto:FSB@dhw.idaho.gov)
- Call BFS at (208) 334-6626
  - Ask for an Assisted Living surveyor