

- _____ Initial (Date) Report
- _____ Follow Up (Date) Report
- _____ Completed Report

OFFICE OF HEALTH CARE ASSURANCE
601 Kamokila Blvd., Room 395
Kapolei, Hawaii 96707
Phone: (808) 692-7420
Fax: (808) 692-7447

EVENT REPORT

Please answer all questions fully and address only one event per report.

Facility Name: _____

Facility Contact Person/Title: _____

Facility Phone Number: _____

Type of Event: (use CMS guidance and facility policy and procedures)

- Elopement
- Financial Exploitation
- Injury (*significant injury of known source and/or any injury of unknown source*)
- Resident Care
- Resident to Resident Abuse
- Staff to Resident Abuse
- Unexpected Death
- Other: please specify _____

Today's Date: _____

Date of Event: _____

Time of Event: _____

Notifications: (date and time)

	<i>Date</i>	<i>Time</i>
Physician:	_____	_____
Guardian/Family:	_____	_____
Administrator/Designee:	_____	_____

Name of Patient/Resident/Client: _____

Date of Birth: _____

Event Report

Nurse Aide Involvement:

If the event is an allegation of abuse, neglect, or misappropriation of resident funds by a nurse aide, please provide the following information:

Name of Nurse Aide: _____

Mailing Address: _____

Phone Number: _____

Certification Number: _____

Certification Expiration Date: _____

Please attach any documents helpful in describing the allegation/event as well as evidence of a thorough investigation of the allegation.

GUIDANCE FOR COMPLETION
OFFICE OF HEALTH CARE ASSURANCE
EVENT REPORT

Initial vs. Follow-Up

Following an event or discovery of an injury, Centers for Medicare and Medicaid Services (“CMS”) requires IMMEDIATE notification to the State survey agency, which is defined as within 24 hours of the event or discovery of the injury.

1. If you are able to complete your thorough investigation within the 24 hour timeline, check “Complete” on the top right of page 1 and submit that report to the Office of Health Care Assurance (“OHCA”). That report will complete your reporting requirement for the event.
2. If you are not able to submit a thorough investigation within the 24 hour timeline, check “Initial Report” on the top right of page 1 and AT LEAST complete page 1 and #1 on page 2 then submit to OHCA within the 24 hour period.

You have five (5) working days to complete and submit the thoroughly investigated event report. When submitting the completed report, check “Follow-Up on the top right of page 1, which assists the OHCA staff to match the “Initial Report” with the completed report.

Facility Information

A facility may wish to fill in its name, name of contact person, and telephone number before copying the form for future use. This may save time in completing the form.

Type of Event

Refer to your facility’s policy and procedures for defining the event types. “Resident Care” and “significant injury” can encompass a wide range of events. When in doubt, you may contact OHCA at (808) 692-7420, or submit a report. OHCA will review these reports for compliance with reporting regulations and appropriateness of interventions to prevent further injury.

Facility policy and procedures should follow CMS definitions for:

Mistreatment – The negligent commission or omission of acts that result in harm.

Neglect – Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Abuse – The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

Injuries of Unknown Source – An injury is to 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**
- 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).

Misappropriation of Resident Property – The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Dates and Notifications: Complete as indicated on the form.

Patient/Resident/Client Name: Complete as indicated.

Event: Complete page 2, questions numbers 1 thru 4.

The facility may choose to include any other documentation to assist in demonstrating the thoroughness of the investigation and your interventions implemented. Remember the regulation is specific in asking you to rule out abuse.