Five-Day Follow-Up Report

Report Type: ☐ Licensure ☐ Certification

Date: _____

Facility: _____

Address: _____

Phone _____

Certified Bed: ☐ yes ☐ no

Resident's Name: _____

DOB: _____

Room #: _____

Additional Resident Information (as applicable): _____

_____

Type of Reportable Incident:

- ☐ physical abuse
- ☐ verbal abuse
- ☐ sexual abuse
- ☐ attempted suicide
- ☐ bone or joint fracture
- ☐ patient death
- ☐ mental abuse
- ☐ neglect
- ☐ fire
- ☐ involuntary seclusion
- ☐ medication error (with adverse reaction)
- ☐ elopement
- ☐ misappropriation of resident property
- ☐ crimes against residents
- ☐ severe hematoma, laceration, or burn requiring medical or hospitalization
- ☐ hospitalization as a result of accident/injury
- ☐ injury involving use of restraints
- ☐ injury of unknown source

Name of Alleged Perpetrator: _____

Date/Time of Reportable Incident: _____

Diagnoses/Medications with potential for placing resident at risk for injury:

Time of last observation prior to Reportable Incident: _____

Resident condition prior to Reportable Incident:

Witnesses to Alleged Abuse: ☐ yes ☐ no

Witnesses and other Staff on duty at time of/or prior to Reportable Incident:

Details of Reportable Incident:

Characteristics of Injury (location, size, number, pattern, color):

History of similar Injury: ☐ yes ☐ no
If "yes" please give details:

Interventions in place prior to Reportable Incident:

Immediate corrective action/assessment following Reportable Incident:

Physician notified: ☐ yes ☐ no

Date/Time: _____

Interventions by facility to prevent future Injury/Alleged Abuse:

Summary Report of Facility Investigation:

_____ _____
Signature/Title Of Reporter Date

DHEC
Healthcare Quality
2600 Bull Street, Columbia, S. C. 29201
Voicemail: 1-800-922-6735 Fax: 803-545-4292

Please attach <u>copies</u> of all applicable interviews, witness statements, and any other applicable documents.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND ENVIRONMENTAL CONTROL

DHEC FORM 0269
Instructions for Completing

PURPOSE:

This form is used for all facility reported incidents for Healthcare Quality. Healthcare Quality is required through Federal regulations to have documentation of all facility reported incidents. This form serves as that documentation.

ITEM BY ITEM INSTRUCTIONS:

Date:	Enter the completion date of the form
Facility Name:	Enter the facility's name
Address:	Enter the facility's physical address
Phone #:	Enter the facility's phone number, include area code
Resident's Name:	Enter the name of the resident with an injury of unknown origin or abuse
DOB:	Enter resident's date of birth
Room #:	Enter the room number in which the resident resides, including specific location identifiers (i.e. floor, wing, unit, ward, etc.)
Certified Bed:	Identify if bed is Certified by Centers for Medicare and Medicaid Services
Type of Injury or Unknown source:	Describe the type of injury or unknown source
Type of Alleged Abused:	Check type of alleged abuse observed/reported
Name of Alleged Perpetrator:	Enter the alleged perpetrator's name, include if they are a resident or staff member and the staff member's title
Date/Time of Reportable Incident:	Enter the date/time the incident occurred (not the date of notification)
Diagnoses/Medications with potential for placing resident at risk for injury:	Enter detailed information of any diagnoses or medications the resident has for risk of injury
Time of last observation prior to Reportable Incident:	Enter the time of the last observation of the resident prior to the incident
Resident condition prior to Reportable Incident:	Describe any changes in the condition of the resident that was noted prior to the incident or if the resident was within their normal behavior
Witness to Alleged Abuse:	Indicate if there are witnesses to the abuse that occurred
Witnesses and Other Staff on duty at the time of/or prior to Reportable Incident	Enter names and titles of witnesses, and indicate if the person named witnessed the incident or was in proximity to where the incident occurred
Details of Reportable Incident:	Include a brief summary of the details of the incident
Characteristics of Injury:	Enter detailed descriptions of the injury
History of Similar Injury:	Check if there is a history of similar injuries with the resident and if yes, provide details of this history
Interventions in Place Prior to Reportable:	List all preventative interventions that were in place at the facility related to the reportable incident

Immediate Corrective Action/ Assessment Following Reportable Incident:	Describe the immediate actions taken by the facility to address the incident
Physician Notified:	Check if a physician was notified and the time and date this notification occurred
Interventions of Facility to Prevent Future Injury/Alleged Abuse:	Include all preventative measures put in place to prevent future occurrence of incident
Summary of Report of Facility Investigation:	Explain how determined from investigation if the reported incident was substantiated or unsubstantiated and include what was included in the investigation
Signature/Title of Reporter:	Signature and Title of person completing this form
Date:	Date the report was submitted to the State Agency

Attach other supporting documentation if needed and additional sheets as necessary. Please attached copied of all applicable interview, witness statements, and any other applicable documents.

OFFICE MECHANICS AND FILING:

This form will remain as a part of Healthcare Quality's files in accordance with Federal CMS retention regulations and guidelines.