INCIDENTS, ACCIDENTS AND COMPLAINTS

Support coordination agencies, Adult Day Health Care (ADHC) providers, and direct service providers are responsible for reasonably ensuring the health and welfare of the beneficiary and are required to report all incidents, accidents, or suspected cases of abuse, neglect, exploitation, or extortion. Reporting shall be in accordance with applicable laws, rules, and policies and be made to the appropriate agency named below. Only reporting to a supervisor does not satisfy the legal requirement to report. The supervisor shall be responsible for ensuring that reports or referrals are made in a timely manner to the appropriate agency.

For ADHC providers, refer to Medicaid ADHC Manual Chapter 9, Section 9.9-Incidents/Accidents/Complaints for details on reporting.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the beneficiary. A report of the incident/accident shall be maintained in the beneficiary's record as well as the central records system. The report shall include:

1. Beneficiary identifying information;
2. Event information (including date, time, location, etc.) of the incident/accident;
3. Circumstances surrounding the incident/accident;
4. Description of the incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
5. Action taken to correct or prevent future occurrence of incident/accident; and
6. Name of person completing the report.

Critical Incident Reports

Additional provider responsibilities apply to incidents defined as critical. Critical incidents include, but are not limited to, those involving:

1. Abuse;
2. Neglect;

3. Exploitation;
4. Extortion;
5. Major injury;
6. Major medical events;
7. Death;
8. Major behavioral incidents;
9. Involvement with law enforcement;
10. Loss or destruction of a beneficiary's home;
11. Falls; and
12. Major medication incidents.

Critical incidents are fully defined in the Office of Aging and Adult Services' (OAAS) *Critical Incident Reporting Manual* and includes the specific provider and support coordination agency responsibilities that must be followed. Non-compliance will result in administrative actions (See Appendix B for link to this manual).

Imminent Danger and Serious Harm

Providers must report all suspected cases of abuse (physical, mental, emotional, and/or sexual), neglect, exploitation, or extortion to the appropriate authorities. In addition, any other circumstances that place the beneficiary's health and well-being at risk should be reported to the appropriate authorities. (See Appendix A for contact information).

For beneficiaries ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation, or extortion. (See Appendix A for contact information).

For beneficiaries aged 60 years or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect, and/or exploitation of individuals aged 60 years or older. (See Appendix A for contact information).

If the beneficiary needs emergency assistance, the worker must call 911 or the local law enforcement agency before contacting the supervisor.

The responsibilities of the support coordination agency and providers (direct service providers and ADHC providers) are outlined in the *OAAS Critical Incident Reporting Manual* (See Appendix B for the link to this manual).

Internal Complaint Policy

Beneficiaries must be able to file a complaint regarding their services without fear of reprisal. The support coordination agency, ADHC providers, and direct service providers must have a written policy to handle beneficiary complaints. In order to ensure that the complaints are efficiently handled, the agency/provider must comply with the following procedures:

1. Designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must include the following:

    a. Date the complaint was made;

    b. The name and telephone number of the complainant;

    c. Nature of the complaint; and

    d. Resolution of the complaint.

2. All written complaints must be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator;

3. The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within 5 working days**;

4. The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the beneficiary, the responsible representative, the employee, and other interested parties. The agency/provider is encouraged to use all available resources to resolve the complaint internally. The employee's supervisor must be informed of the complaint and the resolution;

5. The agency/provider must inform the beneficiary, the complainant, and/or the responsible representative in writing **within 10 working days** of receipt of the complaint and the results of the internal investigation;

6. If the beneficiary is dissatisfied with the results of the provider's internal investigation, they may continue the complaint resolution process by contacting the Health Standards Section (HSS). (See Appendix A for contact information); and

7. If the beneficiary is dissatisfied with the results of the support coordination agency's internal investigation, they may continue the complaint resolution process by contacting the OAAS Regional Office (RO). (See Appendix A for contact information).