

- (14) "Reportable Event" means a happening, occurrence, situation or circumstance which was unusual or inconsistent with the policies and practices of the facility;

Reportable event(s)

- (1) Classification. All reportable events shall be classified as follows:
  - Class A: an event that has caused or resulted in a patient's death or presents an immediate danger of death or serious harm;
  - Class B: an event that indicates an outbreak of disease or foodborne outbreaks as defined in section 19a-36-A1 of the Regulations of Connecticut State Agencies; a complaint of patient abuse or an event that involves an abusive act to a patient by any person; for the purpose of this classification, abuse means a verbal, mental, sexual, or physical attack on a patient that may include the infliction of injury, unreasonable confinement, intimidation, or punishment;
  - Class C: an event (including but not limited to loss of emergency electrical generator power, loss of heat, loss of water system) that will result in the evacuation of one (1) or more patients within or outside of the facility and all fires regardless of whether services are disrupted;
  - Class D: an event that has caused or resulted in a serious injury or significant change in a patient's condition, an event that involves medication error(s) of clinical significance, or an adverse drug reaction of clinical significance which for the purpose of this classification, shall mean an event that adversely alters a patient's mental or physical condition, or
  - Class E: an event that has caused, or resulted in minor injury, distress or discomfort to a patient.
- (2) All reportable events shall be documented in a format required by the Department. All documentation of reportable events shall be maintained at the facility for not less than three (3) years.
- (3) Report. The licensed administrator or his/her designee shall report any reportable event to the Department as follows:
  - Classes A, B and C: immediate notice by telephone to the Department, to be confirmed by written report as provided herein within seventy-two (72) hours of said event;
  - Class D: written report to the Department as provided herein within seventy-two (72) hours of said event; and
  - Class E: written report of event at time of occurrence or discovery shall be maintained on file at the facility for review by the Department.
- (4) Each written report required by subdivision (3) of this subsection shall contain the following information:
  - (A) date of report and date of event;
  - (B) licensed level of care and bed capacity of the facility;
  - (C) identification of the patient(s) affected by the event including:
    - i. name;
    - ii. age;
    - iii. injury;
    - iv. distress or discomfort;
    - v. disposition;
    - vi. date of admission;
    - vii. current diagnosis;
    - viii. physical and mental status prior to the event; and
    - ix. physical and mental status after the event;
  - (D) the location, nature and brief description of the event;
  - (E) the name of the physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders;
  - (F) the names of any witnesses to the event;

- (G) any other information deemed relevant by the reporting authority or the licensed administrator; and
  - (H) the signatures of the person who prepared the report and the licensed administrator.
- (5) All reportable events, which have occurred in the facility, shall be reviewed on a monthly basis by the administrator and director of nurses. All situations which have a potential for risk shall be identified. A determination shall be made as to what preventative measures shall be implemented by the facility staff. Documentation of such determination shall be submitted to the active organized medical staff. This documentation shall be maintained for not less than three years.
- (6) An investigation shall be initiated by the facility within twenty-four (24) hours of the discovery of a patient(s) with an injury of suspicious or unknown origin or receipt of an allegation of abuse. The investigation and the findings shall be documented and submitted to the facility's active organized medical staff for review. This document shall be maintained at the facility for a period of not less than three (3) years.
- (7) Numbering. Each report shall be identified on each page with a number as follows: the number appearing on the facility license, the last two digits of the year and the sequential number of the report during the calendar year.
- (8) Subsequent Reports. The licensed administrator shall submit subsequent reports relevant to any reportable event as often as is necessary to inform the Department of significant changes in the status of affected individuals or changes in material facts originally reported. Such reports shall be attached to a photocopy of the original reportable event report.