Notification of Nurse Aide/Nontechnical Service Worker
Abuse, Neglect, Mistreatment or Misappropriation of Property
ODH Form No. 718
Revised 06/2008

Form Use/Purpose: The purpose of this form is for long term care facilities to report nurse aides, certified medication aides and nontechnical service workers who have been identified as being a possible perpetrator in an alleged incident involving abuse, neglect or misappropriation of property of a resident at a long term care facility in the state of Oklahoma. The Notification of Nurse Aide/ Nontechnical Services Worker Abuse, Neglect, Mistreatment and Misappropriation of Property form is generally included with the Incident Report Form and provides information about alleged perpetrator and related information. This information includes the date, facility ID, facility name, address of the facility, name of reporting party, the employee's name, employee's completed current address, social security number, nurse aide certification number, telephone number, alternate contact person's demographics, the action taken against the employee (e.g. suspended or terminated) and brief details regarding the incident.

Instructions for Form Use: Providers/facilities are to complete the entire form once the perpetrator has been identified. This form can be sent with any part of the incident report (initial, five day, final or separately).

Form Routing/Filing: Providers/facilities submit incident reports to long term care complaints area. Long term care staff review the incident reports and refer all incident reports that include a completed ODH form 718 to the legal division.

If action is deemed necessary, the legal division will either investigate the incident or refer the information to the office of the Attorney General for further action.

A record of the report is kept in the imaging system used in the long term care area. These reports are available to long term care surveyors for review during offsite survey preparation.

§ 483.13 Resident behavior and facility practices.

(a) *Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
(b) *Abuse.* The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
(c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
(1) The facility must—
(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
(ii) Not employ individuals who have been—
(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.
(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
[56 FR 48870, Sept. 26, 1991, as amended at 57 FR 43924, Sept. 23, 1992]

OAC 310, Chapter 675, Nursing and Specialized Facilities

310:675-7-5.1. Reports to state and federal agencies[1]

(a) The facility shall report communicable diseases to the Department as specified by the Board.

(b) The facility shall report deaths by unusual occurrence, such as accidental deaths or deaths other than by natural causes, and deaths that may be attributed to a medical device, according to applicable state and federal laws. The facility shall also report such deaths to the Department.

(c) The facility shall report to the Department allegations of resident abuse, neglect or misappropriation of residents' property. The facility shall report allegations of resident abuse, neglect, or misappropriation of residents' property by licensed personnel to the appropriate licensing board.

(d) The facility shall report unusual incidents, such as missing residents, abuse and neglect of residents, to the Department and to other appropriate agencies.

(e) All reports to the Department shall be made by telephone or facsimile within twelve hours[2] of the reportable incident. An initial report of the incident shall be mailed or faxed to the Department within five working days after the incident. The final report shall be filed with the Department when the full investigation is complete.

(f) The facility shall report to the Department allegations of abuse, neglect, or misappropriation of resident property by a nurse aide by submitting a completed Nurse Aide Abuse, Neglect, Misappropriation of Resident Property Form (ODH Form 718), which requires the following:

(1) facility name, address, and telephone;
(2) facility type;
(3) date;
(4) reporting party name or administrator name;
(5) employee name and address;
(6) employee certification number;
(7) employee social security number;
(8) employee telephone number;
(9) termination action and date;
(10) other contact person name and address; and
(11) facts of abuse, neglect, or misappropriation of resident property.

[**Source:** Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 20 Ok Reg 2399, eff 7-11-2003]

---

[1] Incident reporting requirements were amended by state law effective May 30, 2003. The rules in this section have not yet been updated to reflect the new law. For current statutory requirements, see the Nursing Home Care Act, Title 63 of the Oklahoma Statutes, Section 1-1939.

[2] This requirement was changed to twenty-four hours in Oklahoma law at 63 O.S. Section 1-1939(I)(1), effective June 6, 2003.

OAC 310, Chapter 675, Nursing and Specialized Facilities

310:675-7-12.1. Incident reports

(a) An incident is any accident or unusual occurrence where there is apparent injury, or where injury may have occurred, including but not limited to, head injuries, medication, and treatment errors.

(b) Each facility shall maintain an incident report record and shall have incident report forms available.

(c) Incident reports shall be on a printed incident report form.

(d) The charge nurse, at the time of the incident, shall prepare and sign the report. The report shall include the names of the persons witnessing the incident and their signatures where applicable.

(e) The incident report shall cover all unusual occurrences within the facility, or on the premises, affecting residents, and incidents within the facility or on the premises affecting visitors or employees.

(f) A copy of each incident report shall be on file in the facility.

(g) The facility shall notify the Department within twelve hours of all incidents pertaining to fire, storm damage, death other than by natural causes, missing residents, a utility failure for more than four hours, and incidents affecting the life and safety of residents. An initial incident report shall be submitted to the Department within five working days. A final report shall be filed with the Department, when the investigation is complete or the incident is resolved.

(h) The resident's clinical record shall describe the incident and indicating the findings on evaluation of the resident for injury.

(i) All incident reports shall be reviewed by the director of nursing and the administrator and shall include corrective action taken where health and safety are affected.

[**Source:** Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

Nursing Home Care Act
Title 63 of the Oklahoma Statutes

§63-1-1939. Liability to residents - Injunctive and declaratory relief - Damages - Waiver of rights - Jury trial - Retaliation against residents - Immunity - Report of abuse or neglect.

H. A facility employee or agent who becomes aware of abuse, neglect or exploitation of a resident prohibited by the Nursing Home Care Act shall immediately report the matter to the facility administrator. A facility administrator who becomes aware of abuse, neglect, or exploitation of a resident shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department.

I. 1. The facility shall be responsible for reporting the following serious incidents to the Department within twenty-four (24) hours:

a. communicable diseases,
b. deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes, and deaths that may be attributed to a medical device,
c. missing residents. In addition, the facility shall make a report to local law enforcement agencies within two (2) hours if the resident is still missing,
d. situations arising where criminal intent is suspected. Such situations shall also be reported to local law enforcement, and
e. resident abuse, neglect and misappropriation of the property of a resident.

2. All other incident reports shall be made in accordance with federal law.

3. All initial written reports of incidents or situations shall be mailed to the Department within five (5) working days after the incident or situation. The final report shall be filed with the Department when the full investigation is complete.

Laws 1980, c. 241, § 39, eff. Oct. 1, 1980; amended by Section 2 of Enrolled House Bill No. 1442 of the 1st Session of the 49th Oklahoma Legislature, eff. May 30, 2003.