

Questions for Stakeholder Meeting – Unusual Occurrences

The Center for Health Care Quality (CHCQ) within the California Department of Public Health (Department) is revising the regulations governing unusual occurrences in long-term care facilities under Title 22 of the California Code of Regulations (CCR). CHCQ is seeking input from interested stakeholders to ensure the proposed regulatory updates are consistent with other laws and regulations, modern facility practices, and other relevant standards.

The proposed regulations would affect the following sections within Title 22:

- **Section 72541: Skilled Nursing Facilities**
- **Section 73539: Intermediate Care Facilities**
- **Section 76551: Intermediate Care Facilities for the Developmentally Disabled**
- **Section 76923: Intermediate Care Facilities for the Developmentally Disabled- Habilitative**

Current regulations define unusual occurrences as “Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors....”

Questions for Discussion

1. How beneficial has this definition been in providing guidance on what occurrences facilities need to report to the CDPH? What type of information would you like to see in a revised definition?
2. What difficulties has your organization encountered when trying to determine if an incident is reportable?
3. What types of facility reported occurrences would you rather L&C focus on investigating?
4. Are there certain categories of incidents (for example, incidents involving fires or major accidents) that are more difficult to determine whether to report than others? If so, what are some specific examples?
5. Are there occurrences, in the absence of more defined regulations, that facilities are reporting which in your judgment could safely not be reported? If so, please provide examples.

6. Currently, facilities must report unusual occurrences within 24 hours via telephone and confirmed in writing to both the local health officer and CDPH. The facility must retain the reports for one year. Facilities must report fires or explosions to the local fire authority or the State Fire Marshal (in areas with no organized fire service). Are there any procedural changes for incident reporting that your organization would like to see updated by CDPH's regulations? If so, please provide examples of the suggested procedural changes.
7. CDPH is considering adding a quality assurance process to the unusual occurrence regulations similar to the Quality Assurance and Performance Improvement (QAPI) program referenced in Title 42 Code of Federal Regulations part 483.75 (2017) as an element in determining if a facility should report an occurrence. Does your organization have any concerns with this concept?
8. What do you think of the concept of having facilities perform a root cause analysis of incidents as an element in determining ways to prevent future occurrences?
9. What other issues, if any, would your organization like to see addressed in CDPH's update of the unusual occurrence regulations?