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OQA 06-026

**To:** Hospitals

Hosp 11

**From:** Cremear Mims, Section Chief  
Health Services Section

**Via:** Otis Woods, Director  
Office of Quality Assurance

**Hospital Death Reporting Requirements**

On September 29, 2006, the Office of Quality Assurance received direction from the federal Centers for Medicare and Medicaid Services (CMS) via a letter, S&C -06-31 <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter06-31.pdf> , to communicate the following information to hospitals in Wisconsin.

The federal Patients' Rights regulation at [42 CFR 482.13\(f\)\(7\)](#) requires that a hospital must report to CMS any patient death that occurs while the patient **is restrained or in seclusion for behavior management**, e.g., for violent behavior toward self or others. It also requires reporting where it is reasonable to assume that a patient's death is the **result of restraint or seclusion used for behavior management**.

CMS noted in S&C -06-31 that there is no death reporting requirement under the standard at [42 CFR 482.13\(e\)](#), "*Restraint for acute medical and surgical care.*" When the restraint/seclusion is used in an emergency to address violent behavior presenting a risk to the patient or others, it falls under the behavior management standard at (f), including the death reporting requirement, rather than the acute medical/surgical standard at (e).

Wisconsin hospitals must report directly to the Region 5 CMS regional office any death that occurs while a patient is restrained or in seclusion for management of behavior, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion used to manage violent behavior. The death must be reported to the RO **prior to the close of business on the business day following the day of the patient's death**.

The CMS contact for Wisconsin hospitals is:

**Justin C. Pak**

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Centers for Medicare & Medicaid Services  
Division of Survey and Certification - Midwest Consortium  
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Within two working days of receipt of the report, the CMS regional office will notify the State Office of Quality Assurance (OQA) authorizing a survey to investigate the hospital's compliance with the Patient's Rights Condition of Participation. Prior to OQA going onsite, the CMS regional office will provide OQA with the Restraint/Seclusion Death Report Worksheet containing all the data the regional office has collected to date from the hospital. The CMS regional office will also notify the CMS Central Office and the hospital's accrediting organization, if deemed, and the appropriate State Protection and Advocacy Group (Disability Rights Wisconsin), providing them with the hospital's name and address, the patient's name, and the date of death.

The Office of Quality Assurance will complete an investigation of the death within five working days of receiving the survey authorization from the Region 5 CMS regional office. The investigation will include the surveyor's completion of the federally required Restraint/Seclusion Death Report Worksheet, which will be e-mailed or faxed to the CMS regional office within two working days of completing the survey.

Within two working days following receipt of the completed Restraint/Seclusion Death Report Worksheet from OQA, the Region 5 CMS regional office will send the worksheet via e-mail or fax to the CMS Central Office. The CMS Central Office regularly reviews the status of all outstanding restraint/seclusion death reports with each region.

The full text of S&C-06-31, including the mandated Restraint/Seclusion Death Report Worksheet, will be referenced in the next OQA Quarterly Information Update. Because OQA has recently been relocated in the DHFS organization, the Quarterly Information Update may be moved to a new web address. The new address can be located, starting November 2006, by going to <http://dhfs.wisconsin.gov/> and entering "OQA Quarterly Information Update" in the DHFS search engine.