New Jersey Department of Health
Office of Program Compliance
P O Box 358
Trenton, NJ 08625-0358

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY) *GUIDELINES*

Dear Administrator:

Accused:
Allegation Type:
Resident:

An accused certified nurse aide (CNA) or medication aide (CMA) is entitled to a hearing regarding the above-referenced allegation of mistreatment, abuse, neglect or misappropriation of resident property. In order to afford timely due process to the accused, yet protect the vulnerable, frail and/or elderly residents of licensed healthcare facilities, the Department of Health (Department) requests that you provide all of the information required by the Facility Reporting Incident Data and Analysis Yield (FRIDAY) form within 5 business days of receipt of this letter [CRF §483.13(c)]. The Department requires that the entire form be completed, and submitted together with all supporting documentation requested therein. *Please note: Complete one form for each accused aide.*

Sections 1 through 14 shall be completed and the required supporting information submitted *regardless* whether the facility, Complaint Program, or Office of the Ombudsman for the Institutionalized Elderly substantiated the allegation. Further, all information and supporting documentation shall be submitted in response to this letter notwithstanding any previous submissions provided to the Complaint Program or the Office of the Ombudsman for the Institutionalized Elderly.

If more than one aide has been accused of this incident, please complete a separate report for each accused aide and attach all of the requested information to each form. For example, if three aides have been identified, please duplicate all of the information so that three separate complete packages are submitted. You may place the three separate packages into one envelope for mailing/courier services.

Return the completed original form and legible copies of all supporting documents, and keep a copy of this form for your records. Please forward all packages as follows:

Mailing Address via U.S. Postal Service:
New Jersey Department of Health
Office of Program Compliance
Certified Nurse Aide Reporting
P. O. Box 358
Trenton, NJ 08625-0358

Overnight Couriers (DHL, FedEx, UPS):
New Jersey Department of Health
Office of Program Compliance
Certified Nurse Aide Reporting
25 South Stockton Street, 2nd Floor
Trenton, NJ 08608-1832

Due to the volume of ongoing cases, it is difficult to notify you of the status of a particular case. Once all information has been received and reviewed, you will be notified of the determination in writing.

Thank you for your anticipated cooperation with this important matter. This program cannot succeed in its mission to protect the frail and/or elderly population of our licensed health care facilities without your complete participation.

Please be aware that the Nursing Home Administrators Licensing Board is notified of all instances where an administrator fails to respond to this request. Any sanctions that may be imposed against administrators are in accordance with N.J.A.C. 8:34-1 et seq., specifically N.J.A.C. 8:34-9.1(a)9, and N.J.S.A. 26:2H-5(b), N.J.S.A. 26:2H-27 and 26:2H-28.

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY) GUIDELINES
(Continued)

If you are unable to meet the time frame required in this letter or have questions about the contents of this letter, please contact the office at 609-633-9547.

Finally, remember to check the New Jersey Nurse Aide Registry prior to hiring any new nurse aides and again, periodically to check the status of all currently employed aides by visiting njna.psiexams.com. N.J.A.C. 8:39-42.15(a) states, "No licensed long term care facility shall employ a person as a nurse aide without making inquiry to the New Jersey Nurse Aide Registry, by calling 1-877-774-4243, and to any other state where the facility believes the nurse aide to be registered." This includes those individuals sent to the facility by private employment agencies. Certificates, wallet cards, and/or telephone verification sheets are not competent evidence of certification.

Sincerely,

Lisa King, Regulatory Officer
Office of Program Compliance

Please Note: This form is also available on our website at *nj.gov/health/forms*, under form number "LCS-8."

New Jersey Department of Health
Office of Program Compliance
P O Box 358
Trenton, NJ 08625-0358

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY)

Please print or type your responses.

Information Requested about the Accused Aide:
(Please submit one form for each accused aide involved in the allegation.)

Type of Allegation: Check *all* that apply

☐ Abuse:

Type: ☐ Physical ☐ Verbal ☐ Emotional ☐ Involuntary Seclusion ☐ Sexual

☐ Neglect *(Examples include Failure to Report, Failure to Follow Care Plan, Job Abandonment)*

☐ Misappropriation of Resident Property

☐ Mistreatment (Specify): ______________________________

Regardless of the employment status of the accused (i.e., the accused was employed in your facility through an employment/staffing agency or salaried by your facility or the agency), **YOU MUST** complete the entire FRIDAY form.

1. Name of the Accused Aide: ______________________________
2. Home Street Address: ______________________________

   Apartment/Floor Number: ______________

   P. O. Box Number (if applicable): ______________

   City: ______________ State: ______________ Zip Code: ______________

   Home Phone: ______________ Cell Phone: ______________
3. Social Security Number: ______________
4. Date of Hire: ______________

Ensure that all possible steps were taken to verify the accuracy of social security numbers, as there have been incidents of individuals using multiple social security numbers for their employer, NJDOH and/or PSI.

5. Information Requested About the Resident Victim(s):

   a. Name(s): ______________________________

   b. Age(s) at Time of Incident: ______________ (No birthdates, please!)

   c. Actual date and time the incident occurred: ______________

   d. At the time of the incident, was the victim alert and oriented? ☐ Yes ☐ No

   e. Is the victim now alert and oriented? ☐ Yes ☐ No

   f. Most recent cognitive assessment tool score/date (i.e., B.I.M.S., Mini Mental):

   ____

   g. Is the victim still a resident at the facility? ☐ Yes ☐ No ☐ Deceased-Date: ______________

   If "No," please provide the resident's current address and telephone number:

   ____

   h. If this incident required a resident physical assessment, please include it with your investigation report. *Note: Injuries may not immediately appear and will require additional assessments.*

   i. Does the resident victim have a language or communication barrier? ☐ Yes ☐ No

   If "yes," please explain: ______________________________

6. At the time of the incident, the accused was employed by: ☐ the facility ☐ an agency
   (If the accused was a facility employee, leave 6a through 6e blank.)
   a. Agency Name: ____________________
   b. Agency Contact Person: ____________________
   c. Agency Telephone Number: ____________________
   d. Agency Address: ____________________
   e. Agency Email Address: ____________________

7. Complete only if the accused is not certified:
   a. PSI ID Number: ____________________
      (The ID Number is listed on the passing exam score report and begins with NJ-06. Note: Regarding individuals who are not yet certified, keep a copy of the passing score report in the employee's file.)
   b. Is aide also a certified medication aide or health aide? ☐ Yes ☐ No
      If "Yes," list certification/ID number(s):
      ____

8. Complete only if the accused is certified:
   a. Certificate Number: ____________________
      Expiration Date: ____________________
   b. Verify the aide's current status and attach one copy of the current **(within the last 30 days)** certification(s) verification sheet. This information may be obtained from the Department's registry vendor, PSI, by visiting their website at www.psiexams.com. Click on "Registry Services," then "NJ Nurse Aides" or "NJ Assisted Living Administrator/Medication Aide."
      Please note: Certificates and/or wallet cards ARE NOT permitted to be photocopied, submitted, and used as competent evidence of certification.

9. Identify any disciplinary action that was taken against the accused as a result of the investigation:
   a. ☐ In-service Training ☐ Reassigned ☐ Suspended ☐ Terminated
      ☐ Other: ____________________
   b. If terminated/suspended, was the accused rehired/reinstated? ☐ Yes ☐ No
   c. Submit copies of past and present disciplinary actions regarding resident care or any similar practice issues.
      ☐ Enclosed ☐ No Prior Disciplinary Actions

10. Were the police notified? ☐ Yes ☐ No ☐ N/A
    (If you checked "No" or "N/A", you may leave the remainder of Question 10 blank.)
    a. Name of Police Department: ____________________
    b. Name of the Investigating Officer/Detective: ____________________
    c. Telephone Number of the Officer/Detective: ____________________
    d. Did the police conduct an investigation? ☐ Yes ☐ No
    e. Is a copy of the police report enclosed? ☐ Yes ☐ No
       If "No," forward a copy of the police report immediately upon receipt.

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY)
(Continued)

11. Collateral Due Process Hearings (facility, union, or governmental hearing):
    a. ☐ Facility ☐ Union ☐ Governmental Hearing ☐ Arbitration
    b. Was a hearing offered to the accused to contest the allegations? ☐ Yes ☐ No
    c. If "Yes," what is the date of the hearing? ____________________
    d. Is a copy of the written decision by the arbitrator/hearing officer enclosed? ☐ Yes ☐ No
    If "No," forward a copy of the written decision immediately upon receipt.

12. Facility Information:
    a. Name: ____________________
    b. Mailing Address: ____________________
    c. City and Zip Code: ____________________
    d. Administrator Name: ____________________
    Telephone Number: ( ) ____________________ Fax Number: ( ) ____________________
    Email Address: ____________________
    e. Director of Nursing Name: ____________________
    Telephone Number: ( ) ____________________ Fax Number: ( ) ____________________
    Email Address: ____________________
    f. Facility Investigator Name: ____________________
    Telephone Number: ( ) ____________________ Fax Number: ( ) ____________________
    Email Address: ____________________

13. Office of the Ombudsman for the Institutionalized Elderly (OOIE) (if the resident victim(s) is/are age 60 or older):
    a. Was this incident reported to OOIE? ☐ Yes ☐ No
    b. Name of Person to Whom Reported: ____________________
    c. Was a visit to the facility made? ☐ Yes ☐ No
    d. Did the investigator substantiate the allegation? ☐ Yes ☐ No
    e. Case Number: ____________________
    f. Name of OOIE Investigator: ____________________
    g. Were other agencies, as applicable, notified of the incident(s) (i.e., Medicaid Fraud Unit, Adult Protective Services, or Office of the Public Guardian)? ☐ Yes ☐ No
    h. If "Yes," date of referral: ____________________

14. Investigation Report Requirements
    a. Did the facility investigation substantiate the allegation that mistreatment, abuse, neglect, or misappropriation of resident property occurred? ☐ Yes ☐ No
    b. Is there videotape (i.e. security camera, etc.) of the incident? ☐ Yes ☐ No
    If "Yes," please include a copy of the videotape with this form.
    c. Do the witnesses speak English? ☐ Yes ☐ No
    If "No," please indicate language spoken:

    ____

d. The Detailed Facility Investigation Report shall include:

Yes	No	N/A	
☐	☐	☐	A detailed explanation of the incident.
☐	☐	☐	The comprehensive facility investigation will include how the facility investigation determined how the resident victim(s) and identify of the accused was identified and shall include all relevant findings, recommendations and conclusions.
☐	☐	☐	The investigation shall indicate how the allegation was or was not substantiated.
☐	☐	☐	A resident victim physical and psychosocial assessment related to this incident. (Note: Injuries sustained may not manifest immediately and follow up assessment may be necessary. Include psychiatrist, psychologist, and social worker documentation, as applicable, for psychosocial status.
☐	☐	☐	Photographs and a copy of surveillance video related to the incident, including a written timeline of events, including dates.
☐	☐	☐	The signature of the facility investigator and date completed.
☐	☐	☐	If the incident involves: (1) theft of checks, enclose a copy of the cancelled check(s) (front and back). (2) use of the resident's telephone, enclose a copy of the resident's telephone bill. (3) theft of the resident's credit card, enclose a copy of the resident's credit card bill.
☐	☐	☐	Provide proof (e.g., copy of time cards, assignment sheets) that on the date/time of incident, the accused was on duty, assigned to or had access to the area where the incident occurred, if the accused was monitoring the resident at meals/activities, or providing transport, etc.
☐	☐	☐	Written statements by the resident victim(s), accused, and all witnesses.
☐	☐	☐	Include a list of witnesses on a separate sheet, identifying all witnesses by name and title. Examples of witnesses include: (1) Someone who saw and/or heard the incident while it was occurring. (2) An employee and/or visitor (e.g., family member, contractor/vendor) (3) Someone to whom the resident victim spoke directly to about the incident.
☐	☐	☐	Every written statement shall be in the first person and in the writer's own words and explaining in detail exactly what happened. Include the writer's printed name, daytime telephone number, date of statement, and signature.
☐	☐	☐	Please include all original statements. If the handwriting on any statement is not legible, include a typed transcription that includes the writer's and the transcriber's signatures.
☐	☐	☐	If a writer is non-English speaking, the written statement shall be in his or her own language. A written, signed, dated, verbatim translation shall be provided.
☐	☐	☐	If a writer has difficulty writing or otherwise making a written statement, write or type the statement verbatim and have the individual sign and date the statement. Please make a notation on the statement signifying that you are providing a verbatim statement, print your name, sign your name, and date.
☐	☐	☐	If an individual making a statement cannot sign his or her name, the statement may be signed with an "X," if signed below the "X" by two witnesses.

NOTES:

- **Character references, stand-alone summaries, and the Reportable Event Record/Report forms *ARE NOT* acceptable.**
- Each written statement shall be on a separate sheet of paper. A sample individual statement form is enclosed for your use or reference.

INDIVIDUAL STATEMENT FORM

Complete the following 4 steps.
Attach additional sheet(s) if necessary. Sign and date additional sheet(s).

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1. Where and when (date and time) did the incident occur:

2. Tell us step by step, in your own words, what happened (what you actually observed and/or heard).

3. Individual Completing Form:

   Name (Print): ____________________

   Daytime Telephone Number: (   ) ____________________

4. Signature: ____________________

   Date Completed: ____________________