

RESIDENTIAL REPORTING INCIDENT AND COMMUNICATIONS GUIDE

RESIDENTIAL INCIDENT REPORTING

Incident Reporting is an online portal that allows the employee to submit an incident report and attachments electronically to the South Dakota Office of Licensing and Accreditation (OLA) and the Department of Health (DOH). This guide will outline the Incident Reporting permissions, variances, and communications.

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PROVIDER PORTAL WEBPAGE

The DSS Medicaid Portal webpage can be accessed via the following URL:
<https://dss.sd.gov/medicaid/portal.aspx>

The Portal webpage is updated periodically with User Documents, FAQs, and Portal-related announcements from the Medicaid Portal Team.

A provider may also access the Portal via the drop-down under the Medicaid Tab on the <https://dss.sd.gov> website.



NEW REGISTRATION

The Medicaid Portal registration process accepts registration requests for one or multiple Billing NPI(s) and is not limited to the number of Billing NPIs which can be requested at one time.

If you are a group care only provider, and not registered with a Billing NPI to bill South Dakota Medicaid please contact your Licensing Specialist to receive the Billing NPI associated with your FACIS/Group Care ID number.

The organization's Provider Administrator (Provider Admins) will assume responsibility for the oversight and administration of all additional Portal user accounts within the Billing NPIs they control.

Administration includes but is not limited to adding users within their Billing NPI(s) and receiving requests for Portal accounts from users within their Billing NPIs. They can delegate oversight to additional Provider Admins for one or more of their Billing NPIs to help establish the appropriate levels of hierarchical access and permissions to their organization's users. Additional information can be found under the [Login](#) heading.

To submit a New Registration form, users must complete all required fields, add at least one Billing NPI as "requested" and check the important message acknowledgment regarding paper remittance advice.

A valid combination of the following three data elements is required for a Billing NPI to be requested. The unique combination of these three values is verified against our database for accuracy before users can "ADD" a requested Billing NPI:

The seven (7) digit SD MEDX ID – SD MEDX is the SD Medicaid Provider Enrollment system, for which your organization's Provider Administrator has login credentials. If it is unknown, please contact your Licensing Specialist to receive the Billing NPI associated with your FACIS/Group Care ID number.

If you do not know the SD MEDX ID for your Billing NPI(s), please contact your Licensing Specialist to receive the Billing NPI associated with your FACIS/Group Care ID number.

The enrollment specialist will be able to search for one or more of your organization's Tax IDs and provide you with a list of each unique SDMEDX ID & Billing NPI combination.

If the SDMEDX ID & Billing NPI combination is NOT entered correctly for each Billing NPI, the user will receive an error that "This combination is not valid."

Nine (9) digit Tax ID - Federal Employer Tax ID Number (FEIN or TIN) for which an organization is enrolled with SD Medicaid. If it is not known, please contact your Licensing Specialist to receive the Billing NPI information associated with your FACIS/Group Care ID number.

If you do not have a FEIN, you may be enrolled with SD Medicaid as sole ownership. In such instances, your FEIN could be your Social Security Number (SSN).

Ten (10) digit Billing NPI – Billing National Provider Identification number(s) enrolled with SD Medicaid.

If enrolled with SD Medicaid as sole ownership, your "Billing" NPI could be your Type 1, Servicing NPI.

The screenshot shows the 'Medicaid Portal' interface for 'New Registration for Provider Administration'. The form includes fields for Contact First Name, Contact Last Name, Contact Phone, Contact Email, Confirm Contact Email, Contact Address, State, City, and Zip. It also has fields for SDMEDX ID, Tax Id, and Billing NPI, with an '+ ADD' button. A search box for Billing NPIs is present. The form is marked with red asterisks for required fields. At the bottom, there are 'Submit' and 'Cancel' buttons, and a footer with copyright information and navigation links.

New Registration Contact Form field information should be populated with the Requestor's business contact information. The New Registration Form Contact Email address entered will become the Requestor's Username.

If the system identifies that an account has already been requested or approved for an email address, the requestor will receive an error that the email already exists and will not be able to submit the New Registration form. If the Requestor does not receive a submission confirmation email at the Contact Email address listed in their registration form, they may have typed their email incorrectly. If this occurs, please send an email to DSSOnlinePortal@state.sd.us regarding the email address being entered incorrectly on the pending registration request.

The Contact form fields do have some built-in functionality in place that is important to note:

Help Text - When populating the Contact details, users can hover their mouse pointer over the “?” icon to display Help Text. Help Text defines the expected value or input, for that field.

Asterisk (*) – Each required field is indicated with an asterisk (*) symbol. Screens containing required input fields will also display an information message that “* indicates required fields”

Contact Phone – This field is formatted to only accept numeric values and to automatically populate () and – as the user types. Users will not be able to delete or modify the format in place for this field.

Ext. – The extension field allows up to seven (7) numeric-only values. This is not a required field.

Contact Email – The email address can only be validated for format accuracy. If users do not type in their email address correctly (i.e., misspell a word) in both email fields, they will only be aware of the error if they do not receive an email confirmation at the expected email address they entered within a short timeframe of submitting their request.

State, City & Zip – These fields are dynamic and require users to select them in the order in which they are displayed on the screen. Once the user selects State, the city dropdown allows users to select the list of cities specific to that State. After selecting the appropriate City, the user can select the appropriate Zipcode value. If the City/Zip dropdowns do not automatically populate after State is selected, the Portal may be querying the address database. Please wait a few additional seconds and try again if this occurs.

SDMEDX ID, Tax ID & Billing NPI – These fields will only accept numeric values. If any combination of the three cannot be validated against the database and are incorrect,

the user will receive a “This combination is not valid” error, when attempting to click the “ADD” button. **If you are a group care only provider, and not registered with a Billing NPI to bill South Dakota Medicaid please contact your Licensing Specialist to receive the Billing NPI associated with your FACIS/Group Care ID number.**

Important Message Checkbox – This acknowledgment must be checked to submit a New Registration request. If the user clicks “Submit” before checking the acknowledgment box, they will receive an error and their form will not be submitted.

New Registration for Provider Administration (you can request access to one or more Billing NPI's)

* indicates required fields

<input type="text" value="Contact First Name"/> *	<input type="text" value="Contact Last Name"/> *	<input type="text" value="SDMEDX ID"/> *
<small>Please enter Contact First Name</small>	<small>Please enter Contact Last Name</small>	<small>SDMEDX Id is required</small>
<input type="text" value="()"/> *	<input type="text" value="Ext"/>	<input type="text" value="123"/> *
<small>Please enter a valid Contact Phone Number</small>		<small>Tax Id is invalid</small>
<input type="text" value="Contact Email"/> *		<input type="text" value="2345"/> * <input type="button" value="+ ADD"/>
<small>Please enter a valid Contact Email</small>		<small>Billing NPI is invalid</small>
<input type="text" value="Confirm Contact Email"/> *		
<small>Confirm Contact Email</small>		
<input type="text" value="Contact Address"/> *		
<small>Contact Address is required</small>		
<input type="text"/>		
<input type="text"/>		
<input type="text" value="State"/> *		
<small>Please select a valid City</small>		
<input type="text" value="City"/> *		
<small>Please select a valid Zip</small>		
<input type="text" value="Zip"/> *		
<small>Please select a valid Zip</small>		

IMPORTANT: Once you are registered within this Portal your organization will no longer receive paper remittance advices. Remittance advices will be accessible immediately upon logging in.

After submitting a New Registration request, the Requestor will be directed back to the Login screen and receive a “Success” message notifying them that their request was submitted for approval. The user will also receive a confirmation email at the email address listed in their New Registration form that their request was submitted for approval.

Success

Your registration was submitted to your Administrator. You will receive an email notification upon approval.



Welcome to the DSS Online Portal

Use a valid username and password to gain access to the portal

For assistance with username and password, contact your administrator.

For more help contact the State at DSSOnlinePortal@state.sd.us

LOGIN

*

(Note: This is your login email)

[Register](#) | [Forgot Password](#)

New Registration requests will be received by a State Reviewer and will remain pending until Approved/Rejected. If there are any questions concerning the Registration request, the Requestor may be contacted directly by the State Reviewer via phone or email. Incomplete or invalid registration forms will not be submitted for review. If the Reviewer cannot validate the form or confirm details in a question, the Requestor will receive an email notification that their registration request has been rejected.

Contact Email	Contact Last Name	Contact First Name	Submit Date/Time	Provider Name	Billing NPI	Tax Id	Action
PendingRegistration@WorkQueue.com	WorkQueue	ProviderAdmin	01/25/2017	Fairview Southdale Hospital	1770663031	410991680	Accept / Reject

Once approved, the Requestor will receive an approval email confirmation with temporary login credentials and details. The initial login process must be completed within 3 days (72 hours), or the password will expire. If the request is rejected, the Requestor will receive a rejection email notification.

LOGIN

The first time a user logs into the Medicaid Portal, they will need to log in using the Temporary Password, they received in their Portal account approval email notification. The Username for Login will always be the user's email address, with which they registered their Portal account. Temporary passwords are only valid for 3 days (72 hours) after receipt of the approval confirmation email notification. If a user forgets or loses their password, they can select "Forgot Password" to complete the steps as outlined in the Forgot Password section.

Welcome to the DSS Online Portal

Use a valid username and password to gain access to the portal

For assistance with username and password, contact your administrator.

For more help contact the State at DSSOnlinePortal@state.sd.us

LOGIN

Username
(Note: This is your login email)

Password

Login Register | Forgot Password

When logging in for the first time, users will be prompted to enter their Login Username and temporary password. After successful login, users will be directed to the Change Password form where they will need to complete the following:

Re-enter Temporary Password - The password received via email.

Type in a New Password - Please note the State Password Security Standards, below.

Retype New Password - The New Password entered and the Retype New Password to confirm. If the new password and re-typed password do not match, the user will receive an error.

Select three Security Questions and Responses - These Security Questions and Responses will be used for the “Forgot Password” functionality.

Username - The Username field is grayed out on the “Change Password” form. The Contact Email Address submitted on the Registration form or when the user account was added becomes the unique account Username.

Email addresses cannot be duplicated, and users will not be able to have two active accounts for the same Username.

If a user's email address changes, their Portal Provider Admin will need to update the user's account to “Inactive” status and create a new account for them under their new email address.

The screenshot shows the 'Change Password' form in the Medicaid Portal. At the top left is the 'Medicaid Portal' logo with 'DSS Social Services' and 'South Dakota' text. At the top right, it says 'You are logged in as [User Name]'. Below the logo are links for 'User Guide' and 'FAQ'. The form title is 'Change Password'. A red asterisk indicates required fields. The 'Username' field is grayed out and has a note: '(Note: This is your login email)'. To the right, there is a red instruction: 'Please select security questions and provide answers. Each security question should be unique.' Below this are three dropdown menus for selecting security questions. The 'Old Password' field is followed by a dropdown menu. The 'New Password' field has a note: '(Note: Password should be 8 to 15 characters)'. The 'Retype New Password' field is at the bottom. There are 'Submit' and 'Cancel' buttons. At the bottom of the page, there is a copyright notice: '© 2016 - 2021 State of South Dakota MMIS. All Rights Reserved.' and a footer with links: 'Home | State Home Page | Disclaimer | Accessibility | Privacy Policy | Contact Us | HIPAA', the address '700 Governors Drive | Pierre, SD 57501', and the phone number '605.773.3495'.

STATE PASSWORD REQUIREMENTS & SECURITY STANDARDS

The following are State Standards for Passwords, including those used in the Portal. When considering your Portal password, please review and apply these standards to ensure compliance with State Security Standards:

Must be changed every ninety days.

Must be at least eight characters.

Must contain at least three of the following four character groups:

English uppercase characters (A through Z).

English lowercase characters (a through z).

Numerals (0 through 9).

Non-alphabetic characters (!, \$, #, %)

Must not be one of the six most recent passwords.

Must not have been changed within the last seven days.

Does not contain your account or full name that exceeds two consecutive characters.

ADDING PERMISSIONS

PROVIDER ADMINISTRATOR ROLE

A Provider Administrator can add the reporting permissions to the Provider User staff.

Open User Maintenance, under the Administration tab.

Select the user you would like to add the permissions to.

The user must be registered with the application to allow for access to be added, updated, or terminated.

Click Update, then click Next.

In the "Permission Available" select RR Reporting, RR Communications, or both.

RR Reporting will only give the user ability to enter the incident for reporting purposes.

RR Communications will allow for discussions between OLA, DOH, and the user at the facility based on the user's Billing NPI or group care facilities.

Eligibility will allow for the search of the a South Dakota resident's Medicaid Id number if not known or to check eligibility of one that is known.

Once selected click the arrow that is pointing to the right to move these options to the selected users' permissions and click "Update"

Permissions Available		Permissions Selected
<input type="checkbox"/> Select All		<input type="checkbox"/> Select All
<input type="checkbox"/> Adjudicated Claims Listing	→	<input type="checkbox"/> Eligibility
<input type="checkbox"/> Census Status Report		<input type="checkbox"/> RR Communications
<input type="checkbox"/> Claim Submission		<input type="checkbox"/> RR Incidents
<input type="checkbox"/> Claim Submission View	←	
<input type="checkbox"/> Claims Work Queue Modify		

Once permissions are updated, the user will see the Resident Reporting as a displayed tab. The user may have to log out and log back into the application.

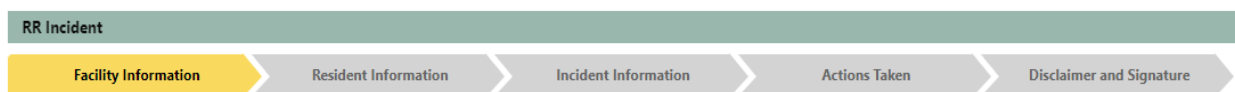


SUBMITTING AN INCIDENT

Under the Resident Reporting, hover with your mouse and select Incidents



For the Incidents, the incident form has been split into 5 separate sections. Each page will be required to be "saved" before proceeding to the following page. As a user, you haca nchange any of your entered information before submission. You may navigate between pages by using the "Next" button or the page labels.



FACILITY INFORMATION:

Please use the indicated NPI Number that has been assigned to your facility. If your facility is not paid directly by South Dakota Medicaid, you have been assigned a "dummy" NPI for

using this incident reporting tool. Please contact your Portal Administrator or OLA for this information.

After selecting the NPI and clicking Verify, the facility's address will populate to the right of the Verify button. Please select the corresponding address to the facility where the resident resides.

PRTF Incidents

Facility Information Resident Information Incident Information Actions Taken Disclaimer and Signature

NPI Number Select One

Select the correct address for the facility. The facility information will populate in the grey areas of the screen below. Please enter the facility phone number in this format ((XXX) XXX-XXXX).

Address

City State Zip Code

Email Facility Phone

The Provider's License Number and CMS Certification Number, both are required fields if submitting an incident to the Department of Health (DOH). The only special character allowed is "-" all other characters will cause an error.

Provider's License Number CMS Cert. #

Reporting person's name (defaults to user's email address), position, reporting person's phone number and the report date and time (to nearest five minutes) are required fields. If the time is unknown, please report with the time selected as 00:00 and minutes as 00:00, this will default the time to midnight.

Reporting Person Position

Reporting Person's Phone Report Date/Time

This is a sample of all of the fields filled in. If a field is required, an error will appear if any of the required fields are not filled in.

PRTF Incidents

Facility Information **Resident Information** Incident Information Actions Taken Disclaimer and Signature

NPI Number

Name

Address

City State Zip Code

Email Facility Phone

Provider's License Number CMS Cert. #

Reporting Person Position

Reporting Person's Phone Report Date/Time

You may use the "SAVE" button, to save your work and exit or the "NEXT" button to proceed to the next section of the report.

RESIDENT INFORMATION:

This is related to the Medicaid recipient that was involved in the incident. Use the 9-digit Medicaid ID/Recipient ID number. Once entered, click "Verify". The recipient's information will be populated according to the information in the Medicaid system.

Facility Information **Resident Information** Incident Information Actions Taken Disclaimer and Signature

Recipient ID

Recipient Name

Address

City State

Date of Admission

Recipient Gender

Date of Birth

Zip Code

Guardian of Resident Information

Name (First/Middle/Last)

Address

State City

Phone #

Staff Reporting To Guardian

Relation to Recipient

Zip Code

Date/Time Notified

Title / Position

If the 9-digit Recipient ID number is not known, a user may use the eligibility tab to find the recipient's ID number or to verify eligibility for coverage. For more information on how to use that function please refer to the [Portal User Guide](#).

If the Resident's Medicaid ID number cannot be located, additional functionality is available. As a user, you may enter nine 9's in the Recipient ID field and click verify. This action will open the Recipient Name, Recipient Gender, Address, Date of Birth, City, State, and Zipcode for free text entry.

Recipient's Name must be entered in the following format:
Last Name, First Name MI (Doe, John L)

Recipient Gender uses "M" for Male and "F" for Female

Date of Birth may be chosen using the calendar option or entering as MM/DD/YYYY format.

Address, City, State, and Zipcode will use the recipient's home address, not the facility's.

Facility Information	Resident Information	Incident Information	Actions Taken	Disclaimer and Signature
Recipient ID	<input type="text" value="99999999"/> <input type="button" value="Verify"/>	Date of Admission	<input type="text" value="Date/Time Admitted"/> <input type="button" value="Calendar"/>	
Recipient Name	<input type="text"/>	Recipient Gender	<input type="text"/>	
Address	<input type="text"/>	Date of Birth	<input type="text" value="Date of Birth"/> <input type="button" value="Calendar"/>	
City	<input type="text"/> State <input type="text"/>	Zip Code	<input type="text"/>	

You may use the "SAVE" button, to save your work and exit or the "NEXT" button to proceed to the next section of the report.

The Date of Admission will need to be entered with the time as close to the five minutes. If the time is unknown, please report with the time selected as 00:00 and minutes as 00:00, this will default the time to midnight.

Facility Information	Resident Information	Incident Information	Actions Taken	Disclaimer and Signature
Recipient ID	<input type="text" value="99999999"/> <input type="button" value="Verify"/>	Date of Admission	<input type="text" value="11/29/2021 12:10 AM"/> <input type="button" value="Calendar"/>	
Recipient Name	<input type="text" value="Doe, John L"/>	Recipient Gender	<input type="text" value="M"/>	
Address	<input type="text" value="PRAIRIE PAYEE SERVICES INC FOR PO BOX 207"/>	Date of Birth	<input type="text" value="MM/DD/YYYY"/>	
City	<input type="text" value="SIOUX FALLS"/> State <input type="text" value="SD"/>	Zip Code	<input type="text" value="57101-0207"/>	

GUARDIAN OF RESIDENT INFORMATION:

The information entered is for the recipient's guardian. Enter the guardian's information as First, Middle, and Last Name. The relation to the recipient (mother, father, sister, step-mother, caretaker, etc).

Please fill in the street address. You may select the state first from the drop-down. The city list will create a dropdown of available cities in the state. Enter the phone number for the guardian in the xxx-xxx-xxxx format.

The Staff Reporting to Guardian needs to be filled in with the staff member's name and title or position of that staff member.

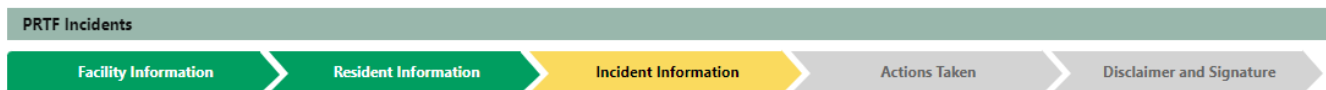
The date and time of the call to the nearest five minutes will need to be entered for the date and time notified. If the time is unknown, please report with the time selected as 00:00 and minutes as 00:00, this will default the time to midnight.

Guardian of Resident Information

Name (First/Middle/Last)	<input type="text" value="Jane L Smith"/>	Relation to Recipient	<input type="text" value="Mom"/>
Address	<input type="text" value="7321 Hellen Dr"/>		
State	<input type="text" value="South Dakota"/>	City	<input type="text" value="BLACK HAWK"/>
Zip Code	<input type="text" value="57718"/>		
Phone #	<input type="text" value="(554) 644-4555"/>	Date/Time Notified	<input type="text" value="03/28/2022 09:10 AM"/>
Staff Reporting To Guardian	<input type="text" value="Jane Doe"/>	Title / Position	<input type="text" value="Staff"/>

INCIDENT INFORMATION:

In this area, the reporting staff member or supervisor will be providing information and any details for the incident that had occurred. As a user or admin, you are allowed to report any incident up to 1 year before today's date.



Please select the date and time that the incident occurred. The location is a free-form text as to where the incident had occurred (i.e. kitchen, common area, bathroom). If the time is unknown, please report with the time selected as 00:00 and minutes as 00:00, this will default the time to midnight.

Incident Information

Date/Time	<input type="text" value="03/28/2022 08:10 AM"/>	Location	<input type="text" value="Common Area"/>
-----------	--	----------	--

The Staff Involved are any that were involved with the resident or with the incident itself. Start by typing the staff member's name in the box to the left of the "+" sign. Once the staff member's name has been entered, click the "+". This will add the record below. If a staff was entered incorrectly, you may remove the incorrect entry by clicking the "-" button.

Staff(s) Involved

	+
Jane Doe	-
Johnny Be Good	-

Resident(s) Involved relates to any resident that was involved in the incident. Please include the resident that was listed in the resident information. This can be entered by typing the resident's name in the box to the left of the "+" sign. Once the resident's name has been entered, click the "+". This will add the record below. If a resident(s) is entered incorrectly, you may remove the incorrect entry by clicking the "-" button.

Resident(s) Involved

	+
Josie Danger	-
Elsa Ice	-

TYPE OF INCIDENT:

Type of Incident is referring to what caused or what has happened during the incident. You may choose one or multiple selections. Each incident will expand to add additional details once a selection is made.

Type of Incident (Check all that apply)

- Injury During Restraint
- Elopement
- Death
- Serious Illness
- Seclusion
- Serious Injury
- Suicide Attempt
- Other

INJURY DURING RESTRAINT:

Please document the restraint type (i.e hold) and the restraint length as accurately as possible. Use the check box to indicate if there was an injury during the restraint. If a selection is not available, please type your response into the "Other" box.

Injury During Restraint

Restraint Type

Restraint Length

Bruise Cut

Skin Tear (Abrasion) Broken/Fractured Bone

Scratches Muscle Soreness

Other

SECLUSION:

Please document the place of seclusion and the length as accurately as possible. Use the check box to indicate if there was an injury during the seclusion. If a selection is not available, please type your response into the "Other" box.

Seclusion

Place of Seclusion

Seclusion Length

Bruise Cut

Skin Tear (Abrasion) Broken/Fractured Bone

Scratches Muscle Soreness

Other

ELOPEMENT:

This is related to the resident having left the facility without approval or notification to staff members (i.e. missing resident, run-a-away). Document the date/time the resident was last seen as accurately as possible. The "Yes" and "No" responses are entered for the time of the incident. If the youth was returned to the facility, the Returned Date/Time is required. Document the Date/Time Resident Found by Staff as accurately as possible. Use the check box to indicate if there was an injury during the elopement. If a selection is not available, please type your response into the "other" box.

Elopement

Date/Time Last Seen

Youth was Located Yes No

Youth was returned to Facility Yes No

Returned Date/Time

Was Resident found by Staff? Yes No

Date/Time Resident found by Staff

Bruise Cut

Skin Tear (Abrasion) Broken/Fractured Bone

Scratches Muscle Soreness

Other

SERIOUS INJURY:

Use this selection for indicating if a serious injury had occurred during the incident. Type the injury type. Use the Injury Date/Time to record as accurately as possible. If medical care was provided, please document the date/time the medical attention was provided as well as if any additional details of the serious injury can be documented with the selection boxes. If a response is not available, the "Other" option allows for free text entry.

Serious Injury

Injury Type

Injury Date/Time

Date/Time Medical Attn Provided

Bruise Cut

Skin Tear (Abrasion) Broken/Fractured Bone

Scratches Muscle Soreness

Other

DEATH:

This is used to document the resident's death. If this selection is made, you must contact CMS. Document the Date/Time Resident Found as accurately as possible. Use the checkboxes to indicate if the death was related to any of the options. If the reason is unknown, please type "unknown" into the "Other" box.

Death

CMS Contacted

Name of Person Contacted

Date/Time of Death

Suicide Accident

Seclusion Medical Condition

Restraint

Other

SUICIDE ATTEMPT:

Please document the date/time the resident was last seen as accurately as possible. Please choose the "Yes" or "No" for the two questions. If the youth was returned to the facility, the Return Date/Time is required. Record the Date/Time Resident Found by Staff as accurately as possible.

Suicide Attempt

Suicide Type

Date/Time Resident Last Seen

Date/Time Resident Found by Staff


Was the Resident Responsive? Yes No

SERIOUS ILLNESS:

The Serious Illness is to report if the resident required medical attention and if it was provided. If the resident received medical attention please select "Yes" if no medical attention was provided please select "No". Please document the date/time the resident received medical attention.

Serious Illness

Medical Attention Provided Yes No


Date/Time Medical Attention Provided 

OTHER:

The Other item is used to document any incident that is not or cannot be documented in the above selections. "Other" is a free text entry. Please provide the date and time if medical attention was received.

Other

Other Type

Date/Time Medical Attention Provided 

SUMMARY OF INCIDENT:

This may be used to document additional details of the incident. You can add additional comments within the text box provided. If additional information is more than half a page of a word document, please attach additional information using a file extensions PDF, JPEG, or GIF formats. You may choose EITHER Text Box or Attachment, but you may not use both.

Only one selection is allowed for the Summary of Incident text or attachment. If you toggle between the selections your previous entry will clear.

Summary of Incident

Text Box Attachment

ACTIONS TAKEN:

This is the fourth section of the incident reporting document. Actions Taken refers to the facility's response to the incident.



In the first area, please select a single response or all that apply. If none of the responses are appropriate, please use the Additional Facility Response. You can add additional comments within the text box provided. If additional information is more than half a page of a word

document, please instead attach additional information using a file extension in PDF, JPEG, or GIF formats.

Only one selection is allowed for the Additional Facility Response text or attachment. If you toggle between the selections your previous entry will clear.

Please check all that apply. If none apply, please provide additional details in the Additional Facility Response section:

- Emergency Dept.
- First Aid
- Hospitalization
- Outpatient Medical Treatment
- Increased Supervision

Additional Facility Response

Text Box Attachment

Please select at least one option from "Check All that Apply" or "Additional Facility Response".

SUBSTANTIATION AND ACTION:

Please answer the six questions by choosing a "Yes" or "No" option with the date and time of notifications. A response is required for each question. If you have not completed any of these items, please save your page and return it when completed. If you are not a PRTF facility, the first three questions are not required, please enter a "No".

Substantiation and Action

Did a face to face assessment take place between staff and resident within one hour of the incident?

Yes No 

Did a debriefing session occur between the staff and resident within 24 hours of the incident?

Yes No 

Did a debriefing session occur between all staff involved in the incident?

Yes No 

Was the guardian notified?

Yes No 

Was law enforcement notified?

Yes No 

Was leadership notified?

Yes No 

In this section, please choose all that apply. This is for additional facility action. Based on your selection, the item may expand to ask for additional information.

Please Choose all that apply:

- Active Treatment / Plan of Care Reviewed / Revised
- Personal Education / Training
- Abuse / Neglect
- Personnel Suspended
- Personnel Terminated
- Facility Procedures Reviewed/Revised

Under Choose All at Apply on screen 4, the following if selected will need to have more information. Abuse/Neglect: Did you report to Central Intake? Select "Yes" or "No".

Personnel Suspended or Personnel Terminated has the option to add multiple staff members, if appropriate. To add or view, please click the button.

Please Choose all that apply:

- Active Treatment / Plan of Care Reviewed / Revised
- Personal Education / Training
- Abuse / Neglect
 - Report to Central intake?
 - Yes No
- Personnel Suspended
[+ Add New / View](#)
- Personnel Terminated
[+ Add New / View](#)
- Facility Procedures Reviewed/Revised

Personnel Suspended allows for the entry of the staff member's name, title, license number, hire date (required), SSN, current address, previous actions taken with personnel, and explanation of the suspension. Once all information has been entered, click the "+Add" to complete the record. If additional personnel need to be added, repeat the steps. If all are entered, return to the incident form by clicking "Done".

Personnel Suspended

Name Title License Number

Hire Date SSN

Current Address

Previous Actions

Explain

+ Add ✓ Done

Personal Suspended

ID	Name	Title	License #	Hire Date	SSN	Action
No data available!						

Go to page: Row count:

↺ Reset ✕ Cancel

Personnel Terminated allows for the entry of the staff member's name, title, license number, hire date (required), SSN, current address, previous actions taken with personnel, and explanation of the termination. Once all information has been entered, click the "+Add" to complete the record. If additional personnel need to be added, repeat the steps. If all are entered, return to the incident form by clicking "Done".

Personnel Terminated

Name Title License Number

Hire Date SSN

Current Address

Previous Actions

Explain

+ Add ✓ Done

Personal Terminated

ID	Name	Title	License #	Hire Date	SSN	Action
No data available!						

Go to page: Row count:

↺ Reset ✕ Cancel

DISCLAIMER AND SIGNATURE:

This is the fifth section of the incident reporting document. The Disclaimer and Signature page will display the attachments that have been added in the incident summary in Section Three or the Actions Taken in Section Four.



Please type in your signature and add the date. By signing below, you certify that your answers are true and correct to the best of your knowledge.

A submission should be completed in its entirety before clicking the submit button. If edits need to be made, please use the "Save" button versus the "Submit" button. Once you click the "Submit" button, no further edits can be made to the incident form.

By signing below, I Certify that my answers are true and correct to the best of my knowledge.

Signature Date

[← Previous](#) [✕ Cancel](#) [✓ Save](#) [✓ Submit](#)

ATTACHMENTS

You may add attachments in either a PDF, JPEG, and/or GIF format. These attachments can be added to the incident summary in Section Three or the Actions Taken in Section Four. Each attachment can be a max of 10 MB. Please review your attachments. If you are not able to clearly read the document attached, the reviewing agencies will encounter the same difficulty.

Disclaimer Information

Attachments

Incident Summary

Actions Taken

SUBMISSION

Once you hit "OK", the program will give you an Incident number in your Communications list.

This action will close the incident report. Corrections, additions, or additional information will need to be added to the communications options.

appstest.sd.gov says

PRTF form has been submitted successfully. PRTF reference number:
20221010500000

OK

STATUS INFORMATION

In Process

The incident has been started but has not yet been sent for agency review.

Submitted

The incident has been completed and submitted to the agency for review. **Once the incident has been submitted no more changes will be allowed.**

In-Review

The incident review has been started by the agency and a communication channel has been opened.

Request for Info

One or both agencies are requesting additional information from the facility.

Reply

This will indicate that the facility has commented or attached documentation for a response.

Closed

The incident has been reviewed and closed by both agencies.

COMMUNICATION LIST

The communication list will show a history of all statuses as listed above. The default priority order for a user is:

- 1- In-Process
- 2- Request for Info
- 3- In-Review
- 4- Submitted
- 5- Reply
- 6- Closed

Locked

As a user, you may see that incident is locked. This means that the incident is currently in use by another user. If you hover over the padlock or hit update, it will give you the email of the person working on the claim. The record cannot be viewed until the person exits the claim, or in this case, they have walked away from their computer, 24 hours later.

Search Options

A user or provider administrator can use any of the combinations to search for a specific communication on an incident.

PRTF Communication

Status info <input type="text"/>	Ref. ID <input type="text"/>	BNPI <input type="text"/>	FACIS ID <input type="text"/>
From DOI <input type="text"/>	To DOI <input type="text"/>	Recip. ID <input type="text"/>	DOA <input type="text"/>

In-Process - Incident has been started but has not yet been sent to agency.
Submitted - Incident has been completed and sent to agency.
In-Review - Incident review has been started by the agency and communication channel has been opened.
Request for Info - Agency is requesting additional documentation.
Reply - Facility has Provided additional documentation.
Closed - Incident has been reviewed and closed by both agencies.

Status Info:

Search options are limited to drop-down of the statuses In process, Submitted, In Review, Request for Info, Reply, or closed.

Ref. ID:

This is related to the Incident ID number given to the form and communication channel created.

BNPI:

If the user or provider administrator has multiple billing national provider identifiers (BNPI), this can be used to search for the specific BNPI needed.

FACIS ID:

This is used if the FACIS Facility Id is known. It will require to start with an "R" followed by the respective 14 digits.

From DOI:

You may search by the start of the date of the incident (DOI). Make sure the date is formatted to MM/DD/YYYY or you may select it from the calendar.

To DOI:

You may search by the end of the date of the incident (DOI). Make sure the date is formatted to MM/DD/YYYY or you may select it from the calendar.

Recip ID:

This is specific to the resident's Medicaid id number. This must be 9 numerical digits long.

DOA:

This is for the date of admission search. Make sure the date is formatted to MM/DD/YYYY or you may select it from the calendar.

INCIDENT REVIEW

The incident review will be opened when the user clicks on the communication button of the selected incident. The incident, based on the user's permissions, will allow for communication

pathways to be opened. There are three different pathways a user will have access to. OLA and DOH statuses will display as listed under status information.

Provider to Department of Health:

This communication is between the provider and the Department of Health only. This information will not be shared with the Office of Licensing and Accreditation.

Provider to Office of Licensing and Accreditation:

This communication is between the provider and the Office of Licensing and Accreditation only. This information will not be shared with the Department of Health.

Provider to Department of Health and Office of Licensing and Accreditation:

This communication is between the provider, the Department of Health, and the Office of Licensing and Accreditation.

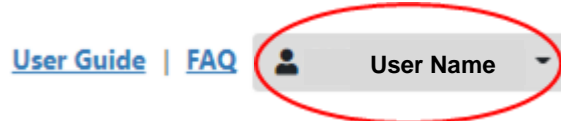
The screenshot shows a form titled "Incident Review" with a green header. Below the header are several input fields and dropdown menus. The first row contains "OLA Status" (dropdown), "DOH Status" (dropdown), "Incident Ref. Num" (text), "Billing NPI" (text), and "FACIS ID" (text). The second row contains "Status info" (dropdown), "Status info" (dropdown), "Inc Ref #" (text), "Serv NPI" (text), and "FACIS ID" (text). The third row contains "Start Date/Time of Inc." (text), "End Date/Time of Inc." (text), "Recipient ID" (text), and "Date of Admission" (text). The fourth row contains "From DOI" (text), "To DOI" (text), "Recipient ID" (text), and "DoA" (text). Below these fields are three radio button options: "Provider & DOH Comments", "Provider, DOH, & OLA Comments", and "Provider & OLA Comments". At the bottom are two buttons: "Update" (green) and "Close" (red).

The communication options can be used to update or add additional information related to the incident form. For example, if the resident required Medical Attention after the incident was completed, a comment may be added under the channel of Provider, DOH, and OLA. This will allow for all parties to be notified of additional action that was required.

FREQUENTLY ASKED QUESTIONS

1. What if the resident involved with the incident is from out of state or has an out-of-state Medicaid ID Number?
 - a. Please refer to the [resident information](#) for the nine 9's use.
2. Do I need to fill out separate forms for the Office Licensing and Accreditation (OLA) and Department of Health (DOH)?
 - a. No, the form is universal. Although, some information will be required for DOH but not for OLA.

3. Under the facility information is the Provider's License Number or CMS Certification number needed?
 - a. These two fields are only required if reporting an incident to the Department of Health. Group Care/FACIS only facilities do not require this information.
4. How do I find my facility's NPI that I have access to?
 - a. Log into your account. Then go to the right side of the screen and click on your name.



- b. After clicking on your name, choose "My Profile". This will open to a window that will display the NPI's I control.
 - c. The list will show what NPIs you have access to with your profile.

