

**REPORT OF A HOSPITAL DEATH ASSOCIATED WITH THE USE OF RESTRAINT OR SECLUSION**

**CMS-10455 (Revised)**

**\*\*If a Two Point Soft Wrist Restraint was used alone without use of seclusion, drug used as restraint, or other physical restraint, DO NOT SEND REPORT OF DEATH TO THE RO. Documentation of this death must be entered in the hospital/CAH internal log or tracking system as well as in the patient's medical record, per 42 CFR § 482.13(g).**

**If any other combination of restraint and/or seclusion was used, COMPLETE SECTIONS A-D**

**A. Hospital Information:**

Hospital Name		CCN
Address		
City	State	Zip Code
Name of Person Filing the Report		Filer's Phone Number
Title of Person Filing the Report		

**B. Patient Information:**

Name	Date of Birth	
Primary Diagnosis(es) / Psychiatric Diagnosis(es) if applicable:		
Date of Admission	Date of Death	Time of Death
Condition Leading to Death		

Mortality Review to be Completed:  Yes  No      Report Submission Documented in Medical Record  Yes  No

**C. Restraint Information Part I (check only one) - Patient Death Occurred:**

- While in Restraint, Seclusion, or Both
- Within 24 Hours of Removal of Restraint, Seclusion, or Both
- Within 1 Week, Where Restraint, Seclusion or Both is **REASONABLE TO ASSUME** Contributed to the Patient's Death

Type (check all that apply):

- Physical Restraint     Seclusion     Drug Used as a Restraint

If Physical Restraint(s), Type (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Two Point, Hard Wrist  | <input type="checkbox"/> Vest Restraint                          |
| <input type="checkbox"/> Two Point, Soft Wrist  | <input type="checkbox"/> Elbow Immobilizer                       |
| <input type="checkbox"/> Four Point, Soft   | <input type="checkbox"/> Bilateral Secured Mitten                |
| <input type="checkbox"/> Four Point, Hard   | <input type="checkbox"/> Bilateral Unsecured Mitten              |
| <input type="checkbox"/> Side Rail (x4)   | <input type="checkbox"/> Roll Belt                               |
| <input type="checkbox"/> Soft Ankle <input type="checkbox"/> (x1) <input type="checkbox"/> (x2) | <input type="checkbox"/> Lap Belt                                |
| <input type="checkbox"/> Forced Medication Hold   | <input type="checkbox"/> Drug Used as Restraint/Violent Behavior |
| <input type="checkbox"/> Therapeutic Hold   | <input type="checkbox"/> Spit hood                               |
| <input type="checkbox"/> Take-down  | <input type="checkbox"/> Other Restraint Type: _____             |
| <input type="checkbox"/> Enclosed Bed   |  |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1210 (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **0.33 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **\*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Caroline D. Gallaher at [caroline.gallaher@cms.hhs.gov](mailto:caroline.gallaher@cms.hhs.gov)**

---

**D. Restraint Information Part II:**

---

1. Reason(s) for Restraint/Seclusion use: \_\_\_\_\_

2. Circumstances Surrounding Death: \_\_\_\_\_

3. Restraint/Seclusion Order Details:

a. Date & Time Restraint/Seclusion Applied: \_\_\_\_\_

b. Date & Time Patient Last Monitored: \_\_\_\_\_

c. Total Length of Time in Restraint/Seclusion: \_\_\_\_\_

d. Drug: Name/Route/Dose/Time: \_\_\_\_\_

4. Was restraint/seclusion used to manage violent or self-destructive behavior? If **NO**, stop here.  Yes  No

a. If **YES**, was 1 hour face-to-face evaluation documented?  Yes  No

b. Date/Time of Last Face-to-face Evaluation: \_\_\_\_\_

c. Was the order renewed at appropriate intervals based on patient's age?  Yes  No

5. If simultaneous restraint and seclusion ordered, describe continuous monitoring method(s): \_\_\_\_\_

---

**For Regional Office to Complete:**

---

**E. RO Action(s):**

1. Was a survey authorized?  Yes  No

If **YES**, date SA received authorization for investigation: \_\_\_\_\_

If **NO**, provide brief rationale: \_\_\_\_\_

2. In the past two years, has a survey related to a restraint/seclusion death at this hospital resulted in finding condition-level or IJ patients' rights deficiencies?  Yes  No

3. If applicable, what deficiencies were cited related to Restraint/Seclusion or patient rights: \_\_\_\_\_

4. If an Immediate Jeopardy (IJ) was cited, was the Accrediting Organization notified (if deemed)? \_\_\_\_\_

5. Does Protection & Advocacy (P&A) have a current Data Use Agreement (DUA): (Do not notify the P&A unless a survey was authorized)  Yes  No

6. If answer to E1 and E5 is **YES**, date RO notified P&A \_\_\_\_\_

---

CMS-10455 (Revised 2017)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1210 (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **0.33 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **\*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Caroline D. Gallaher at [caroline.gallaher@cms.hhs.gov](mailto:caroline.gallaher@cms.hhs.gov)**