

**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE**

DMS-731

Incident & Accident Next Day Reporting Form

Purpose/Process

This form is designed to standardize and facilitate the process for the reporting allegations of resident abuse, neglect, misappropriation of property or injuries of an unknown source by individuals providing services to residents in Arkansas long term care facilities for next day reporting pursuant to Section 507.1.

The purpose of this process is for the facility to compile the information required in the form DMS-731, so that next day reporting of the incident or accident can be made to the Office of Long Term Care.

Completion/Routing

This form, with the exception of hand written witness statements, MUST BE TYPED!

The following sections are **not** to be completed by the facility; the Office of Long Term Care completes them:

1. The top section entitled COPIES FOR:
2. The FOR OLTC USE ONLY section found at the bottom of the form.

All remaining spaces must be completed. If the information can not be obtained, please provide an explanation, such as “moved/address unknown”, “unlisted phone”, etc.

If a requested attachment can not be provided please provide an explanation why it can not be furnished or when it will be forwarded to OLTC.

The original of this form must be faxed to the Office of Long Term Care the next business day following discover by the facility. Any material submitted as copies or attachments must be legible and of such quality to allow recopying.

COPIES ATY GEN _____ PASARR _____ APS _____ OLTC ENG _____ QMRP _____
 FOR OLTC PAHRM _____ NEXT VISIT _____ FOLLOW UP NEEDED _____ SPC VISIT # _____
 DATE: _____ INITIAL: _____ NOTES: _____

OLTC INCIDENT AND ACCIDENT REPORT (I&A)

Date & Time Submitted (if known): _____ Date & Time of Discovery: _____

Facility Name: _____

Facility Area Code and telephone # () _____

Facility Address: _____

Staff reporting I & A: _____ Title: _____

Date of I & A _____ Time: _____ AM or PM

Name of Injured Resident: _____ Age: _____ Sex: _____ Race: _____

Status of Alleged Perpetrator: Facility Employee Family Visitor Other Unknown

Type of Incident: **Neglect** _____ **Misappropriation of Property:** Drugs _____
Abuse: Verbal _____ Personal Property _____
 Sexual _____ Resident Trust Fund _____
 Physical _____
 Emotional/Mental _____

NOTIFICATIONS: FAMILY: Yes No DOCTOR: Yes No

LAW ENFORCEMENT: Yes No ADMINISTRATOR: Yes No

Summary of Incident: _____

(cont. on page 2)

Steps taken to prevent continued abuse or neglect during the investigation: _____

(cont. on page 3)

FOR OLTC USE ONLY

CODES: A-Abuse E-Elopement F-Fire PO-Power outage DI-Disease OT-Other
 RA-Res to Res Abuse MP-Misappropriation of Property UD-Unusual Death
 ND-Natural Death IUS-Injury of Unknown Source NG-Neglect

**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
OFFICE OF LONG TERM CARE**

DMS-742

**Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property,
& Exploitation of Residents in Long Term Care Facilities**

Purpose/Process

This form is designed to standardize and facilitate the process for the reporting allegations of resident abuse, neglect, or misappropriation of property or exploitation of residents by individuals providing services to residents in Arkansas long term care facilities. This investigative format complies with the current regulations requiring an internal investigation of such incidents and submittal of the written findings to the Office of Long Term Care (OLTC) within five (5) working days.

The purpose of this process is for the facility to compile a substantial body of credible information to enable the Office of Long Term Care to determine if additional information is required by the facility, or if an allegation against an individual(s) can be validated based on the contents of the report.

Completion/Routing

This form, with the exception of hand written witness statements, MUST BE TYPED!

Complete **all** spaces! If the information can not be obtained, please provide an explanation, such as “moved/address unknown”, “unlisted phone”, etc. Required information includes the actions taken to prevent continued abuse or neglect during the investigation.

If a requested attachment can not be provided please provide an explanation why it can not be furnished or when it will be forwarded to OLTC.

This form, and all witness and accused party statements, **must be originals**. Other material submitted as copies must be legible and of such quality to allow re-copying.

The facility’s investigation and this form must be completed and submitted to OLTC within five (5) working days from when the incident became known to the facility.

Upon completion, send the form by certified mail to:
Office of Long Term Care, P.O. Box 8059, Slot 404, Little Rock, AR 72203-8059.

Any other routing or disclosure of the contents of this report, except as provided for in LTC 507.4 and 507.5, may violate state and federal law.

**Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property,
& Exploitation of Residents in Long Term Care Facilities**

Section I-Reporting Information

Name of Facility: _____

Phone #: (_____) _____

Address: _____

City _____ State _____ Zip Code _____

Facility Staff Member Completing DMS 762: _____

Title: _____

Date Incident Reported/Faxed to OLTC: _____ Time: _____ AM/PM

Date & Time of Incident (if known): _____

Time & Time of Discovery: _____

Type of Incident: Neglect _____	Misappropriation of Property:	Drugs _____
Abuse: Verbal _____		Personal Property _____
Sexual _____		Resident's Trust Fund _____
Physical _____		
Emotional/Mental _____		

Name of Involved Resident: _____ Room #: _____

Social Security #: _____ DOB: _____

Height _____ Weight _____ Physician _____

Is Resident still Living: _____ If not, Date of Death: _____

Ambulatory? YES _____ NO _____ Oriented Time, Place, Person, Events (Circle one or all).

Physical Functional Level/Impairment _____

Mental Functional Level _____

Primary Diagnosis _____

Section IV- Notification/ Status

Administrator/Written Designee Must Be Notified!

Name of Administrator _____

Date: _____ Time: _____ AM / PM

Family Notified: YES _____ NO _____ NONE _____ Date: _____ Time: _____ AM/PM

Name of Family Member: _____

Relationship: _____ Phone #: _____

Doctor Notified: YES _____ NO _____ Date: _____ Time: _____ AM/PM

Doctor's Name: _____ Phone #: _____

Resident Sent to Hospital: YES _____ NO _____ Date: _____ Time: _____ AM/PM

Admitted to Hospital: YES _____ NO _____

Name/ Address/ Phone of Hospital: _____

Law Enforcement Must Be Notified for abuse and neglect

Date: _____ Time: _____ AM/PM

Name of Law Enforcement Agency: _____

Phone #: _____

Address: _____

City/Zip: _____

Was an Investigation Made by the Law Enforcement Agency?: YES _____ NO _____

Date of Investigation: _____ Time: _____

Name of Officer: _____

Section VI-Accused Party Information

Name of Accused Party: _____

Job Title (if any): _____ Phone #: _____

Home Address: _____

City/State/Zip: _____

Social Security #: _____ DOB: _____

Dates of Current Employment: From _____ To _____

Certified Nursing Assistant: YES _____ NO _____

Registration # : _____ Date Issued: _____

Date Criminal Background Check Completed: _____

Licensed by State Board of Nursing: YES _____ NO _____

Type of License: RN # _____ LPN # _____

Date Issued: _____

Section VII- Attachments

Attach the following information to the back of this form. If you do not have one of the specified attachments, please provide an explanation why it can not be obtained or if it will be forwarded in the future.

1. Statement from the accused party.
2. All witness statements. Use the attached OLTC Witness Statement Form for all witness statements submitted. If the statement is a typed copy of a handwritten statement, the handwritten statement must accompany the typed statement.
3. Law enforcement incident report. This can be mailed at a later date if necessary.
4. Other pertinent reports/information, such as Ombudsmen, autopsy, reports, etc. These can be mailed at a later date if necessary.

C. If privately owned list Ownership status

(1) [] Sole Proprietorship (2) [] Partnership (3) [] Corporation

Partnership: List names and addresses of partner

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

Corporation: List names and addresses of corporate officers and percentage of individuals owning 5% or more stock (List % of ownership by the individual's names)

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

Non-Profit: List names and addresses of Board of Directors of the Governing Body

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

D. If ownership of building is different from the person(s) or group operating the facility, explain the relationship including names and addresses of the owner(s).

<u>Name</u>	<u>Address</u>
_____	_____
_____	_____
_____	_____

II. Licensure

A. Number of beds _____ (Total) _____ (Level I) _____ (Level II)

B. If above total is different from that which you are currently licensed, explain the difference

C. Name and address of facility manager/director if different from the ownership

_____	_____
Name	Address
_____	_____
State	Telephone #

III. Certification and Verification

State of _____ County of _____

I hereby certify that I have read the aforementioned Application and that all statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any material fact contained on the Application will subject me to penalties as prescribed in the State Licensing Law including, but limited to revocation and/or suspension of this license.

I further affirm that I understand that I am eligible for a license only if the facility is in compliance with the law and regulations thereunder, and that the Office of Long Term Care is empowered to deny, suspend, or revoke my license on any of the grounds listed in the State Licensing Law.

Signature of person(s) authorized to sign in
accordance with instruction II. C

Subscribed and sworn to before me on this the _____ day of _____,

Notary Public

(Notary Seal)

My Commission expires on _____

INSTRUCTIONS

- A. Enclosed are two (2) copies of Application for Licensure. Complete one copy and return to the Office of Long Term Care and retain one copy for your files.
- B. Please read these instructions carefully and complete this application in full. This application must be completed in ink or typed.
- C. This application is not valid unless it is notarized.
- D. This license application must be signed by the following person(s) dependent upon the type of management and ownership.
 - 1. If the institution is public (i.e., County, City, etc.) it must be signed by the person who is head of the governmental department having jurisdiction over it (i.e., Chairman of County Board or Chairman of Commission) or his duly authorized representative. This authorization must be in writing, notarized and submitted along with this application.
 - 2. If the institution is private, it must be signed by the following dependent upon the type of business organization.

<u>Type</u>	<u>Signer</u>
Sole Proprietorship	Owner
Partnership	One of the partner
Corporation, Church, Non-Profit Association	

If someone other than the above named is authorized to sign in his or her behalf, such authorization must be in writing, notarized and attached to this application.

- E. All license expire on **midnight June 30 of the calendar year** in which they are issued.
- F. Application for annual renewal **must be postmarked no later than June 1 of the current year** in order to avoid the payment of a penalty. This penalty shall be 10% of the facility's licensure fee.
- G. This application should be returned by **certified mail** to the following address:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LONG TERM CARE
P.O. BOX 8059 SLOT S408
LITTLE ROCK, AR 72203

Please make certain that you use the above listed address only. All other addresses used could cause delays and may result in penalties being applied to your annual licensure renewal fees.

- H. **A check or money order for the required licensure fee made payable to Arkansas Department of Health and Human Services must accompany this submission except for those facilities operated by the State, County or City.**

Licensure Fee: \$10.00 per bed