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 II-Complete Description of Incident

"See Attached Is Not Acceptable!"

(Attach Additional Pages as Necessary)

Section III- Findings and Actions Taken

Please include Resident's current medical condition

Facility Administrator’s Signature

Date

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.

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OLTC Witness Statement Form

Date:_____ Time:_____AM/ PM

Witness Full Name:_____

Job Title:_____ Shift:_____

Home Address:_____ City/Zip_____

Home Phone #:_____ Work Phone #:_____

Relation to Resident (If Any?)_____

State in your own words what you witnessed (be very descriptive) and sign below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ (Continue on Back as Necessary)

The information provided above is true to the best of my knowledge:

Signature of Witness:_____ Date:_____