



150 N. 18th Ave., Ste. 440
 Phoenix, AZ 85007
 Phone: (602) 364-2690
 After Hours: (602) 364-2677
 Fax: (602) 324-0993

400 W. Congress, Ste. 116
 Tucson, AZ 85701
 Phone: (520) 628-6965
 After Hours: (520) 628-6973

REPORTABLE EVENT RECORD/REPORT

Please answer all questions fully and address only one event per report
 Submit via Fax within 5 days of event

Today's Date (mm/dd/yyyy)	Date of Event (mm/dd/yyyy)	Time of Event <input type="checkbox"/> AM <input type="checkbox"/> PM
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Was this a significant event? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was significant event called in? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date (mm/dd/yyyy)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM
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Full Name of Facility

Street Address

City	State	Zip Code
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Facility Telephone Number	Facility License Number	Provider ID Number
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Person Reporting	Title
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Type of Incident:

<input type="checkbox"/> Elopement	<input type="checkbox"/> Injury Unknown Origin
<input type="checkbox"/> Environmental Emergency	<input type="checkbox"/> Neglect
<input type="checkbox"/> Financial Exploitation	<input type="checkbox"/> Resident Care
<input type="checkbox"/> Injury	<input type="checkbox"/> Resident-to-Resident Abuse
<input type="checkbox"/> Incident	<input type="checkbox"/> Staff-to-Resident Abuse
<input type="checkbox"/> Involuntary Discharge	<input type="checkbox"/> Unexpected Death
<input type="checkbox"/> Other, Specify:	

Who was notified of the occurrence?

<input type="checkbox"/> Law Enforcement	Police Dept. Name	Case Number	Officer
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<input type="checkbox"/> Nursing Board	<input type="checkbox"/> Medical Examiners	<input type="checkbox"/> Pharmacy Board	<input type="checkbox"/> Physician	<input type="checkbox"/> Ombudsman	<input type="checkbox"/> APS
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<input type="checkbox"/> Family/Guardian	<input type="checkbox"/> Other
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Pool Agency (Name and Phone Number)

REPORTABLE EVENT RECORD/REPORT
(Continued)

Resident Name	Date of Admission	Date of Birth
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Exact Location of Incident:

Narrative:
1) Describe the event, including timeframes/risk factors related to the incident/event (relevant resident dx and cognitive status)

2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? For example, a chair alarm or a lap buddy in place.
 Yes No Please describe:

3) What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:

REPORTABLE EVENT RECORD/REPORT
(Continued)

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

Use Separate sheet for each witness/person interviewed

Witness Statement Form		
Date:	Time:	<input type="checkbox"/> AM <input type="checkbox"/> 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.

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

Signature of Witness	Date
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