Arizona Department of Health Services
Division of Licensing Services
Long Term Care Licensing

Confidential File
Date:_____
Init:_____

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 ☐ AM ☐ PM

Was this a significant event? ☐ Yes ☐ No	Was significant event called in? ☐ Yes ☐ No	Date (mm/dd/yyyy)	Time ☐ AM ☐ PM

Full Name of Facility

Street Address

City	State	Zip Code

Facility Telephone Number	Facility License Number	Provider ID Number

Person Reporting	Title

Type of Incident:
☐ Elopement
☐ Environmental Emergency
☐ Financial Exploitation
☐ Injury
☐ Incident
☐ Involuntary Discharge
☐ Other, Specify:
☐ Injury Unknown Origin
☐ Neglect
☐ Resident Care
☐ Resident-to-Resident Abuse
☐ Staff-to-Resident Abuse
☐ Unexpected Death

Who was notified of the occurrence?

☐ Law Enforcement	Police Dept. Name	Case Number	Officer

☐ Nursing Board	☐ Medical Examiners	☐ Pharmacy Board	☐ Physician	☐ Ombudsman	☐ APS

☐ Family/Guardian	☐ Other
☐ Pool Agency (Name and Phone Number)	

Resident Name	Date of Admission	Date of Birth

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:

Is the event an allegation of abuse, neglect or misappropriation of funds? If yes, complete the following:	☐ Yes	☐ No

ALLEGED PERPETRATOR INFORMATION			
Name: Last	First	MI	Alias

Address:			
Street/Box	City	State	Zip

Telephone Number:	Date of Hire:

AP Suspended? ☐ Yes ☐ No	Date:	AP Terminated? ☐ Yes ☐ No	Date:

CREDENTIALING/LICENSURE INFORMATION	
Certificate or License No.	
Type of Certification (check all that apply)	
☐ Nurse Aid (NA)	☐ Certified Nurse Aid (CNA)
☐ Registered Nurse (RN)	☐ Licensed Practical Nurse (LPN)
☐ Other (specify type:)	

FOR ADHS USE ONLY

Reviewed By	Date	AZ Intake #
Second Reviewer	Date	Date Report Received:

Disposition:	☐ Complaint Investigation	☐ No Action	☐ Pending	☐ Offsite Investigation

☐ Referral, specify:	

☐ Closed, specify date closed:	

Comments:

Facility Investigation Report for Rresident 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:	☐ 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.

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

Signature of Witness	Date