ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

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

150 N. 18th Ave., Ste. 440
Phoenix, AZ 85007
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Confidential File
Date:_____
Init:_____

REPORTABLE EVENT RECORD/REPORT

Please answer ALL questions fully and address only one event per report.
Complete Investigations Include: staff,resident, and witness interviews as well as ALL pertinent information.
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

Full Name of Facility

Street Address

City	State	Zip Code

Facility Telephone Number	Facility License Number	Provider ID/CCN

Person Reporting	Title

Type of Incident (check all that apply):

- ☐ 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 (check all that apply)?

☐ Law Enforcement - Police Dept. Name | Case Number | Officer

- ☐ Nursing Board
- ☐ APS
- ☐ Physician
- ☐ Pharmacy Board
- ☐ Family/Guardian
- ☐ Medical Examiner
- ☐ Ombudsman
- ☐ ADHS (Name of surveyor you spoke to and time you called.)
- ☐ Other

Is the event an allegation of abuse, neglect or misappropriation of funds? If yes, complete the Alleged Perpetrator Information Section.	☐ Yes	☐ No

ALLEGED PERPETRATOR INFORMATION			
Name: Last	First	MI	Alias

Address:			
Street/Box	City	State	Zip

Telephone Number	Date of Hire (mm/dd/yyyy)

AP Suspended? ☐ Yes ☐ No	Date (mm/dd/yyyy)	AP Terminated? ☐ Yes ☐ No	Date (mm/dd/yyyy)

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:)	

Resident Name	Date of Admission (mm/dd/yyyy)	Date of Birth (mm/dd/yyyy)

Exact Location of Incident

Narrative:
1) Describe the event, including timeframes/risk factors related to the incident/event (relevant resident dx and cognitive status. If resident to resident altercation is this the first time the resident was involved in an altercation?)

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:

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