TEXAS Department of Aging and Disability Services

Provider Investigation Report

For use **only** by Skilled Nursing Facilities (**SNF**), Nursing Facilities (**NF**), Intermediate Care Facilities for Individual with an Intellectual Disability or Related Conditions (**ICF/IID**), Assisted Living Facilities (**ALF**), Adult Day Care Facilities (**ADC**), and Day and Activity Health Services Facilities (**DAHS**).

Fax Cover Sheet

Date: _____

To: **DADS Consumer Rights and Services Section**

Attention: **Intake Coordinator**

Fax Area Code and Telephone No.: **1-877-438-5827**

Regarding DADS Intake ID No.: _____

No. of Pages, including cover: _____

From:

Provider Name: _____ **Vendor / ID No.:** _____

Street Address: _____

City: _____

Telephone No.: _____ – _____ – _____

Fax: _____ – _____ – _____

Provider Investigation Report Information

Agency Name		License No.
Street Address		
City, State, ZIP Code		County
Area Code and Telephone No. – –	Fax Area Code and Telephone No. – –	☐ Parent ☐ Branch/Alternate Delivery Site

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SNF, NF, ICF/IID, ALF, ADC, DAHS

Provider Investigation Report

Fax this report to: 1-877-438-5827 (toll free)
or
Mail this report to: Texas Department of Aging and Disability Services, Consumer Rights and Services Section, E-249, P.O. Box 149030, Austin, TX 78714-9030

Note to reporter: Do not mail if faxed.

DADS Intake ID No.	Date Reported to DADS 800-458-9858	Time Reported : ☐ A.M. ☐ P.M.

Provider Type	Vendor / ID No.	Telephone No. – –
Name		Fax – –
Street Address	City	ZIP Code

Incident Category
☐ Death ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Missing Resident/Individual ☐ Drug Diversion ☐ Fire ☐ Bomb Threat
☐ Tornado ☐ Flood ☐ Emergency Power Failure ☐ Sprinkler System Failure ☐ Fire Alarm Failure ☐ Firearms in the Building
☐ Air Conditioning Failure if Outdoor Temperature is or will be 90 Degrees or Above
☐ Heating System Failure if Outdoor Temperature is 65 Degrees or Below
☐ Others, specify

Who made the allegation? ☐ Individual /Resident ☐ Family ☐ Other | When?

Incident Date	Time : ☐ A.M. ☐ P.M.	Location

Individual(s)/Resident(s) Involved, Including Alleged Victim(s) or Alleged Aggressor(s)

Name	☐ Female ☐ Male	Social Security No.	Date of Birth

Functional Ability: ☐ Total assistance ☐ Extensive ☐ Minimal ☐ No assistance
Level of Supervision: ☐ No special supervision ☐ Within eyesight ☐ Within hearing ☐ Within arm's length
☐ Within specified distance: ________ ☐ Specified observation time frame: ________
Other: ________
Independently ambulatory ☐ Y ☐ N Interviewable ☐ Y ☐ N Capacity to make informed decisions ☐ Y ☐ N
History of ☐ Combativeness ☐ Verbal aggression ☐ Physical aggression ☐ Sexual misconduct
☐ Wandering Wearing wander guard at time of incident ☐ Y ☐ N ☐ Similar allegations
Other pertinent history:

Name	☐ Female ☐ Male	Social Security No.	Date of Birth

Functional Ability: ☐ Total assistance ☐ Extensive ☐ Minimal ☐ No assistance
Level of Supervision: ☐ No special supervision ☐ Within eyesight ☐ Within hearing ☐ Within arm's length
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Other pertinent history:

DADS Intake ID No.

Alleged Perpetrator(s) (AP)

(If alleged perpetrator is somebody other than a staff member, indicate this individual's relationship to the person. E**xample:** relative, visitor, etc.)

Name	Date of Birth	Social Security No.	License/Certificate No.

How was the AP identified? ☐ By name ☐ By description ☐ Other: _____

Perpetrator: ☐ Denied ☐ Confirmed History of similar allegations? ..... ☐ **Yes** ☐ **No**

Did investigation reveal the presence of a witness? ..... ☐ **Yes** ☐ **No**

Statement attached (signed and notarized, if possible) ..... ☐ **Yes** ☐ **No**

Witness(es) Name	Individual/Patient/Family/Staff/Other	Address	Area Code and Telephone No.
			– –
			– –
			– –
			– –

Description of the Allegation

Injury/Adverse Effect? ..... ☐ **Yes** ☐ **No**

Description of Injury

Assessment	Date	Time : ☐ A.M. ☐ P.M.

Description of Assessment

Treatment provided? ..... ☐ **Yes** ☐ **No**	Treatment/Transfer Date	Time : ☐ A.M. ☐ P.M.
Treatment location: In-House..... ☐ **Yes** ☐ **No**	Off-site	City

Provider Response

DADS Intake ID No.

Investigation Summary (attach additional sheets, as necessary)

Investigation Findings

☐ Confirmed ☐ Unconfirmed ☐ Inconclusive ☐ Unfounded

Provider Action Taken Post-Investigation

Signature	Title
Printed Name	Date