Department of Health, Center for Health Facilities Regulation
Nursing Facility Required Reporting[1]
Licensed-Only Facilities

Reporting Facility:		Date of Report:
Reported by:	Title:	Contact Number:

Abuse, Neglect, & Mistreatment: Must be reported within 24 hours, or by the next business day (as defined in §23-17.8- 2). Please select the most appropriate:

☐ *Resident to Resident Abuse ☐ *Staff to Resident(s) Abuse ☐ *Injury of Unknown Origin ☐ *Neglect ☐ *Misappropriation /Exploitation	If reported by a person other than a physician, certified registered nurse practitioner, or physician assistant that a resident has been harmed, then the resident must be examined by a licensed physician, certified registered nurse practitioner, or physician assistant and a preliminary report must be made to the Department within (48) hours after the examination, and a follow-up written report within five (5) days after examination (as defined in Section 23-17.8- 3.1)

Accidents /Incidents/ Death: Must be reported within 24 hours or by the next business day, unless otherwise indicated. Please select the most appropriate:

☐ Accident or incident resulting in hospital admission	☐ Death within 24 hours of admission or prior to physical exam
☐ Accident or incident resulting in death in the facility	☐ Elopement: (Only required if police were notified)
☐ *Accident or incident resulting in death in the hospital following an accident	☐ Unscheduled <u>implementation</u> of fire/evacuation/disaster plan. Report immediately via phone (401) 222-5200, then fax this form within three (3) business days.

***Indicates 5-Day Facility Investigation Report must be faxed to the Department within five (5) business days.**

Resident(s) Information:

Last Name:	First:	DOB:	Room #	☐ Female ☐ Male
Last Name:	First:	DOB:	Room #	☐ Female ☐ Male

Alleged Perpetrator(s) Information (if applicable):

Last Name:	First:	☐Resident ☐Non-resident ☐Staff
Last Name:	First:	☐Resident ☐Non-resident ☐Staff

Has Victim(s) and/or Abuser(s) been involved in previous reportable incidents? If yes, please describe.

Incident Information:

Date of Incident:	Time:	Location of Incident:
Witness(s): ☐ No ☐ Yes (Provide names)		

Description of incident and immediate action taken to ensure safety of resident(s). Include any resident(s) injury.

CONTINUE ON ADDITIONAL PAGES AS NEEDED

FAX to: Facilities Regulation: (401) **222-3650 or** (401) **222-3999** and RI LTC Ombudsman: (401) **785-3391**

[1] Reports may be called in immediately to DOH-222-5200 and the RILTCOO-785-3340 with follow-up faxes of this form by the next business day.