***Initial reports should include the areas highlighted in BLUE (at a minimum) and are due within 24 hours of discovery of the incident/allegation. Final reports should include the specific details of the incident and investigation, and are due within 5 business days.***

***Submit self-reports to:*** [***HSS-ARCP-ADHCSurveyPackets@la.gov***](mailto:HSS-ARCP-ADHCSurveyPackets@la.gov)***.***

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| --- | --- | --- | --- | --- |
| **SECTION A. INCIDENT TYPE** | | | | |
|  | **Abuse (including death, exploitation, extortion)** | |  | **Injuries of Unknown Origin** |
|  | **Neglect (including death and elopements)** | |  | **Misappropriation of Personal Property** |
|  |
| **SECTION B. LICENSED PROVIDER AND CONTACT INFORMATION** | | | | |
| 1. Name of provider: | | Click or tap here to enter text. | | |
| 2. Provider state ID & license #: | | Click or tap here to enter text. | | |
| 3. Address: | | Click or tap here to enter text. | | |
| 4. Phone Number: | | Click or tap here to enter text. | | |
| 5. Administrator: | | Click or tap here to enter text. | | |
| 4. Name of person submitting the report, if not Administrator: | | | | Click or tap here to enter text. |
| 5. Submitter’s email: | | Click or tap here to enter text. | | |
| 6. Submitter’s phone #: | | Click or tap here to enter text. | | |

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| **SECTION C. INCIDENT INFORMATION** | | | | | | | |
| 1. Date of incident (if known): | Click or tap to enter a date. | 2. Time of incident (if known): | Click or tap here to enter text. | | | | |
| 3. Date of **DISCOVERY**: | Click or tap to enter a date. | 4. Time of **DISCOVERY**: | Click or tap here to enter text. | | | | |
| 5. Location of incident: | | | | | | | |
| 6. Brief description of incident, including immediate actions to safeguard the resident (due within 24 hours of discovery) | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 7. Full description of incident (due within 5 business days): | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 8. Describe injury and/or adverse effects, assessment/treatment and follow-up care provided: | | | | | | | |
| Click or tap here to enter text. | | | | | | | |
| 9. Symptoms of pain/injury discussed with the physician | | | | YES |  | NO |  |

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| **SECTION D. RESIDENT INFORMATION** *(INCLUDE ALL RESIDENTS DIRECTLY INVOLVED)* | | | | | |
| Name | DOB | Cognitively Impaired | | | |
| Click or tap here to enter text. | Click or tap to enter a date. | YES |  | NO |  |
| Click or tap here to enter text. | Click or tap to enter a date. | YES |  | NO |  |

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| --- | --- | --- |
| **SECTION E. STAFF/OTHER INFORMATION** *(INCLUDE ALL STAFF/PERSONS DIRECTLY INVOLVED)* | | |
| Name/Title | Date of Hire | Date of Birth, SSN, Professional License Number, Address, Phone Number, & Email Address |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. |

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| **SECTION F. WITNESSES** | |
| Name | Address | |
| Click or tap here to enter text. | Click or tap here to enter text. | |
| Click or tap here to enter text. | Click or tap here to enter text. | |

|  |
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| **SECTION G. ACTIONS TAKEN** *(DESCRIBE ACTIONS TAKEN TO PREVENT FUTURE INCIDENTS)* |
| Click or tap here to enter text. |

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| **SECTION H. NOTIFICATIONS** | | | | | | | |
| 1. Family Member/Responsible Party Notified, if Applicable | | Yes |  | No |  | Date/Time | Click or tap here to enter text. |
| 2. Law Enforcement Notified, if Applicable | | Yes |  | No |  | Date/Time | Click or tap here to enter text. |
| 3. Other Appropriate Authorities, if Applicable | | Yes |  | No |  | Date/Time | Click or tap here to enter text. |
| 4. Name of Agency Notified, if Applicable: | Click or tap here to enter text. | | | | | | |

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| **SECTION I. INVESTIGATION RESULTS** | | | | | |
|  | **VERIFIED**  the allegation was verified by evidence collected during the investigation |  | **NOT VERIFIED**  the allegation was refuted by evidence collected during the investigation |  | **INCONCLUSIVE**  the allegation was unable to be verified or refuted by the evidence |

|  |  |
| --- | --- |
| Signature of Person Completing Report | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |
| Signature of Director/Administrator or Designee | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |