

5-Day Investigation Report

<input type="checkbox"/> Initial
<input type="checkbox"/> Update
<input type="checkbox"/> Final

INVESTIGATION REPORT DATE	IR TODAY NUMBER (CENTRAL OFFICE)	FACILITY IR NUMBER	SIU ID NUMBER
ALLEGED VICTIM(S)	DDA NUMBER	DATE OF BIRTH	PAT / HOME
LOCATION OF INCIDENT	DATE OF DISCOVERY	TIME OF DISCOVERY	
REPORTER(S) / POSITION OR TITLE	DATE REPORTED	TIME REPORTED	
ACCUSED STAFF / PERSON(S) / POSITION OR TITLE			
ALTERNATE ASSIGNMENT <input type="checkbox"/> Yes <input type="checkbox"/> No	ALTERNATE ASSIGNMENT LOCATION		
PROTECTIVE MEASURES TAKEN BY FACILITY TO SAFEGUARD CLIENTS <input type="checkbox"/> Nursing Assessments <input type="checkbox"/> Alert Charting / APOC <input type="checkbox"/> Medical TX <input type="checkbox"/> Psychological Harm Assessment <input type="checkbox"/> Other:			
PERSON WHO NOTIFIED GUARDIAN	NOTIFIED CRU <input type="checkbox"/> Yes <input type="checkbox"/> No	LAW ENFORCEMENT NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
DATE GUARDIAN NOTIFIED	DATE CRU NOTIFIED	LAW ENFORCEMENT CASE NUMBER IF APPLICABLE	
	CRU CONFIRMATION NUMBER	JURISDICTION	
INVESTIGATOR <input type="checkbox"/> SIU <input type="checkbox"/> RHC Staff	DATE INVESTIGATOR NOTIFIED		
Investigative Report			

DESCRIPTION OF INCIDENT (ENTER AN EXACT DESCRIPTION OF THE INCIDENT OR ALLEGATION. INCLUDE NAMES WITH TITLES, DATES, TIMES, ETC., THAT WILL ANSWER WHO, WHAT, WHERE AND WHEN.)

INVESTIGATIVE QUESTION (STATE THE QUESTION(S))

SUMMARY OF TESTIMONIAL AND DOCUMENTARY EVIDENCE (ENTER A SUMMARY OF ALL EVIDENCE ATTACHED AND REVIEWED FOR THE INVESTIGATION. INTERVIEWS CONDUCTED SHOULD INCLUDE THE NAME AND TITLE OF EACH PERSON INTERVIEWED AS WELL AS THE DATE AND TIME INTERVIEWS WERE CONDUCTED)

Interviews are summaries and are not verbatim. Interviews completed were:

Telephonic Video Conference In-person unless otherwise specified.

CHECK BOX IF APPLICABLE:

Because the allegations as described in the incident report may constitute a criminal act, the accused staff, _____, has (have) not been interviewed. This interview will be completed at the request of the Appointing Authority and/or when Law Enforcement complete their investigation(s).

Documentary Evidence

Incident Specific Documents (Check appropriate boxes for documents attached to report.)

<input type="checkbox"/> Incident Report	<input type="checkbox"/> Initial Inquiry	<input type="checkbox"/> Director's Review (Event Report Analysis)
<input type="checkbox"/> CRU Online Report	<input type="checkbox"/> Central Office Report (IR Today)	<input type="checkbox"/> Guardian Notification
<input type="checkbox"/> Nursing Assessment	<input type="checkbox"/> Psych Assessment	<input type="checkbox"/> Witness Statements
<input type="checkbox"/> Alternate Assignment Letter	<input type="checkbox"/> Staffing Sheets / Assignments	<input type="checkbox"/> Communication log
<input type="checkbox"/> Post Schedules / Assignments	<input type="checkbox"/> 24 Hour Activity Log	<input type="checkbox"/> Restrictive Procedures Record

Related Relevant Documentation (Check appropriate boxes for documents attached to report.)

- | | | |
|--------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Annual Healthcare Assessments | <input type="checkbox"/> IHP / Care Plan | <input type="checkbox"/> PBSP / BMP |
| <input type="checkbox"/> Behavior Data / TBL | <input type="checkbox"/> Incident History | <input type="checkbox"/> Photographs / Diagrams |
| <input type="checkbox"/> Correspondence | <input type="checkbox"/> Daily Shift Exchange | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> Dietary Orders / Guidelines | <input type="checkbox"/> MAR / TAR | <input type="checkbox"/> Progress Notes / RUR |
| <input type="checkbox"/> Fall Reports | <input type="checkbox"/> Med Stat / Behavior Stat | <input type="checkbox"/> Quarterly Assessments / Reports |
| <input type="checkbox"/> Health Service Orders | <input type="checkbox"/> Medication List | <input type="checkbox"/> Therapy Records (PT / OT / SLP) |
| <input type="checkbox"/> Hospital records | <input type="checkbox"/> Nursing Orders | <input type="checkbox"/> X-ray / Laboratory Reports |
| <input type="checkbox"/> Other (indicate below): | | |

Relevant Excerpts

Check box if no relevant excerpts are included.

Testimonial Evidence

ANALYSIS (ENTER AN ANALYSIS OF EVIDENCE GATHERED)

FINDINGS (LIST THE INVESTIGATIVE QUESTIONS(S) AND RESULTS OF INVESTIGATION. NOTE: SUPERINTENDENT WILL DETERMINE WHETHER STAFF ACTION, OR INACTION, RISES TO THE LEVEL OF MEETING CFR DEFINED ABUSE, NEGLIGENCE, OR MISTREATMENT.)

INFORMATION FOR FACILITY REVIEW (INFORMATION FOUND DURING INVESTIGATION THAT MAY POSE A THREAT TO CLIENT RIGHTS AND/OR PROTECTIONS OR THAT MAY REQUIRE FURTHER REVIEW AND/OR ACTION BY THE FACILITY)

TBD N/A

INVESTIGATOR'S NAME	DATE COMPLETED
RECEIVED BY	DATE
Conclusions: To be completed by Superintendent / Designee	
Did abuse, neglect, or mistreatment occur based on CFR rule and guidance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes above, please select one or more of the following types: <input type="checkbox"/> Abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Mistreatment	
COMMENTS	
SUPERINTENDENT'S / DESIGNEE'S NAME	DATE COMPLETED