RESIDENT MALTREATMENT INVESTIGATION FORM
FORM DMS-762

This form is designed to standardize and facilitate the process for investigating alleged, suspected, or witnessed acts of resident by individuals providing services to residents in Arkansas nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).

The purpose of this process is for the facility to compile a substantial body of credible information to enable the Office of Long Term Care to determine if additional information is required by the facility, or if an allegation against an individual(s) can be validated based on the contents of the report.

Completion and Routing Instructions

THIS FORM MUST BE TYPED

THIS FORM CANNOT BE ALTERED

The top section of the attached form, entitled **COPIES FOR** will be completed by the Office of Long Term Care. All remaining sections must be completed by the facility. If the information necessary to complete the form cannot be obtained or if a section of the form is not applicable, please provide an explanation.

This form, and all witness and accused party statements, must be **originals**. Other material submitted as copies must be legible and of such quality to allow re-copying.

The facility's investigation and this form must be completed and submitted to OLTC within five (5) working days from when the incident became known to the facility.

Upon completion, send the form by certified mail to Office of Long Term Care, P.O. Box 8059, Slot 404, Little Rock, AR 72203-8059.

Any other routing or disclosure of the contents of this report, except as provided for in regulations, may violate state and federal law.

The original form must be maintained on the facility premises for three (3) years.

Facility Investigation Report for Resident Maltreatment

Section 1 - Reporting Information

Name of Facility: _____

Phone: (501) _____

Address: _____

City: _____ State: AR Zip Code: _____

Facility Staff Member Completing DMS-762: _____

Title: _____

Date Incident Reported to OLTC: _____ Time: _____ AM

Date and Time of Incident (if known): _____ Time: _____ AM

Date and Time of Discovery: _____ Time _____ AM

Type of Incident: **Neglect**: ☐

Abuse: Verbal ☐
Sexual ☐
Physical ☐
Emotional/Mental ☐

Misappropriation of Property: Drugs ☐
Personal Property ☐
Resident's Trust Fund ☐

Name of Involved Resident: _____ Room # _____

Social Security #: _____ DOB: _____

Height: _____ Weight: _____ lbs. Physician _____

Is Resident Still Living? ☐ Yes ☐ No If not, Date of Death _____

Ambulatory? ☐ Yes ☐ No Oriented ☐ Time ☐ Place ☐ Person ☐ Event

Physical Functional Level/Impairment _____

Mental Functional Level _____

Primary Diagnosis _____

Section II - Complete Description of Incident

“See Attached” Is Not Acceptable!

Section III - Findings and Actions Taken

Please include Resident's current medical condition

Section IV - Notification/Status

Administrator/Written Designee Must Be Notified!

Name of Administrator _____

Date _____ Time _____ AM

Family Notified ☐ Yes ☐ No ☐ None Date _____ Time _____ AM

Name of Family Member _____

Relationship _____ Phone # (501) _____

Doctor Notified ☐ Yes ☐ No Date _____ Time _____ AM

Doctor's Name _____ Phone # (501) _____

Resident Sent To Hospital ☐ Yes ☐ No Date _____ Time _____ AM

Name/Address/Phone of Hospital _____

_____

_____ Phone (501) _____

Law Enforcement Must Be Notified For Abuse And Neglect

Date _____ Time _____ AM

Name of Law Enforcement Agency _____

Phone # (501) _____

Address _____

City/Zip _____

Was an Investigation Made by the Law Enforcement Agency? ☐ Yes ☐ No

Date of Investigation _____ Time _____ AM

Name of Officer _____

Section VI - Accused Party Information

Name of Accused Party _____

Job Title (if any) _____ Phone # (501) _____

Home Address _____

City/State/Zip _____

Social Security # _____ DOB _____

Dates of Current Employment From _____ To _____

Certified Nursing Assistant ☐ Yes ☐ No

Registration # _____ Date Issued _____

Date Criminal Background Check Completed _____

Licensed by State Board of Nursing ☐ Yes ☐ No

Type of License RN # _____ LPN # _____

Date Issued

Section VII- Attachments

Attach the following information to the back of this form. If you do not have one of the specified attachments, please provide an explanation why it cannot be obtained or if it will be forwarded in the future.

1. Statement from the accused party.

2. All witness statements. Use the attached OLTC Witness Statement Form for all witness statements submitted. If the statement is a typed copy of a handwritten statement, the handwritten statement must accompany the typed statement.

3. Law enforcement incident report. This can be mailed at a later date if necessary.

4. Other pertinent reports/information, such as Ombudsmen, autopsy, reports, etc. These can be mailed at a later date if necessary.

Facility Investigation Report for Resident Maltreatment

OLTC Witness Statement Form

Date _____ Time _____ AM

Witness Full Name _____

Job Title _____ Shift _____

Home Address _____ City/Zip _____

Home Phone # (501) _____ Work Phone # (501) _____

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 _____

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Witness Full Name _____

Job Title _____ Shift _____

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