

Caregiver Report No.

ALLEGED NURSING HOME RESIDENT MISTREATMENT, NEGLECT, AND ABUSE REPORT

- Completion of this form is necessary to meet the requirements in Federal regulation 42 CFR 483.12(c)(1). Nursing homes are required to report incidents of alleged mistreatment, neglect, exploitation, and abuse of nursing home residents (**including injuries of unknown source**), and misappropriation of resident property to the Division of Quality Assurance (DQA), the state survey and certification agency.
- Nursing homes must ensure that all alleged incidents be reported **immediately** to the administrator of the facility and to other officials in accordance with state law through established procedures, which include reporting the incident to DQA. The Centers for Medicare and Medicaid Services (CMS) defines "immediately" to be as soon as possible, but not to exceed 24 hours after discovery of the incident. Failure to provide the following information to DQA within 24 hours of discovering an incident may result in the issuance of a statement of deficiency.
- Questions about completion of this form may be directed to **608-261-8319**.
- **NOTE:** Upon completion of the facility's investigation, attach a copy of this form to the completed Caregiver Misconduct Incident Report (DQA form F-62447) and submit to the address listed in the instructions for F-62447.
- **Submit this completed form to DQA via email at dhs caregiverintake@wi.gov or by fax at 608-264-6340.**
- **TYPE OR PRINT NEATLY IN BLACK INK.**
- **Items with an asterisk (*) are required fields.**

ENTITY INFORMATION				
Name - Entity or Facility *			WI License, Approval, or Registration No. *	
Street Address *	City *	State	Zip Code *	County *
SUMMARY OF INCIDENT				
Name – Resident *		Allegation Type *		
Name – Accused		Title – Accused (<i>CNA, RN, caregiver, resident, family, stranger, etc.</i>)		
<i>Indicate when the incident occurred. If the exact date and time are unknown, make a reasonable estimate and indicate that the date and time are estimated. Include the date the incident was discovered, if other than the date the incident occurred.</i>				
Date Occurred (MM/dd/yyyy)	Time Occurred <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date Discovered (MM/dd/yyyy) *	
BRIEF SUMMARY OF INCIDENT *				

PERSON PREPARING THIS REPORT		
Name *	Title	Date Completed (MM/dd/yyyy)
Telephone No. *	Email Address *	