

CONFIDENTIAL

DHSS POLICY MEMORANDUM #46 PRESCRIBES THE STANDARDIZED REPORTING AND INVESTIGATION OF SUSPECTED ABUSE, NEGLECT, MISTREATMENT, FINANCIAL EXPLOITATION AND SIGNIFICANT INJURY OF RESIDENTS/CLIENTS RECEIVING SERVICES IN RESIDENTIAL FACILITIES OPERATED BY OR FOR DHSS.

Information contained in the standardized PM-46 Investigative Report is CONFIDENTIAL AND PRIVILEGED under 24 Del.C. Section 1768 and the governmental executive privilege for investigative files.

Distribution of this Investigative Report, and the information it contains, must be restricted to only those persons who are authorized to see it.

INVESTIGATOR, please list all persons to whom you have distributed this Investigative Report:

Name	Agency
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DELAWARE HEALTH AND SOCIAL SERVICES

ALLEGATION TYPE:

PM 46

INVESTIGATIVE REPORT

ABUSE NEGLECT

Physical

Emotional

MISTREATMENT

FINANCIAL EXPLOITATION

SIGNIFICANT INJURY

DPH

DHCI

EPB

GBHC

DDDS

Stockley Ctr

CS/ASP.

DSAMH

DPC

SUB. AB.

CMH

DIAGNOSIS

Victim Name:			
Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.:	Age:
Communication Style			
Facility Admission Date:			
Contractor & Program Name			
If victim information requested above is <u>NOT</u> known please provide:			
Height		Weight	Race:
Other Identifying Marks:			

<u>ALLEGED INCIDENT</u>	<u>INITIATOR OF REPORT</u>
Date:	Name:
Time:	Title:
Location:	Report Date:

Accused Name:			
Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	
Address:		Phone #:	
		Occupation:	
		License/ Certificate #:	
IF accused information requested above is <u>NOT</u> known please provide:			
Height:		Weight:	Race:
Other Identifying Marks:			

INVESTIGATORY PROCESSES

Investigation Started Date		Time		<input type="checkbox"/> am	<input type="checkbox"/> pm
Completion Date					
Investigator					

TO BE COMPLETED BY DIVISION:

Notifications:

	NAME	DATE	TIME	REPORTED BY
FACILITY DIRECTOR				
PM 46 MANAGER				
DOCTOR				
DIVISION DIRECTOR				
DHSS SECRETARY				
DLTCRP				
MEDICAID FRAUDUNIT				
OTHER				

ALLEGATION SUMMARY-DESCRIPTION OF ORIGINAL REPORT RECEIVED BY INVESTIGATOR:

Nature of allegation (Who, What, When, Where, How):
Source of allegation (Name & Title):
Date and time of allegation: Reason for delay between time of incident and time reported, if any:

SUMMARY OF INVESTIGATION

Investigator:	
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1. MANNER IN WHICH THE INVESTIGATOR BECAME INVOLVED IN THE INCIDENT:

Notified by:	
When:	
How:	

Date and time the investigation began	
Date and time the investigation ended:	
If investigation did not start immediately, explain:	

2. SECURING THE SCENE OF THE ALLEGED INCIDENT:

Individual who secured scene (Name & Title):	
Date and time scene was secured:	
Manner in which scene was secured:	
If scene was not secured, explain:	

3. INTERVIEWS CONDUCTED DURING THE INVESTIGATION

(Note Reasons for Delays)

Name & Title of Interviewee	Date of Interview	Time of Interview	Interviewee's Role (i.e. Accuser Subject, Witness, etc.)

4. INTERVIEWS WHICH COULD NOT BE CONDUCTED

Name & Title of Individual	Individual's role (i.e Accuser, Subject, Witness, etc.)	Reason interview not conducted

5. MENTAL AND PHYSICAL STATUS OF RESIDENT PRIOR TO INCIDENT:

6. Any change in mental and physical status since this incident took place:

<input type="checkbox"/> Yes		<input type="checkbox"/> No		If <u>yes</u>, explain:

7. Report to Family/ Guardian: Yes No **If yes, provide:**

Name of Family/ Guardian notified	Relationship	Date	Time
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8. If Family/ Guardian not notified, give reason:

9. Was medical attention required for resident?

Physician evaluating resident:

Describe treatment

10. SUMMARY OF TESTIMONIAL EVIDENCE

(Summarize the KEY points of interviews you conducted)

11. SUMMARY OF DOCUMENTARY EVIDENCE

(Summarize the SIGNIFICANCE of applicable patient records, medical reports, employee records)

12. SUMMARY OF PHYSICAL EVIDENCE AND DEMONSTRATIVE

EVIDENCE (Summarize the SIGNIFICANCE of any objects, arrangement of objects, substances, or conditions of a person's body. Also, review the significance of applicable photographs, diagrams, etc.)

13. INVESTIGATION SUMMARY

Signature: _____
Investigator **Date**

Facility/ Program Director

<i>Reviewed/ Approved</i>	(<input type="checkbox"/>) YES	(<input type="checkbox"/>) NO
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Comments:

Signature: _____
Facility/ Program Director **Date**

Division Director

<i>Reviewed/ Approved</i>	(<input type="checkbox"/>) YES	(<input type="checkbox"/>) NO
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Comments:

Signature: _____
Division Director **Date**

02/28/05