



Center for Health Facilities Regulation

Home Nursing Care Provider (HNCP)/Home Care Provider (HCP) Agency Self-Reporting Incident Form

Reporting agency:	Date of report:
Reported by (name/title):	Phone:

- Report can be called in immediately to: 401-222-5200 (RIDOH) and 401-785-3340 (LTC Ombudsman)
- Report must be faxed by end of next day to: 401-222-5901 (RIDOH) and 401-785-3391 (LTC Ombudsman)
- Report can be emailed to doh.ofr@health.ri.gov

Abuse, Neglect, and Mistreatment: HCNPs and HCPs must report within 24 hours, or by the end of the next business day, to RIDOH and to the State Long-Term Care Ombudsman (Refer to RIGL §23-17.8-2 *Duty to report*).

<p>Abuse</p> <p>Neglect</p> <p>Misappropriation/Exploitation</p> <p>Other (describe below)</p>	<p>Reminder: As applicable, the HNCP/HCP must notify additional authorities/agencies such as the LTC Ombudsman, Office of Healthy Aging, or law enforcement. (Refer to RIGL §42-66-8.) If reported by a person other than a physician, registered nurse practitioner (APRN), or physician assistant that a resident has been harmed, the resident must be examined by a licensed physician, APRN, or physician assistant, and a preliminary report must be made to RIDOH within 48 hours after examination, and a follow-up written report within five days after examination (as defined in Section 23-17.8-3.1).</p>
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Description of other:

Communicable Diseases must be reported to RIDOH's Center for Acute Infectious Disease Epidemiology (CAIDE) in accordance with *Reporting and Testing of Infectious, Environmental, and Occupational Diseases* (216-RICR-30-05-01). Call in reports to 401-222-2577 and download applicable reporting forms at <http://health.ri.gov/diseases/about/reporting/>

Client(s) information

Name:	Date of birth:
Phone:	Male Female
Address:	

Alleged perpetrator(s) information (if applicable)

Name:	License #:	RN	CNA	Other
Name:	License #:	RN	CNA	Other

Has victim(s) and/or alleged perpetrator(s) been involved in previous reportable incidents? If yes, please describe:

Incident information

Date:	Time:	Location:
Witness(es): No Yes <i>Provide witness(es) name(s) and contact information</i>		

Description of incident and immediate action taken to ensure safety of client(s). Include any injury and medical treatment required.