



Department of Health
and Human Services
Maine People Living
Safe, Healthy and Productive Lives

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Licensing and Regulatory Services
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9300; Fax: (207) 287-9307
Toll Free (800) 791-4080; TTY Users: Dial 711 (Maine Relay)

December 12, 2013

Dear Provider;

The Department of Health and Human Services has established a protocol for reporting abuse, neglect and/or exploitation in any licensed facility.

Any individual who suspects abuse, neglect or exploitation of a resident should immediately report to Adult Protective Services at 1-800-624-8404, available 24 hours a day / 7 days a week.

If you suspect an adult has been or is at substantial risk of abuse, neglect or exploitation, you must immediately contact:

**Adult Protective Services at 1-800-624-8404
(Available 24 hours a day / 7 days a week)**

If you have reason to believe that a crime has been committed, immediately protect the victim from further harm, seek treatment for the victim, contact law enforcement and ensure that evidence is preserved.
DO NO WAIT TO CONDUCT YOUR OWN INVESTIGATION BEFORE REPORTING.

In addition, initial information called in to APS and all follow up information required for licensing must be faxed to the Division of Licensing and Regulatory Services, on the following business day at (207) 287-9307.

Kenneth Albert, R.N., Esq.
Division Director
Licensing and Regulatory Services

James Martin
Division Director
Office of Aging and Disability Services

Department of Health and Human Services
 Division of Licensing and Regulatory Services

Office Use Only
Date Received _____
Date Reviewed _____
Reviewer's Initials _____
ACTs Number _____
Allegations _____

Nursing Facility Reportable Incident Form

- Augusta Office FAX to 207-287-9307
- Complaint Line Toll Free 1-800-383-2441
- Complaint Line 287- 5038

Please Print Legibly

Facility Information

Facility Name: _____ City/Town: _____ Unit: _____
 Nursing Facility Residential Care Multi-level Facility
 Name of Person Reporting the Incident : _____ Title: _____ Phone Number: _____

Date of the incident:

Time of the incident:

People Involved/Witnesses

List all residents involved:

Full Names	Unit	Room Number

List all witnesses, include any staff present at the time of the incident:

Full name	Title/relationship	Phone Number

List the people alleged to be involved in the incident, if applicable. If staff members are listed, please indicate their status of employment, ex.; suspended/working/leave/etc.

Full Name	Title/relationship	Phone	Empl. Status

Description of Incident



Assessment of the Resident

What was the resident's cognitive and functional status at the time of the event? Check any that apply. Alert Oriented Confused Combative
 Non-ambulatory Independent ambulatory Wheel chair dependent Other (specify)

What interventions were in place at the time of the incident? Please describe in full below:

Extent of injuries and any treatment that was provided (Describe in detail):

Were there any adverse effects to the resident (physical or mental)?

Yes No

Actions Taken by the Facility

Was the Physician notified? Yes No If yes, date and time: _____

Were the Family, Guardian, etc. Notified? Yes No

Was resident transferred to a hospital? Yes No

Where were they transferred to? _____

When were they transferred? _____

What was the outcome, if known (admitted, fracture, death, etc.)? _____

Have any new interventions or corrective actions been implemented? Describe in detail below:

Check any of the authorities below that have been notified.

Police/Law Enforcement Adult Protective Attorney General's Office

Medical Examiner

Other(s): _____

Signature Block

Name (please print):

Title:

Signature:

Date:

Please forward any additional information, if necessary.