FACILITY INVESTIGATION REPORT – 5 Working Days

INSTRUCTIONS:

1. This form is to be completed following telephone notification to the Complaint Hotline (1-800-882-6006) and the submission of the *Facility Incident Report – 24 Hours* (BHS-OPS-362) form which must be faxed/mailed **within 24 hours** of all alleged/possible resident mistreatment, neglect, abuse or injury of unknown source, or misappropriation of property.

DATE REPORTED TO THE COMPLAINT HOTLINE?
State and federal laws require "immediate" reporting. "Immediate" means as soon as possible, but not more than 24 hours after the discovery of the incident. Date: / /

DATE *FACILITY INCIDENT REPORT – 24 HOURS* FORM SENT TO THE BUREAU OF HEALTH SYSTEMS? Date: / /

2. Submit this completed form, *Facility Investigation Report – 5 Working Days*, detailing the incident and investigation findings **within five (state) working days** of the incident to: Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services, Facility Complaint and Investigation Section, Complaint Investigation Unit; P.O. Box 30664, Lansing, MI 48909; Telephone Number (517) 241-4712 Fax Number: (517) 241-0093
For facilities served by the Gaylord Office use fax number: (989) 705-1388

INCIDENT INFORMATION

Facility:	Resident:	Date of Incident: / /

INFORMATION ABOUT ALLEGED PERPETRATOR/INVOLVED STAFF PERSON (IF APPLICABLE)

Name:	Date of Birth (Mo./Day/Yr.): / /	License Number/Michigan Registry Number (if applicable):
Position/Title (at time of incident):		Daytime Telephone Number and Hours Available: ( )
Mailing Address:		

AGENCY/LAW ENFORCEMENT INVOLVEMENT

Check any agency contacted about this matter. ☐ Attorney General ☐ Police Agency ☐ Family/Guardian
Please attach a copy of any agency/law enforcement incident report if available.

Agency/Police Precinct Number (City/Town):	Case Number (if known):
Contact Person:	Telephone Number: ( )

SUMMARIZE FACILITY INVESTIGATION BELOW (No. of pages attached _____ if needed)
Include a description of any related documents/ information such as photos, tapes, medical records, etc.

ACTION TAKEN BY FACILITY: No. of pages attached _____ if needed)
(Additional training for staff person, termination, counseling memo, etc.)

REPORT PREPARED BY:

I hereby attest that the information provided above is true to the best of my personal knowledge.

Name (Printed):	Signature:	Date: / /