**Dynamic Services**

**Vulnerable Adult Maltreatment Report**

Page 1 must be immediately accessible to all staff, at each SLS site & in all consumer on-site books.

**Page 1 needs to be completed by the Mandated Reporter immediately upon first suspicion or knowledge of incident** **and reviewed by Program Manager and presented to the Program Director or Administrator.**

**An incident form also needs to completed for all VA or MOM reports.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A** | **Vulnerable Adult's Name:** | | | Phone: | | DOB: | | Gender: o Male  o Female | |
| Address of Vulnerable Adult: | | | | City: | | State: | | Zip: | |
| Diagnosis of Vulnerable Adult: | | | | | | | | | |
| **B** | Reported to Program Manager by Mandated Reporter on: (Date & Time) | | Program Manager Who Received the Report:(or person on chain of command who received report) | | | |  | | |
| **Date and Time Mandated Reporter first Became Aware of the Vulnerable Adult Situation:**  **The 24 HOUR Reporting Deadlines Begins Here** | | | Date and Time the Incident Actually Occurred: | | | Location of Incident: | | | |
| **Mandated Reporter:** | | | |  | | Home Phone: | | |  |
| Reporter's Home Address: | | | | City: | | State: | | Zip: | |
| Mandated Reporter's Relationship to VA: | | | | | | | | | |
| \_\_\_\_ Direct Care Staff \_\_\_\_ Program Manager \_\_\_\_ Program Director \_\_\_\_ Program Administrator \_\_\_\_ Nurse Consultant \_\_\_\_ Other: Specify | | | | | | | | | |
| **C** | **Alleged Perpetrator:** | Relationship to Vulnerable Adult:  Facility/Site: | | | Phone: | | | | |
| Address of Alleged Perpetrator: | | City: | | | State/Zip: | | | | |
| Is the alleged perpetrator a Pinnacle Staff? \_\_\_ yes \_\_\_no (if no, please provide as much detail as possible and a physical description of the alleged perpetrator) | | | | | | | | | |
| **D** | **Description of the Suspected Maltreatment**  (use back side if necessary) **(Do not use other consumer’s names or initials)** | | | | | | | | |
|  |  | | | | | | | | |
| Evidence of previous, related maltreatment: | | | | | | | | | |
| **E** | **Witnesses** |  | | | | **(Do not use other consumer’s names or initials)** | | | |
|  | Name: | Relationship to VA: | | | | Phone: | | | |
|  | Name: | Relationship to VA: | | | | Phone: | | | |
|  | Name: | Relationship to VA: | | | | Phone: | | | |

Signature of Mandated Reported Date

Signature of Program Manager (or person on the chain of command) Date

**Within the initial 24 hours, the Program Director/Administrator completes Page 2 and ensures call to CEP**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **F** | **Internal Reporting Procedure** | | | |
|  | **Program Director / Administrator Internal Contacts:**  u Program Administrator  u Chief Operating Officer  u Quality Assurance  1. The Program Director/Administrator will follow this  communication chain  2. The Program Director/Administrator will notify each  person (leave message)  3. The Program Director/Administrator must receive further  direction from the first person reached | **Date & Time of Each Contact:**  PA \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  COO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  QA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Received Direction**  **from: \_ \_\_ PA \_\_\_ COO \_\_\_ QA**   1. \_ \_\_ Call In VA   Designated Caller \_\_\_\_ \_\_\_\_\_\_\_  **Continue with Next Section**  2. \_\_\_\_ Not Qualified  Do Not Contact CEP  \_\_\_\_ Accident/Incident Form  \_\_\_\_ Re-Training Issue  \_\_\_\_ Other: Specify  **Stop Completing Form Here,**  **Forward to Quality Assurance** |
| **G** | **External Report** | Designated Caller: | |  |
| County of CEP: | | Date & Time Report was made to CEP: | | Who Took the Call at the CEP: |
| VA's Case Manager: | | | County of Case Manager & Phone Number: | |
| Did the CEP Take the Report: \_ \_\_ yes | | | \_\_\_\_ no | |
| If Yes,  Make a request for notification of initial and final disposition; | | | If No, | |
| Report to the CEP our plan for future action to be taken: | | | Report to the CEP our plan for future action to be taken: | |
| Note any CEP recommendations, suggested at the time of the call: | | | Note any CEP recommendations, suggested at the time of the call: | |
| Complete the next 2 sections, sign the form, and  send the original to Quality Assurance within 3 working days. | | | Complete the next 2 sections, sign the form, and  send the original to Quality Assurance within 3 working days. | |
| **H** | **Immediate Action Taken by Pinnacle**  (use back side if necessary) | | | |
|  | | | | |
| **I** | **External Notification** | | | |
| **Verbal Notification (in addition to the CEP) Information provided to Legal Representative and Case**  **Indicate Only Those Who Were Contacted Verbally (specify who was contacted): Manager:**  1. Nature of suspected maltreatment  2. Agency receiving report (i.e. CEP)  \_\_\_\_\_ Legal Representative Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ 3. Telephone number of DHS  Licensing Division:  \_\_ \_\_ Case Manager: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_ 651-297-4123  \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_  (family, law enforcement...)  **Written Notification**  **The first two pages of this VA Report Sent to** : \_\_ \_\_\_ Quality Assurance (Original)  \_\_\_\_\_ CEP (only if requested):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

Signature of Program Director / Administrator Date

## Page 3 needs to be competed by Quality Assurance

|  |  |  |
| --- | --- | --- |
| **J** | **Response by Quality Assurance** | |
| Further Internal Investigation is based on limitations within the scope of our license:  [ ] Determined to be **within** the scope of our license  Quality Assurance will proceed to complete this form  [ ] Determined to be **outside** the scope of our license  Quality Assurance will complete section L, as appropriate, and sign form.  No further investigating will be done internally | | |
| **If Not Called into the CEP QA Will:** | | **If it was called into the CEP, QA Will:** |
| 1. Send out letter to Mandated Reporter  2. Complete L, if applicable  3. Sign this Page | | 1. Send out letter to Mandated Reporter  2. Complete K; Review and Audit of Time Line of Events  3. Complete Section L  4. Sign Form  5. Send Copies of the full Internal Investigation or this  page of the report to those who received the first two  pages of this VA Report  6. Send Copies to CEO, COO, & Program Administrator |
| **K** | **Review and Audit of Time Line of Events** | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time Staff Became Aware of VA Situation  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time Called into CEP  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Quality Assurance Received pages one and two of the VA Report  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Letter Sent to Mandated Reporter | |
| **L** | Internal Review | |
|  | Identify the organizations policies and procedures related to this incident:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Were these policies and procedures followed by staff in this incident: \_\_\_\_YES \_\_\_\_NO  If no, which staff did not follow these policies and procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Of the related policies and procedures, were all of them adequate: \_\_\_\_YES \_\_\_\_NO  If no, which policies and procedures were inadequate and indicate any changes made to make them so:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is there a need for additional staff training: \_\_\_\_YES \_\_\_\_NO  If yes, which staff need what training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is there a need for further action to be taken  to protect the health and safety of the consumers: \_\_\_\_YES \_\_\_\_NO  If yes, what is it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The findings in this review are conclusive: \_\_\_\_YES \_\_\_\_NO  If no, proceed to follow the Internal Investigation procedure: See attached form PR-GN-510. | |

Signature of Quality Assurance Date