**Incident Reporting form for Montana Facilities**

* **Submission of a completed form should be emailed to** [**mtssad@mt.**gov](mailto:mtssad@mt.gov). If you do not have email capabilities, fax to: 406-444-3456.
* **TYPE** or **PRINT** neatly in **BLACK** ink.
* **Items with an asterisk (\*) are required fields.**
* If you are submitting your initial and final report together, and are within the **initial** reporting timeframe, please select ***BOTH***.

**Nursing Facilities (Swing Beds):**

* Completion of this form is required to meet the CMS requirements in the Federal regulation **§483.12(c)(1-4)**. Nursing homes are required to report incidents of alleged abuse, neglect, mistreatment of nursing home residents **(including injuries of unknown source)**, and misappropriation of resident property.
* Nursing homes must ensure all alleged incidents are reported immediately to the administrator of the facility, to the Certification Bureau as the State Survey Agency, and to other officials in accordance with state law through established procedures. The Centers for Medicare and Medicaid Services (CMS) defines **“immediately”** to be as soon as possible, but not to exceed 24 hours after the discovery of the incident. In accordance with **§483.12(b)**, facilities must report incidents alleging reasonable suspicion of a crime to the Certification Bureau and local law enforcement within 2 (two) hours after forming the suspicion, if serious bodily injury resulted.
* **Note:** Submission of this form to the Certification Bureau **only** satisfies one part of a facility’s requirements under the regulations.

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| ENTITY INFORMATION | | | | | | | | |
| Report Type: \*  Initial  Final | | | | Date of report to Certification Bureau:\* Click here to enter a date. | | | | |
| Name – Entity/Facility\* |  | | | | | | | |
| Street Address: \* | | | | | City \* | | Zip Code\* |
| RESIDENT INFORMATION | | | | | | | | |
| Name \* First:       Last: | | | | | | **Allegation Type:\*** Choose an item. | | |
| ACCUSED INFORMATION | | | | | | | | |
| Name \* First:       Last: | | | | | | **Title:\*** (CNA, RN, resident, family, etc.) | | |
| INCIDENT INFORMATION | | | | | | | | |
| Date: \*  Click here to enter a date. | **Time:\***  a.m.p.m. | | **Date Discovered: \***  Click here to enter a date. | | | Is the individual capable of providing an explanation of the event or capable of participating in the investigation? \*  Yes  No | | |
| SUMMARY OF INCIDENT (INITIAL OR FINAL) \* (Please include: were injuries sustained; was there a need for medical treatment; what immediate interventions were implemented for the protection of the resident, and was the care plan updated as necessary) | | | | | | | | |
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| PERSON PREPARING THIS REPORT\* | | | | | | | | |
| Name:\* | | **Title:\*** | **Date Completed:** Click here to enter a date. | | | | **Telephone No.** | |
| NOTIFICATIONS\* (See Compliance Readiness Bulletin CRB-01-17 for more information) | | | | | | | | |
| Law Enforcement  Yes  No\* | | | | | **State Ombudsman FAX [1-406-444-7743]**  Yes  No\* | | | |
| If you answered no to any of the above, explain: | | | | | | | | |