



## PB-22 Instructions for Completion

### Section 1 – General Information

#### Facility Type

Indicate:

NH – Nursing Home

HH – Home Health

HP – Hospital

ICFMR – Intermediate Care Facility for the Mentally Retarded, etc.

**Facility Name** Use the name under which your license was issued

**Address** Of the facility

**County** In which facility is located

**Zip Code** Of the facility

**Telephone No.** Of the facility

**Date/Time of Alleged Incident:** Be specific, if known. If not known, explain reason in narrative (Section III – Description of Incident)

#### Reported to DOH :

**Name** To whom was it reported in the Division of Nursing Care Facilities' field office

**Telephone No.** Of the Field Office

**Date/ Time** Of the contact

**Date/Time Investigation Initiated:** By the facility

**Date/Time Investigation Completed:** By the facility

**Date PB-22 Submitted to Field Office:** By the facility

### SECTION II – Allegations/Individual Involved

#### Name of Individual/Alleged Perpetrator Involved:

Indicate the name of the individual named or suspected

**Address** Of named individual

**Telephone No.** Of named individual

**DOB/Sex** (Date of Birth/Sex) Of named individual

**Relationship to Victim**

**Worker's Category** Check, if appropriate

**Other** Specify job title (For example: direct care worker; dietary worker; housekeeping staff)

**Date of Hire** By the facility

**Shift** At the time of the incident

**License/Registry #** If applicable

**Nature of Abuse (circle)** See attached definitions

**Name of Resident/Victim**

**Address** If other than at the facility

**Resident Date of Birth**

**Sex** Check as appropriate

**Telephone No.** Indicate resident's personal phone number, if other than facility number

**Family Member/Legal Guardian Notified** Identify full name

**Address** Of family member/guardian

**Telephone No.** Of family member/guardian

**Relationship** If applicable

### SECTION III – Description of Incident

Follow the directions as outlined on the form. Address each issue as is appropriate to the circumstances of the incident. Also reference attachment to the PB-22 entitled Guidelines for Investigation of Abuse, Neglect, and Misappropriation of Property.

Please indicate whether the act was believed to be intentional and the specific harm that was sustained by the resident. If a physical injury was not incurred, describe any physical reaction or emotional trauma suffered by the resident.

### SECTION IV – Investigative Activities

**Who reported it?** Provide name and identify role (resident, staff member, visitor, etc.)

**To whom was it reported?** Provide name and position (Charge nurse, Supervisor, etc.)

**When?** Provide date

**Witness information:** For those identified as witnesses, they must have been a direct observer of the alleged incident or surrounding circumstances. Provide information as requested and note each person's willingness to testify.

**Resident/Accused:** Indicate if the resident and accused were interviewed and if a signed statement was obtained. Note as requested whether the resident is credible, and willing to testify.

**Supportive Documentation:** Indicate information available and whether it is attached or retained at the facility.

**Medical treatment:** Indicate if, as a result of the physical or sexual abuse, the resident was seen by a physician and/or hospitalized.

**State Agency referral:** Indicate all agencies notified/involved: Protective Services, Department of Aging, Department of State, law enforcement. If known, indicate status of any investigation.

### **SECTION V – Findings of Facility Investigation**

Provide narrative that describes all components that the facility determined to be relevant to the investigation. Include evaluations or disciplinary actions of the nurse aide if significant.

### **SECTION VI – Conclusions**

Indicate whether the facility found the allegations to be substantiated or unsubstantiated.

### **SECTION VII – Actions Taken**

Include actions taken with accused.

### **SECTION VIII – Attachments**

This list of relevant/supportive documentation is a check prior to sending to the Field Office.

### **Department of Aging Additional Reporting Requirements**

Indicate the Date and Time of the Oral Report to the Area Agency on Aging (Protective Services) and, if applicable, the report to the Department of Aging.

Include the name of the individual at AAA who received the report.

Indicate the facility person (name, title and signature) making the report.

### **Completion Section**

This section is for the facility person completing the report.

Print and sign name

Provide title and phone number

Date and time of completion.

If the form is being completed manually, please ensure that the handwriting is legible.

Statements from witnesses should also be reviewed, prior to submission, to ensure they can easily be read.