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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02208 (05/2024) | | | | | **STATE OF WISCONSIN**  Page 1 of 2 | | | |
| **ASSISTED LIVING FACILITY SELF-REPORT** | | | | | | | | |
| * Refer to DQA publication P-02007*Reporting Requirements for Assisted Living Facilities,*for reporting requirements pertaining to reports submitted to the Division of Quality Assurance (DQA). * If the type of report being filed does not require a specific form, this form may be used for reporting to DQA. * Submit this signed and fully completed form to your DQA Regional Office. For regional office contact information see: <https://www.dhs.wisconsin.gov/dqa/bal-regionalmap.htm> * Do not use this form to report misconduct (abuse, neglect, misappropriation) by employees or contractors. All incidents, allegations, and/or suspected occurrences of misconduct toward clients/resident must be reported using the Misconduct Reporting System (see <https://www.dhs.wisconsin.gov/misconduct/mir.htm>) | | | | | | | | |
| Name – Facility | | | | | | | | Facility Number |
| Address – Facility | | | City | | | State | ZIP Code | |
| Reason for Report  (Click to Select from Dropdown List) | Outcome  (Click to Select from Dropdown List) | | | Write in Additional Outcomes: | | Date of Report*(MM/dd/yyyy)* | | |
| **Incident Information** | | | | | | | | |
| ***Use page 2 to provide additional information, as needed. Attach supporting documentation, as needed.*** | | | | | | | | |
| Date – Incident *(MM/dd/yyyy)* | | Time – Incident | | | AM  PM | | | |
| **Involved Persons** *(List all residents, staff, guardians, family, etc. involved and their relationship to facility or resident)* | | | | | | | | |
| **Name** | | **Relationship to Facility or Resident** | | | | | | |
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| **Incident Description** *(Include place, individuals involved, details of the occurrence, historical/background information)* | | | | | | | | |
|  | | | | | | | | |
| **Incident Outcome** | | | | | | | | |
|  | | | | | | | | |
| **Action Taken to Ensure Resident’s Health, Safety, and Well-Being** | | | | | | | | |
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| **Person Submitting Report** | | | | | | | | |
| Name – Person Submitting Report *(Print or type)* | | | Title | | | | | |
| **SIGNATURE** – Person Submitting Report | | | Phone Number | | | | | |
| **Assisted Living Facility Self-Report** | | | | | | | | |
| ***Use page 2 to provide additional information, as needed. Attach supporting documentation, as needed.*** | | | | | | | | |
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