Five-Day Follow-Up Report

Type of Reportable Incident

(please circle one)
Injury of Unknown Source*
or
Alleged Abuse

Date: ________________________________

Facility: ________________________________

Address: ________________________________

Phone #: ________________________________

Resident's Name: ________________________________

DOB: ________________________________

Room #: ________________________________

Certified Bed: ☐ **yes** ☐ **no**

Type of Injury of Unknown Source: ________________________________

Type of Alleged Abuse:

- ☐ physical
- ☐ verbal
- ☐ sexual
- ☐ mental
- ☐ neglect
- ☐ involuntary seclusion
- ☐ misappropriation of resident property

Name of Alleged Perpetrator: ________________________________

Date/Time of Reportable Incident:

____

Diagnoses/Medications with potential for placing resident at risk for injury:

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____

Time of last observation prior to Reportable Incident: ________________________________

Resident condition prior to Reportable Incident:

____

____

____

____

Witnesses to Alleged Abuse: ☐ yes ☐ no

Witnesses and other Staff on duty at time of/or prior to Reportable Incident:

Details of Reportable Incident:

Characteristics of Injury (location, size, number, pattern, color):

History of similar Injury: ☐ yes ☐ no
If “yes” please give details:

Interventions in place prior to Reportable Incident:

Immediate corrective action/assessment following Reportable Incident:

Physician notified: ☐ yes ☐ no
Date/Time:

Interventions by facility to prevent future Injury/Alleged Abuse:

Summary Report of Facility Investigation:

Signature/Title Of Reporter

Date

DHEC
Bureau of Certification/Health Regulation
2600 Bull Street, Columbia, S. C. 29201
Voicemail: 803-545-4300 Fax: 803-545-4292

Please attach copies of all applicable interviews, witness statements, and any other applicable documents.

*CMS S&C-05-09