

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
Assessment and Survey Program / Complaint Unit
PO Box 367
Trenton, NJ 08625-0367

Hotline: 1-800-792-9770, Select #1
Fax: 609-943-4977 or 609-633-9060

CONSUMER RESIDENT/PATIENT COMPLAINT REPORT

Please answer all questions fully and deal with only one event per report.

Today's Date (MM/DD/YYYY):

Date of Event (MM/DD/YYYY):

Time of Event:

 AM PM

This form can be used to report complaints pertaining only to the facility types listed below, which are under the jurisdiction of the Division of Health Facilities Evaluation and Licensing. Select Facility Type:

- | | |
|---|--|
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Adult/Pediatric Day Health Services |
| <input type="checkbox"/> Residential Facility | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Sub-Acute Care Facility | <input type="checkbox"/> Ambulatory Surgical Center |
| <input type="checkbox"/> Assisted Living or Comprehensive Personal Care Home | <input type="checkbox"/> Other Ambulatory Care Facility (specify): _____ |
| <input type="checkbox"/> Assisted Living Program | |
| <input type="checkbox"/> Intermediate Care Facility for the Mentally Retarded | |

Full Name of Facility:

Street Address:

City:

State:

Zip Code:

Facility Telephone Number (if known):

Name of Person Reporting:

Home Telephone Number:

Work Telephone Number:

Cell Phone Number:

Relationship:

- | | | | | |
|---|-----------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Employee | <input type="checkbox"/> Friend | <input type="checkbox"/> POA | <input type="checkbox"/> Visitor |
| <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Consumer | <input type="checkbox"/> Anonymous | <input type="checkbox"/> Former Employee | <input type="checkbox"/> Resident/Patient |

Street Address of Person Reporting:

City:

State:

Zip Code:

**CONSUMER RESIDENT/PATIENT COMPLAINT RECORD
(Continued)**

Type of Incident:

<input type="checkbox"/> Unexpected Death	<input type="checkbox"/> Resident/Patient Care Issues
<input type="checkbox"/> Involuntary Discharge (out of facility)	<input type="checkbox"/> Resident-to-Resident or Patient-to-Patient Abuse
<input type="checkbox"/> Involuntary Transfer (within facility)	<input type="checkbox"/> Theft of Resident's/Patient's Belongings/Money
<input type="checkbox"/> Elopement (resident/patient left the building without staff knowledge)	<input type="checkbox"/> Interruption of Service (i.e., water, electric)
<input type="checkbox"/> Staff-to-Resident or Staff-to-Patient Abuse	<input type="checkbox"/> Injury
<input type="checkbox"/> Environmental Emergency	<input type="checkbox"/> Medication Error
	<input type="checkbox"/> Other

Resident/Patient Name:

Room Number:

Date of Birth / Age:

Narrative:

1) Describe the event; be specific, include timeframes, staff/others involved.

NOTE: Additional information will be requested if necessary.

**CONSUMER RESIDENT/PATIENT COMPLAINT RECORD
(Continued)**

2) Was this reported to the facility staff?

Yes No

3) If Yes, to whom did you report the incident/event?

4) What action was taken by the facility? Include this answer in narrative above.

5) Was this reported to any other agency?

Yes No

6) If yes, what was the agency? i.e. Ombudsman, police

**All complaints are handled as quickly as possible based upon severity guidelines and` priority standards.
If an address is provided, a written response will be sent upon conclusion of the investigation.
Response time may be as long as 6 to 8 weeks after the completion of an investigation.**

FOR NJDHSS USE ONLY

Reviewed By (Surveyor ID Number and Initials):

Date (MM/DD/YYYY):

Other Review (ID Number and Initials):

Date (MM/DD/YYYY):

Disposition:

Pending No Action Complaint Investigation

Referral, Specify:

Closed, Specify Date Closed:

Comments: