

# South Carolina Department of Disabilities and Special Needs

## Report on Administrative Review for Improper Conduct toward Consumer

(Provide brief summarized information in this report—explicit details should be provided according to the Outline of Report)

The Administrative Review for Improper Conduct Toward Consumer is conducted by non-ICF/ID providers upon notification from the state investigative agency that an abuse investigation will not be conducted.			
Reviewer:	Name:	Position:	Date/Time Appointed:
Provider:			
Victim 1:	Birthdate:	Victim 3:	Birthdate:
Victim 2:	Birthdate:	Victim 4:	Birthdate:
Alleged Perpetrator(s)	Name & Title (Indicate which victim #):		
Witnesses:			
Residence of Consumer(s):	<input type="checkbox"/> Family/guardian home/own home <input type="checkbox"/> CRCF <input type="checkbox"/> CTH-I <input type="checkbox"/> CTH-II <input type="checkbox"/> SLP-I <input type="checkbox"/> SLP-II <input type="checkbox"/> Other (Specify): Descriptive Location of Residence (i.e., family home, own home, Jim Doe CTH-I):		
<b>INCIDENT:</b>			
Date of Incident:	Time of Incident: <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> Date of Incident Unknown	If Date of Incident is unknown, indicate Date Incident Reported (shown on Initial Report):		
Type/Location of Incident:	<input type="checkbox"/> Family/guardian home/own home <input type="checkbox"/> CRCF <input type="checkbox"/> CTH-I <input type="checkbox"/> CTH-II <input type="checkbox"/> SLP-I <input type="checkbox"/> SLP-II <input type="checkbox"/> Day Service <input type="checkbox"/> Other (Specify):		
Descriptive Location of Incident: (i.e., family home, own home, Jim Doe CTH-I):			
Type of Suspected Abuse:	<input type="checkbox"/> Exploitation <input type="checkbox"/> Neglect <input type="checkbox"/> Physical <input type="checkbox"/> Psychological <input type="checkbox"/> Sexual		
Description of incident (brief summary):			
Nature and extent of injury/harm & medical treatment received:			
<b>ISSUES/RISK SITUATIONS IDENTIFIED:</b>			
<input type="checkbox"/> Personnel Actions	Comment:		
<input type="checkbox"/> Staff Training	Comment:		
<input type="checkbox"/> Environmental Modifications	Comment:		
<input type="checkbox"/> Policy/Procedure Violations	Comment:		
<input type="checkbox"/> Local Services Contract	Comment:		
<input type="checkbox"/> Awareness Training for People Served	Comment:		
Recommendations Pertaining to These Issues/Situations:			
<b>REVIEW OUTCOME:</b>			
<input type="checkbox"/> Rules, Regulation or Policy Violation(s) (Specify which rule, regulation or policy was violated):			
<input type="checkbox"/> Management Action Taken (Specify what action was taken):		<input type="checkbox"/> Other (Specify):	
Comments:			
<b>ACTION TAKEN/TO BE TAKEN:</b>			
Personnel Action Taken:	<input type="checkbox"/> Administrative Leave W/Out Pay <input type="checkbox"/> In-Service Training <input type="checkbox"/> Legal Charges <input type="checkbox"/> NA/No Staff Involved <input type="checkbox"/> None <input type="checkbox"/> Reinstatement <input type="checkbox"/> Resignation/No Longer Works for Agency <input type="checkbox"/> Terminated <input type="checkbox"/> Transferred <input type="checkbox"/> Unknown <input type="checkbox"/> Verbal Reprimand <input type="checkbox"/> Written Reprimand <input type="checkbox"/> Unknown		
Comments:			
Abuse Prevention/Corrective Action to Avoid Reoccurrence: (Include each action, completion date, staff responsible for implementation of each action and staff title)			

<b>OUTSIDE INVESTIGATIVE AGENCIES:</b>				
Has an investigation by an outside agency been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Or, is case still under investigation by an outside agency? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<i>Agency</i>	<i>Date of Referral</i>	<i>Contact Person</i>	<i>Intake # or Case ID #</i>	<i>Result of Agency's Investigation If Known at Time of Completion of Administrative Review</i>
<input type="checkbox"/> DSS				
<input type="checkbox"/> Local Law Enforcement				
<input type="checkbox"/> Ombudsman				
<input type="checkbox"/> SLED				
<input type="checkbox"/> Attorney General				
<input type="checkbox"/> Other (Specify):				
<b>FINDINGS BASED ON ADMINISTRATIVE REVIEW:</b>				
<i>(Please provide only brief summarized information pertaining to the conclusion of the review)</i>				
<b>Disposition of Abuse Allegation:</b> <input type="checkbox"/> Substantiated/Founded (Perpetrator Known) <input type="checkbox"/> Substantiated/Founded (Perpetrator Unknown) (at time of review) <input type="checkbox"/> Unsubstantiated/Unfounded <input type="checkbox"/> Other Agency Investigating				
<b>OUTLINE OF REPORT</b> <i>(Attach detailed information according to this outline which pertains to the alleged abuse):</i>				
<p><b>A. Chronology of Events</b></p> <p>This section shall include in paragraph form, the re-creation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.</p> <p><b>B. Discussion</b></p> <p>This section will list all facts of the case.</p> <p><b>C. Conclusion</b></p> <p><b>D. Supporting Documents to be Included</b></p> <ol style="list-style-type: none"> <li>1. Signed and dated statements from each person involved</li> <li>2. Unusual Occurrence Form</li> <li>3. Photographs</li> <li>4. OD Report</li> <li>5. Injury Report</li> <li>6. Other documents, if needed during the Administrative Review, such as: <ol style="list-style-type: none"> <li>a. Body check report</li> <li>b. Doctor/Nurse reports</li> <li>c. Work schedule</li> <li>d. Security report</li> </ol> </li> </ol>				
<b>SIGNATURE:</b>		<b>Executive Director/ CEO/ Facility Administrator (or Designee)</b>		
Date:	Name of Person Completing Form:			

Send completed forms within ten (10) working days (excluding state and federal holidays) of discovery of suspected abuse, neglect or exploitation to: Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803.898.7450.