

VENDOR & LONG-TERM HEALTH CARE FACILITY SPECIAL INCIDENT REPORT

RCRC use only: _____ original
 _____ copy for SIR Coordinator
 _____ Not reportable in SANDIS -
 CSM initials required _____

Vendor/Long-term Health Care Facility Name:		Vendor Number: HR0540 (if applicable)	
Address:		Phone #:	
Consumer Name:		Date of Birth:	
Date of Incident: ☐ Definite ☐ Approximate		Date of Report:	
Time of Incident: ☐ Definite ☐ Approximate		Location of Incident:	

Requirements (see instructions for further information)

1. Notify Regional Center of all special incidents within 24 hours and submit written report within 48 hours.
2. Notify applicable licensing entity per regulations and document on this report.
3. Notify responsible person (i.e. parent, guardian, conservator) per requirements and document on this report.
4. Retain a copy in individual consumer record.
5. Fax to appropriate office, Eureka – 707/444-2563, Ukiah – 707/462-3314, Lakeport – 707/262-0475, Fort Bragg – 707/964-0226, Crescent City – 707/465-4230, or email according to the instruction sheet.

Type of Incident (check all that apply)	Regional Center Required Supplemental Reporting (check all that apply)
☐ <u>Missing Person</u> (Complete only when a missing person report has been filed with a law enforcement agency.) ☐ <u>Reasonably suspected abuse/exploitation</u> ☐ Physical ☐ Sexual ☐ Fiduciary (Financial) ☐ Emotional/mental ☐ Physical and/or chemical restraint ☐ <u>Reasonably suspected neglect</u> ☐ Failure to provide medical care for physical and mental health needs ☐ Failure to prevent malnutrition or dehydration ☐ Failure to protect from health & safety hazards ☐ Failure to assist in personal hygiene, provision of food, clothing, shelter ☐ Failure to exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult ☐ <u>Serious injury/accident including:</u> ☐ Lacerations requiring sutures or staples ☐ Puncture wounds requiring medical treatment beyond first aid ☐ Fractures ☐ Dislocations ☐ Bites that break the skin and require medical treatment beyond first aid ☐ Internal bleeding ☐ Any medication errors ☐ Medication reactions that require medical treatment beyond first aid ☐ Burns that require medical treatment beyond first aid ☐ <u>Any unplanned or unscheduled hospitalization due to the following conditions:</u> ☐ Respiratory illness ☐ Seizure related ☐ Cardiac related ☐ Internal infections ☐ Diabetes, including diabetes-related complications ☐ Wound/Skin care ☐ Nutritional deficiencies ☐ Involuntary psychiatric admission ☐ Other ☐ <u>Victim of crime (regardless of when or where the incident occurred)</u> ☐ Specify _____ ☐ <u>Death</u> (Report for any and all situations. Also refer to section 5)	☐ <u>Injury/accident to consumer</u> ☐ Known origin ☐ Unknown origin ☐ From seizure ☐ From another consumer ☐ From behavior episode ☐ Motor vehicle accident (regardless of injury) ☐ <u>Aggressive acts</u> ☐ To self ☐ To another consumer ☐ To staff ☐ To family/visitor/community member ☐ Property damage ☐ Hands on management utilized ☐ Recipient of aggression by another consumer/no injury ☐ <u>Other</u> ☐ Use of PRN psychotropic medication ☐ Alleged violation of rights ☐ Medical emergency ☐ Unauthorized absence-missing person report not filed ☐ Suicide attempt ☐ Suicide threat ☐ Other sexual incident-not rape ☐ Pregnancy ☐ Communicable disease/parasites ☐ Fire ☐ Other

Consumer Name:

Other Persons/Entities Notified

	Contact Name	Contact Date	Telephone	Report# (if applicable)
☐ Redwood Coast Regional Center:				
☐ Community Care Licensing:				
☐ Licensing and Certification (DHS):				
☐ Family member/Guardian/Conservator:				
☐ Physician/Hospital:				
☐ Child/Adult Protective Services:				
☐ Long-Term Care Ombudsman:				
☐ Police/Sheriff:				
☐ County Coroner:				
☐ Other:				
☐ No Other Notification Required				

Section 1

Description of incident (Provide description of events preceding the incident, the actual incident & immediate actions taken, and attach a separate page for additional information, if necessary):

Section 2

Medical Care/Treatment Required?

☐ Yes ☐ No

If Yes, give nature of treatment:

Where was the treatment administered?:

Administered by:

Consumer Name:

Section 3

Specific action taken or planned to prevent re-occurrence of incident (attach a separate page for additional information, if necessary):

Section 4

Other comments or information (including name and contact information for all known involved parties/witnesses. For staff include full name & title. For other Regional Center consumers, please use initials only):

Section 5

Describe the circumstances of the consumer's death –

List known health conditions:

Circumstances/changes in condition prior to death:

Cause of death:

Primary Care Physician/Provider:

Phone #:

Date of last medical appointment:

Name/Title of person
writing report:

Name/Title of person reviewing
report (if applicable):

Date Incident Reported to RCRC:

Date Hard Copy Sent to RCRC: