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| **VENDOR & LONG-TERM HEALTH CARE FACILITY**  **SPECIAL INCIDENT REPORT** | RCRC use only:\_\_\_\_\_ original  \_\_\_\_\_ copy for SIR Coordinator  \_\_\_\_\_ Not reportable in SANDIS - CSM initials required\_\_\_\_\_\_\_\_\_\_ |

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| Vendor/Long-term Health  Care Facility Name: | | | | | Vendor Number:  (if applicable) | |
| Address: | | | | | Phone #: | |
| Consumer Name: | | Date of Birth: | | | | Date of Report: |
| Date of Incident: | Definite  Approximate | | | Location of Incident: | | |
| Time of Incident: | Definite  Approximate | | |  | | |
| Requirements (see instructions for further information) | | | | | | |
| Notify Regional Center of all special incidents within 24 hours and submit written report within 48 hours.  1. Notify applicable licensing entity per regulations and document on this report. 2. Notify responsible person (i.e. parent, guardian, conservator) per requirements and document on this report. 3. Retain a copy in individual consumer record. 4. Fax to appropriate office, Eureka – 707-444-2563, Ukiah – 707-462-3314, Lakeport/Clearlake – 1-707-264-6537 (eFax), Fort Bragg – 707-964-0226, Crescent City – 707-465-4230. | | | | | | |
| **Type of Incident** **(check all that apply)** Missing Person (Complete only when a missing person report has been filed with a law enforcement agency.)  Reasonably suspected abuse/exploitation Physical Sexual Fiduciary (Financial) Emotional/mental Physical and/or chemical restraint Reasonably suspected neglect  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  Serious injury/accident including:  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 Any unplanned or unscheduled hospitalization due to the following conditions:  Respiratory illness  Seizure related  Cardiac related  Internal infections  Diabetes, including diabetes-related complications  Wound/Skin care  Nutritional deficiencies  Involuntary psychiatric admission  Victim of crime (regardless of when or where the incident occurred)  Specify  Death (Report for any and all situations. Also refer to section 5) | | | **Regional Center Required Supplemental Reporting**  **(check all that apply)**  Injury/accident to consumer  Known origin  Unknown origin  From seizure  From another consumer  From behavior episode  Motor vehicle accident (regardless of injury)  Aggressive acts  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  Other  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 | | | |

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|  | | | | 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:** | | | | | | | | |
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|  | | | | 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:** | | | | | |