

## VENDOR & LONG-TERM HEALTH CARE FACILITY SPECIAL INCIDENT REPORT

Vendor/Long-term Health Care Facility Name:		Vendor Number: (if applicable)
Address:		Phone #:
Client Name:	Date of Birth:	Date of Report:
Date of Incident:	<input type="checkbox"/> Definite <input type="checkbox"/> Approximate	Location of Incident:
Time of Incident:	<input type="checkbox"/> Definite <input type="checkbox"/> Approximate	

**The Regional Center must be notified of all special incidents within 24 hours and the written report submitted within 48 hours. Additional instructions on the last page.**

DDS-Reportable SIRs (check all that apply)	Additional SIRs Reportable to RCRC (check all that apply)
<input type="checkbox"/> <u>Medication Error</u> (missed medication, wrong medication, wrong dose, wrong time, wrong route)	<input type="checkbox"/> <u>Injury/Accident to Client</u> Specify
<input type="checkbox"/> <u>Falls</u> (2 or more in a 30-day period, can be multiple vendors)	<input type="checkbox"/> <u>Medical Emergency (ER Visit/Ambulance/EMT)</u> Specify
<input type="checkbox"/> <u>Missing Person</u> (When a report has been filed with law enforcement/security.)	<input type="checkbox"/> <u>Communicable Disease/Parasites</u>
<input type="checkbox"/> <u>Reasonably suspected alleged abuse/exploitation/physical or chemical restraint</u> (exploitation, physical, chemical, verbal, emotional/mental, isolation, mechanical, sexual, financial) <b>REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT</b> Specify	<input type="checkbox"/> <u>Use of PRN Psychotropic Medication</u>
<input type="checkbox"/> <u>Reasonably suspected alleged neglect</u> (abandonment, hygiene, dehydration, malnutrition, hazard, food/clothing/shelter, medical, mental health, falls, self-neglect) <b>REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT</b> Specify	<input type="checkbox"/> <u>Aggressive Acts/Property Damage</u> Specify
<input type="checkbox"/> <u>Serious injury/accident</u> (laceration, bruising, burn, fracture, dislocation, bite, head injury/concussion, medication reaction, pressure injury, internal bleeding, puncture, seizure, injury from another consumer) Specify	<input type="checkbox"/> <u>Suicide Threat/Attempt</u>
<input type="checkbox"/> <u>Unplanned or unscheduled hospitalization</u> (bowel obstruction, cardiac, diabetes, due to seizure, internal infection, involuntary psych admission, nutritional deficiency, respiratory illness, wound/skin care, ER visit 5 or more days) Specify	<input type="checkbox"/> <u>Sexual Incident/Pregnancy of Concern</u>
<input type="checkbox"/> <u>Victim of crime</u> (aggravated assault, simple assault, battery, attempted homicide or manslaughter, battery, burglary, fraud, hate crime, identity or credit theft, larceny, personal robbery, rape or attempted rape, stalking, human trafficking) <b>REQUIRES LAW ENFORCEMENT REPORT</b> Specify	<input type="checkbox"/> <u>Alleged Violation of Rights</u> Specify
<input type="checkbox"/> <u>Death</u>	<input type="checkbox"/> <u>Hands-on Management Utilized (per approved plan)</u>
	<input type="checkbox"/> <u>Emergency Event (Fire, Car accident, etc.)</u> Specify
	<input type="checkbox"/> <u>Medication Refusal</u>
	<input type="checkbox"/> <u>Other</u> Specify

Client Name:

**Required Persons/Entities Notified**

	Contact Name	Contact Date	Telephone	Report# (if applicable)
<input type="checkbox"/> Redwood Coast Regional Center:				
<input type="checkbox"/> Parent/Guardian/Conservator (if applicable):				
<input type="checkbox"/> Child/Adult Protective Services:				
<input type="checkbox"/> Long-Term Care Ombudsman:				
<input type="checkbox"/> Community Care Licensing (CCL):				
<input type="checkbox"/> Licensing and Certification (DHS):				
<input type="checkbox"/> Police/Sheriff:				
<input type="checkbox"/> Physician/Hospital:				
<input type="checkbox"/> County Coroner:				
<input type="checkbox"/> Other:				

**Section 1: Incident Description**

Provide description of events preceding the incident, the actual incident & immediate actions taken, and attach a separate page for additional information, if necessary. For medication errors, please ensure the questions in Section 2 are completed. **In the event of the death of a client, please include the following: known health conditions; circumstances/changes in condition prior to death; cause of death, if known:**

**Section 2: Medication Errors**

Please answer the following:

Describe what went wrong (wrong medication, wrong dose, wrong time, wrong route, etc.):

Names and doses of medications involved:

Medical professional that was contacted for instructions about how to proceed:

Adverse effects, if any, were noted due to the medication error (please note any extended medical treatment in Section 3):

Client Name:

**Section 3: Medical Treatment**

Medical Care/Treatment Required?  Yes  No

If Yes, give nature of treatment:

Where was the treatment administered?:

Administered by:

**Section 4: Preventative Actions**

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

**Section 5: Comments**

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

Name/Title of person writing report:

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

Date Incident Reported to RCRC:

Date Written Copy Submitted to RCRC:

**Requirements**

1. **Notify Regional Center of all special incidents within 24 hours and submit written report within 48 hours.**
2. **If applicable, notify the person responsible (i.e. parent, guardian, conservator) per requirements and document on this report.**
3. **Notify applicable licensing (CCL, DHS) entity, APS, CWS, and/or other required entities as per regulations and document on this report.**
4. **Retain a copy in individual client record.**
5. **Fax or hand deliver to the 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**