

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) REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT 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) REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT 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) REQUIRES LAW ENFORCEMENT REPORT 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