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: ☐ Definite ☐ Approximate	Location of Incident:	
Time of Incident: ☐ Definite ☐ 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)

☐ Medication Error (missed medication, wrong medication, wrong dose, wrong time, wrong route)

☐ Falls (2 or more in a 30-day period, can be multiple vendors)

☐ Missing Person (When a report has been filed with law enforcement/security.)

☐ Reasonably suspected alleged abuse/exploitation/physical or chemical restraint (exploitation, physical, chemical, verbal, emotional/mental, isolation, mechanical, sexual, financial) REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT
Specify

☐ Reasonably suspected alleged neglect (abandonment, hygiene, dehydration, malnutrition, hazard, food/clothing/shelter, medical, mental health, falls, self-neglect) REQUIRES APS/CPS/OMBUDSMAN/ OR LAW ENFORCEMENT REPORT
Specify

☐ Serious injury/accident (laceration, bruising, burn, fracture, dislocation, bite, head injury/concussion, medication reaction, pressure injury, internal bleeding, puncture, seizure, injury from another consumer)
Specify

☐ Unplanned or unscheduled hospitalization (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

☐ Victim of crime (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

☐ Death

Additional SIRs Reportable to RCRC (check all that apply)

☐ Injury/Accident to Client
Specify

☐ Medical Emergency (ER Visit/Ambulance/EMT)
Specify

☐ Communicable Disease/Parasites

☐ Use of PRN Psychotropic Medication

☐ Aggressive Acts/Property Damage
Specify

☐ Suicide Threat/Attempt

☐ Sexual Incident/Pregnancy of Concern

☐ Alleged Violation of Rights
Specify

☐ Hands-on Management Utilized (per approved plan)

☐ Emergency Event (Fire, Car accident, etc.)
Specify

☐ Medication Refusal

☐ Other
Specify

Client Name:

Required Persons/Entities Notified				
	Contact Name	**Contact Date**	**Telephone**	**Report#** **(if applicable)**
☐ **Redwood Coast Regional Center**:				
☐ **Parent/Guardian/Conservator (if applicable)**:				
☐ Child/Adult Protective Services:				
☐ Long-Term Care Ombudsman:				
☐ Community Care Licensing (CCL):				
☐ Licensing and Certification (DHS):				
☐ Police/Sheriff:				
☐ Physician/Hospital:				
☐ County Coroner:				
☐ 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**