Multnomah County
Aging, Disability and Veterans Services Division

Adult Care Home
Incident Report

ACH address:		Staff reporting:	
Resident's name:		Date of incident:	
Birthdate:	Prime #:	Time of incident:	☐ AM ☐ PM

Type of Incident: ☐ Accident ☐ Medication Error ☐ Illness ☐ Injury
☐ Missing Money/Property ☐ Behavioral ☐ Police ☐ Fire ☐ Medical
☐ Unexplained or unanticipated absence from home ☐ Other: ☐ Death
☐ Protective Physical Intervention ☐ Suspected abuse/neglect – list date reported:

Where did the incident occur? Persons involved in incident (do not list resident names):	Was the incident witnessed? ☐ Yes ☐ No If so, by whom?

Does resident have a behavior support plan in place? ☐ Yes ☐ No

Details of incident including how and when the incident occurred and who was involved. Include a description of any injuries, property damage, protective physical intervention or restraint used :

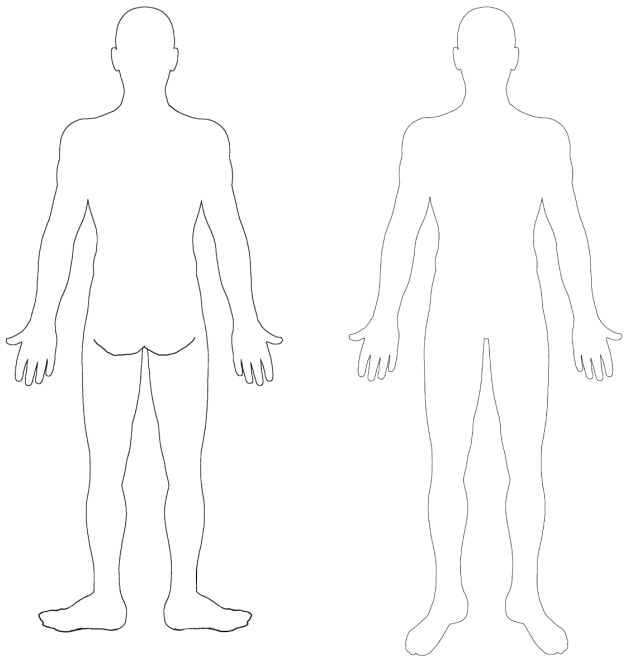
Describe what specific actions were taken by Operator/Staff:

Outcome for resident:

Describe the follow-up plan (what did you do to prevent this from happening again, and what additional follow-up is needed to prevent this from happening again):

Was anyone injured? ☐ Yes ☐ No If yes, who?

Mark and describe any areas injured (i.e., bruises, cuts, abrasions, broken bones, etc.)



Family/Guardian notified? ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

Primary care provider notified? ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

Case manager/service coordinator? ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date Time:

Mental health provider notified? ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

ACHP (private pay only)? ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

Other: ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

Other: ☐ Yes ☐ No
Name:
Notified by: ☐Phone ☐Fax ☐Mail ☐ Secure Email
Date: Time:

Print name of person completing form:	Signature:	Date:	Time:
Operator signature acknowledging review of incident report:		Date of review: Date signed:	

Additional Incident Report Details for Mental Health Residents

Critical Incident ☐ Yes ☐ No **Who:**

Persons Involved
- ☐ Resident to staff
- ☐ Resident to resident
- ☐ Staff to resident
- ☐ Single resident
- ☐ Not applicable
- ☐ Other (please explain):

Medication Incident
- ☐ Wrong drug
- ☐ Wrong dose
- ☐ Wrong time
- ☐ Med refusal
- ☐ Missed med
- ☐ MAR error
- ☐ Med count discrepancy
- ☐ Adverse reaction
- ☐ Other med error

Behavioral/Health Incident
- ☐ Assault
- ☐ Drug/alcohol
- ☐ Contraband
- ☐ Elopement
- ☐ Fall
- ☐ Personal injury
- ☐ Self-harm
- ☐ Threats/intimidation
- ☐ Medical change
- ☐ Clinical/behavioral change
- ☐ Inappropriate behavior
- ☐ Medical emergency
- ☐ Property harm/theft/loss
- ☐ Smoking Violation
- ☐ Exploitation: Sexual
- ☐ Exploitation: Financial

Facility/Other Incidents
- ☐ Unlocked doors/windows
- ☐ Unsecure equipment/supplies
- ☐ Other, please explain: