

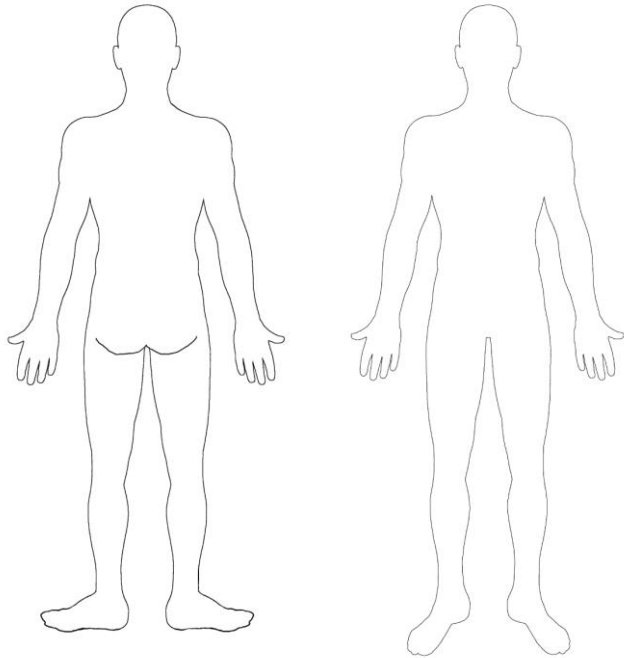
## Adult Care Home Incident Report

Aging, Disability and Veterans Services Division

ACH address:		Staff reporting:	
Resident's name:		Date of incident:	
Birthdate:	Prime #:	Time of incident: <input type="checkbox"/> AM <input type="checkbox"/> PM	
<b>Type of Incident:</b> <input type="checkbox"/> Accident <input type="checkbox"/> Medication Error <input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Missing Money/Property <input type="checkbox"/> Behavioral <input type="checkbox"/> Police <input type="checkbox"/> Fire <input type="checkbox"/> Medical <input type="checkbox"/> Unexplained or unanticipated absence from home <input type="checkbox"/> Other: <input type="checkbox"/> Protective Physical Intervention <input type="checkbox"/> Suspected abuse/neglect – list date reported:			
Where did the incident occur?		Was the incident witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Persons involved in incident (do not list resident names):		If so, by whom?	
Does resident have a behavior support plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
Primary care provider notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
Case manager/service coordinator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
Mental health provider notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
ACHP (for visitor exclusion)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Secure Email
Date: _____	Time: _____
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Notified by: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> 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	Medication Incident	Behavioral/Health Incident	
<input type="checkbox"/> Resident to staff	<input type="checkbox"/> Wrong drug	<input type="checkbox"/> Assault	<input type="checkbox"/> Medical change
<input type="checkbox"/> Resident to resident	<input type="checkbox"/> Wrong dose	<input type="checkbox"/> Drug/alcohol	<input type="checkbox"/> Clinical/behavioral change
<input type="checkbox"/> Staff to resident	<input type="checkbox"/> Wrong time	<input type="checkbox"/> Contraband	<input type="checkbox"/> Inappropriate behavior
<input type="checkbox"/> Single resident	<input type="checkbox"/> Med refusal	<input type="checkbox"/> Elopement	<input type="checkbox"/> Medical emergency
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Missed med	<input type="checkbox"/> Fall	<input type="checkbox"/> Property harm/theft/loss
<input type="checkbox"/> Other (please explain):	<input type="checkbox"/> MAR error	<input type="checkbox"/> Personal injury	<input type="checkbox"/> Smoking Violation
	<input type="checkbox"/> Med count discrepancy	<input type="checkbox"/> Self-harm	<input type="checkbox"/> Exploitation: Sexual
	<input type="checkbox"/> Adverse reaction	<input type="checkbox"/> Threats/intimidation	<input type="checkbox"/> Exploitation: Financial
	<input type="checkbox"/> Other med error		
	<b>Facility/Other Incidents</b>		
	<input type="checkbox"/> Unlocked doors/windows	<input type="checkbox"/> Unsecure equipment/supplies	
	<input type="checkbox"/> Other, please explain:		