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| Name: | Room #: |
| What happened?🖵 Fall🖵 Altercation with another resident🖵 Left campus without needed assistance🖵 Item missing 🖵 Unexpected death/suicide🖵 Other: | Where did it happen?Location – where did incident happen? Be specific: |
| Date of occurrence: | Time of occurrence: |
| Describe what happened: |
| Describe injury (include location and type):1. Skin tear(s)
2. burn(s)
3. blister(s)
4. Nothing apparent at this time
5. Other:
6. redness
7. swelling
8. bruise(s)
9. scratch(es)
10. cut(s)
11. rash

*Indicate on the diagram (below) any of the conditions noted. Mark each condition with a letter (A, B, etc.)* | Did the resident have any discomfort after the incident?  Identify what level: (any level above 3 must be reported to the provider/resident manager)January07PT_60_f1FacesScale12,print |
| LeftRight | RightLeft | **Vital signs:**  | Blood pressure | Pulse | Respirations | Temperature |
| Based on the information you have now, why do you think this incident happened?🖵 Self🖵 Other resident🖵 Staff🖵 Environment🖵 Accidental🖵 Equipment 🖵 Unknown🖵 Other: |
| Was the ambulance called? 🖵 Yes 🖵 No | Was the resident sent to the hospital? 🖵 Yes 🖵 No If yes, which hospital? |
| What did the resident say happened? (ASK: “did anyone hurt you?” If yes, follow abuse reporting policy and protect resident from further harm) |
| Describe other action (first aid, etc.) and by whom: |
| Witness(es): |
| **NOTIFICATIONS** |
| **NAME** | **PHONE** | **DATE** | **TIME** | **INITIALS** |
| Provider | Cell:Home: |  |  |  |
| Resident manager | Cell:Home: |  |  |  |
| Physician Notified | Name: | Indicate by circling:Phone or Fax |  |  |  |
| Family Notified | Name: |  |  |  |  |
| CRU notified | 🖵 Yes 🖵 No | 1-800-562-6078 |  |  |  |
| Police notified | 🖵 Yes 🖵 No | 911 or [local number here] |  |  |  |
| SIGNATURE OF PERSON COMPLETING REPORT | DATE |
| **DETERMINATION OF CAUSE** |
| Check all investigational methods used: 🖵 Staff interviewed 🖵 Resident(s) interviewed 🖵 Witness(es) interviewed 🖵 Documentation reviewed 🖵 Observations made🖵 Other: |
| Upon review of the incident report, along with further investigation, describe probable cause(s) of the incident: |
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| **PREVENTION OF FUTURE SIMILAR INCIDENTS** |
| Based on investigational findings, describe prevention measures implemented: |
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| Is there a change in condition from incident? 🖵 Yes 🖵 No | If yes, please describe: |
| Negotiated care plan updated? 🖵 Yes 🖵 No | If yes, please describe: |
| New physician orders as a result of incident: 🖵 Yes 🖵 No | If yes, please describe: |
| Investigator’s signature: | Date: |
| Provider or Resident Manager signature: | Date: |