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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_f1  FacesScale12,print | | | | | | | | | | | |
| Left  Right | | Right  Left | | | **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: | | | | |