# RCEB VENDOR SPECIAL INCIDENT REPORT

| Consumer's Name | Date of Birth | ☐ M | ☐ F | UCI Number | Date of Report |
|---|---|---|---|---|---|
| **Diagnosis** Primary and secondary diagnoses (e.g. autism, mild mental retardation, seizure disorder, borderline personality disorder) | Consumer's Address | | | Case Manager | |

**TYPE OF INCIDENT** (check all that apply)

**Suspected Abuse/Exploitation Check type:**
- ☐ Physical
- ☐ Sexual
- ☐ Fiduciary
- ☐ Emotional/Mental
- ☐ Physical and/or Chemical Restraint

**Serious Injury/Accident Check type:**
- ☐ Lacerations requiring sutures or staples
- ☐ Puncture wounds requiring medical treatment beyond first aid
- ☐ Fractures
- ☐ Dislocations
- ☐ Bites that break the skin and require medical treatment beyond first aid
- ☐ Internal bleeding
- ☐ Any medication errors
- ☐ Medication reactions that require medical treatment beyond first aid.
- ☐ Burns that require medical treatment beyond first aid
- ☐ Other (specify)

**Victim of Crime Check type**
- ☐ Personal Robbery
- ☐ Aggravated assault
- ☐ Burglary
- ☐ Forcible rape
- ☐ Larceny
- ☐ Other (specify)

**Injury/Accident: Check type:**
- ☐ Injury-Unknown origin
- ☐ Injury from seizure
- ☐ Injury from another consumer
- ☐ Injury from behavior episode

**Aggression Displayed by Consumer.** (Limited to incidents where injury was incurred (notable bruising, scratching, etc.) **Check type:**
- ☐ Aggressive act to self
- ☐ Aggressive act to another consumer
- ☐ Aggressive act to staff

**Suspected Neglect Check type:**
- ☐ Failure to Assist in Personal Hygiene, Provision of Food, Clothing, Shelter
- ☐ Failure to Prevent Malnutrition or Dehydration
- ☐ Failure to Provide Medical Care
- ☐ Failure to Protect from Health & Safety Hazards
- ☐ Exercise a degree of care that a reasonable person would exercise in a position of having the care and custody of an elder or a dependent adult.

**Any Unplanned or Unscheduled Hospitalization: Check type:**
- ☐ Respiratory illness
- ☐ Seizure-related
- ☐ Cardiac related
- ☐ Internal infections
- ☐ Diabetes/Diabetes related complications
- ☐ Wound/skin care
- ☐ Nutritional deficiencies
- ☐ Medical emergency (ER)
- ☐ Other (specify)
- ☐ Involuntary psychiatric admission

☐ **Missing Person**

☐ **Death (Regardless of living arrangement, cause or perpetrator)**

**Other: Check type:**
- ☐ Violation of Rights
- ☐ Disease outbreak
- ☐ Fire
- ☐ Suicide attempt
- ☐ Property damage
- ☐ Other sexual incident—Not rape
- ☐ Unplanned Absence–law enforcement not notified
- ☐ Restraint
- ☐ Other

| **Incident date**<br>☐ **Definitive**<br>☐ **Approximate**<br><br>**Date incident reported to Regional Center:**<br><br>**To whom:** | **Time of incident**<br>☐☐ **Definitive**<br>☐ **Approximate**<br><br>**Medical Care/Treatment Required?**<br><br>**If YES Describe:**<br><br>**Name of treating physician:**<br><br>**Name of hospital/clinic:** |
|---|---|

| **Relationship of alleged perpetrator to consumer (used for neglect or abuse, and victim of crime only)** | |
|---|---|
| ☐Unknown<br>☐Self<br>☐Vendor or Employee of Vendor<br>☐Non-Vendor or Employee of Non-Vendor | ☐Another Consumer<br>☐Relative/Family Member<br>☐Individual known to consumer (Not a provider or another consumer)<br>☐Not applicable |

| **Incident location** | |
|---|---|
| ☐ Psychiatric treatment center<br>☐ SNF<br>☐ Consumer's residence<br>☐ Other | ☐ Job site<br>☐ Community setting<br>☐ Day program<br>☐ In transit |

| **Agency or person making the report** (Vendors have to complete this section to its entirety) | |
|---|---|
| Vendor Name:<br><br>Vendor Type:<br><br>Vendor Phone #:<br><br>Vendor Number: (only when known)<br><br>☐ Self/Spouse ☐ Residential<br><br>☐ Parent/Family ☐ Day Program<br><br>☐ Other: | (When responsible party is not a vendor)<br><br>Name:<br><br>Address:<br><br>City/Zip:<br><br>Telephone: |

## Other agencies notified

| | |
|---|---|
| ☐ Community Care Licensing Contact Date<br>Name of CCL Contact | ☐ DHS Licensing & Certification Contact Date<br>Name of DHL Contact |
| ☐ Child Protective Services Contact Date<br>Name of CPS Contact | ☐ Adult Protective Services Contact Date<br>Name of APS Contact |
| ☐ Parent/Guardian/Conservator Contact Date<br>Name of Contact | ☐ Long-Term Care Ombudsman Contact Date<br>Name of LTCO Contact |
| ☐ Police/Law Enforcement Contact Date<br>Name of Police/Law Enforcement | ☐ Other: Contact Date<br>Name Contact |

## NARRATIVE

**ANSWER ALL Questions for sections not specified as Optional**

**Description of incident Include Significant Events *Before* Incident Occurred** (Statement of Facts of the incident (who, what, when, where)

**Immediate Action Taken** (What immediate and short-term things were done to **keep the individual safe**, or what immediate **medical care** was provided, or any other actions that were taken including what was done or is being to determine the cause of the incident so that an appropriate prevention plan can be implemented. Who did what? What are the expected outcomes?)

**Specific preventative action taken or planned by the vendor** (What is being done to make sure this does not happen again? Include future appointments, consultations, training, policy changes, individual service plan changes; who will be responsible for implementation, the dates by when they will occur, how and where the outcomes will be documented)**:**

**Witnesses to the Incident Name and Contact Telephone Numbers**:

*Optional* **Comments** (Is there anything else significant about the incident or the mitigation/prevention plan that needs to be reported for the record?)

**Reporting Person's Name and Contact Number:**

Signature: _____ Date: ______

(SIR template – 07/01/08) mk/ar