Incident - Occurrence Report
To be completed by the staff member on Duty who witnessed or found the subject of this Incident Report. This form must be filled out during the shift the incident occurred, and submitted to the Community Licensed Nurse or Executive Director, prior to shift end.

Community Name: ____________________________ Date: ___________________

Person Involved: ____________________________ Apt. #(if applicable): ______

(Check One)  □ Resident  □ Visitor  □ Vendor  □ Other: _____________

Date of Occurrence: ___________________ Time of Occurrence: ___________________

Exact location of Incident-Occurrence: ___________________________________________

**Type of Occurrence:**
- Fall
  - Witnessed Fall
  - Un-witnessed Fall
- Found on Floor
- Res. To Res. Altercation
- Res. To Staff Altercation
- Staff to Res. Altercation
- Choking/Aspiration
- Transfer related
- Equipment Failure
- Missing Resident
- Unknown
- Other

**Nature of Injury:**
- Pressure Area
- Skin Tear
- Bruise
- Laceration
- Burn
- Hematoma (bruise)
- Complaint of Pain
- Swelling/soft tissue
- No Visible Injury
- Equipment Failure
- Unknown
- Other

First Aid Given: □ Y □ N  Physical Assessment (ROM): ___________________________

Vital Signs: T ______  P ______  R _____  BP _______

Treatment Provided:
___ Ice  ___ Heat  ___ Dressing  ___ Other  ____________________________

Transported to Hospital? □ Y □ N  On Hospice? □ Y □ N  Hospice Notified? □ Y □ N

Description of Occurrence: (i.e. what was the person doing? What was the environment condition, i.e.: Lighting, floor surface, icy, throw rug, etc. Be factual, don’t speculate. List names of all staff, residents, visitors, etc., involved or who witnessed the incident. (Chart on back of this form if you need more room)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Non-Employee Incident-Occurrence Report  Updated: 11/16/2011
Non-Employee Incident-Occurrence Report

Person (resident, family, vendor, etc.) and/or witness statement of occurrence (Please only list exact facts and/or statements – do not speculate):
__________________________________________________________________________
__________________________________________________________________________
Was there any change in the environment such as foreign object, liquid on the floor, throw rug, etc.__________________________________________________________________________

What position was the person found in?________________________________________
__________________________________________________________________________

What was the person wearing at the time of the incident including shoes?____________________________________________________________
__________________________________________________________________________

(Notified if needed or appropriate):

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td>Physician:</td>
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<td>Family/Responsible Party:</td>
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<td>Law Enforcement:</td>
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<td>911 Called?</td>
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<td>Faxed to Home Office?</td>
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<td>ROER Completed?</td>
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<td>Resident place on 24 Hr. Report?</td>
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<td>LN and/or ED Notified:</td>
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(Report Incidents Listed Below to Home Office)

♦ Outbreaks of illness such as Norwalk-like viruses or food poisoning; ♦ Suspected abuse; ♦ Incidents of violence or threats of violence by residents, visitors, staff, phone calls, written correspondence or others; ♦ Incidents or occurrences involving visitors, guests or vendors; ♦ Investigation of incident by a State Regulatory Authority; ♦ Incidents involving property damage or vehicles.

Action taken to resolve incident and prevent further occurrences? ______________________________
__________________________________________________________________________

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<thead>
<tr>
<th></th>
<th>Name</th>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td>Person Filing Report:</td>
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<tr>
<td>Executive Director Review:</td>
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<td>Licensed Nurse Review:</td>
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<td>Reported to Hotline:</td>
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<td>Care Plan Modified:</td>
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Non-Employee Incident-Occurrence Report Updated: 11/16/2011
Non-Employee Incident - Occurrence Management Investigation Report

To be completed by Facility Nurse or Management Team Member

Results of resident and Staff interviews:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Has similar incident occurred before?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What were previous interventions in place if any?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What are the incident similarities?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Results of investigation/possible causes: Do you suspect Abuse or Neglect?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
What steps are being taken to prevent further occurrence of this incident?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Person Completing Incident/Occurrence Investigation:
___________________________________________________ Date: __________

Signature

Facility Nurse Signature: ____________________________ Date: __________
Administrator Signature: ____________________________ Date: __________