

**2642 Georgetown DR NW Rochester, MN 55901 Phone: 507-258-3950 FAX: 507-258-3950**

**Incident Report Form**

\*The following incidents must be reported within 24 hours of occurrence, or within 24 hours of receipt of information11.

**SECTION I**

**Time/Date of Incident**: **Time/Date of Receipt:**

**Consumer Name:** **Program Name:**

**Reporters Name:**   **Location of Incident:**

(If a VA/MOM, please leave off reporter’s name)

**Date/Time Reported to Chain of Command:**

**Date/Time Reported to Registered Nurse (if applicable):**

**Incident Type**:  Serious Injury  Death  Medical Emergency

Unexpected Serious Illness  Consumer Unauthorized/Unexplained Absence  VA/MOM

Sexual activity between consumers involving force or coercion

Significant unexpected change in an illness or medical condition of a person that requires the program to call “911,” physician treatment, or hospitalization

Any incident that requires the program to call “911,” law enforcement, fire department, or a mental health crisis intervention team

Consumer on consumer aggression

Emergency Use of Manual Restraint  Biohazardous accidents  Communicable Disease

Infection Control  Use or possession of weapons  Vehicle Accidents

Suicide or attempted suicide  Fall  Sexual assault

Unauthorized use or possession of licit or illicit substances

Other:

(Including but not limited to consumer aggression/violence, administrative incidents, etc.)

**Describe Incident/Staff Intervention:**  (use additional sheets if necessary)

**Document in Daily Log Notes or Health Progress Notes:**  Yes  No

Signature of Reporter (If not a VA/MOM): Date:

**SECTION II: Founder/CEO Complete This Section:**

**Resolution of Incident:** (Describe the response to the incident, use additional sheets if necessary)

Administrative Use Only: (check all that apply)

Notify Supervisor Immediately

Ensure Staff completes VA/MOM form (if necessary)

**Persons Notified within 24 Hours: Date Time Left Message:**

Case Manager:

Legal Rep:

Designated Emergency Contact:

Caregiver (school/day program/residential program):

(call and send reports as they occur – i.e. during school breaks/summer breaks)

\*Ombudsman:

\*Commissioner – DHS Licensor:

\*\*County Foster Care Licensor:

(\*\*for incidents involving 911 and Law Enforcement as determined by Administrator)

# SERIOUS INJURY AS DEFINED BY THE OMBUDSMAN’S OFFICE

\*Ombudsman and Commissioner notified for deaths and serious injury only. Fractures, possible fractures, dislocations, evidence of internal injuries, head injury with loss of consciousness, lacerations involving injury to tendons/organs, and for those which complications are present, extensive second or third degree burns or frost bite, and for those which complications are present, irreversible mobility or avulsion of teeth, injuries to the eyeball, ingestion of foreign substances and objects that are harmful, near drowning, heat exhaustion or sunstroke, self-injurious behavior requiring physician treatment, suicide attempts, and all other injuries considered serious by physician.

\*\*Some individual County Foster Care Licensors have requested copies of incident reports involving 911 and/or Law

Enforcement. Founder/CEO will determine if Incident Report is to be sent to County Foster Care Licensor.

Signature of Founder/CEO: Date:

**SECTION III**

**Administrator Review**

1. Was the person’s Service or Support Planimplemented as applicable*?*

Yes  No: if no address in the corrective action section of this review

2. Were policies and procedures implemented as applicable?

Yes  No: if no, address in the corrective action section of this review

3. Identification of patterns:

4. Is corrective action necessary based upon the review?  Yes  No: If yes, what corrective action will be implemented as necessary to reduce occurrences:

Check all that apply:  Notify Supervisor Immediately

Ensure pg1 of VA/MOM form is completed  Complete Ombudsman Report Form

Complete pg2 of VA/MOM form  Contact/Fax Ombudsman

Contact/Fax CEP  Contact/Fax DHS Licensing Division

Forward pg1 and pg2 to QA  Contact/Fax County Foster Care Licensor

Founder/CEO Signature: Date:

**CC: Safety Committee/Legal Representative/Case Manager/Residential Provider within 7 days of incident (if requested in CSSPAddendum or ISP)**