Reporting Vendor/ Long -term Care Name:

License #:

Vendor Number:

Report to Regional Center
Special Incident Report – Other Observations and Events

INSTRUCTIONS

1. Notify Westside Regional Center of all special incidents within 24 hours, (310) 258-4000
2. Submit written report within 48 hours, **WRC SIR Fax (310) 258-4222**
3. Notify applicable licensing (CCL, DHS, APS, Ombudsman, Police) entity per regulations.
4. Notify responsible person, (i.e., parent, guardian, conservator) per requirements.
5. Submit update to Westside Regional Center within 30-days

Consumer Name:	**Sex:**		**Date of Birth:**		**UCI Number**		**Date of Report:**
	☐M ☐F						

Check Applicable ☐Verbal ☐Non- Verbal ☐Ambulatory ☐Non-Ambulatory Conserved ☐ Yes ☐ No

Date of Incident:

Time of Incident:

Site of Incident:

SPECIAL INCIDENTS (TITLE 17, §54327)

- ☐ Death of a consumer (regardless of cause or location)
- ☐ The consumer is missing and the vendor has filed a missing persons report with a law enforcement agency
- ☐ The consumer was a victim of a crime (regardless of location)

☐ Reasonably suspected abuse or exploitation:

- ☐ Physical Abuse
- ☐ Sexual
- ☐ Fiduciary
- ☐ Psychological
- ☐ Physical Restraint
- ☐ Chemical Restraint

☐ Reasonably suspected neglect:

- ☐ Failure to provide medical care
- ☐ Failure to prevent malnutrition or dehydration
- ☐ Failure to protect from health and safety hazard
- ☐ Failure to assist in personal hygiene or the provision of food, clothing or shelter

☐ Unplanned / Unscheduled hospitalization due to:

- ☐ Respiratory illness
- ☐ Seizure-related activity
- ☐ Cardiac-related activity
- ☐ Internal infection
- ☐ Diabetes-related
- ☐ Wound/ skin care
- ☐ Nutritional deficiencies
- ☐ Involuntary psychiatric admission

☐ A serious injury or accident including:

- ☐ Laceration(s) requiring sutures
- ☐ Fractures
- ☐ Dislocations
- ☐ Burns, bites, puncture wounds, internal bleeding, or medication reactions requiring medical treatment beyond first aid
- ☐ **ANY** medications errors

OTHER OBSERVATIONS AND EVENTS

- ☐ Alleged violation of consumer's right
- ☐ Other sexual incident:
- ☐ Sexual harassment
- ☐ Inappropriate sexual contact
- ☐ Pregnancy
- ☐ Medical Emergency
- ☐ Emergency room visit
- ☐ Seizure
- ☐ Injury Unknown Origin

☐ Suicide episode: ☐ Attempt ☐ Threat

☐ Behavioral episode:

- ☐ Verbal aggression
- ☐ Aggressive act to self
- ☐ Aggressive act to consumer
- ☐ Aggressive act to staff
- ☐ Aggressive act to family/visitor
- ☐ Property damage
- ☐ Use of restrictive behavior intervention/ physical containment

I.D. Team Staffing within 24-Hours required*

***H&S Code 1180-1180.6** (Restraint/Seclusion)

☐ Other occurrence involving:

- ☐ Earthquake
- ☐ Vehicular accident
- ☐ Fire
- ☐ Other: _____

Other Consumers/ Staff Present: (Include the full name and relationship of any witness to the incident)

Medical Treatment: (If yes, describe) ☐ Yes ☐ No

Where Administered: _____

Administered by:

Client Name: _____

Date: _____

Reporting Vendor/ Long -term Care Name:

License #:

Vendor Number:

Description of Incident (Include possible cause of incident / who, what , when where, how & why)

Immediate Action Take by Service Provider/ Staff (Vendor/Administrator/Licensee/Other)

Plan To Prevent Further Occurrences

Follow-Up Plan within 30-days/ Comments

(Attach a separate page for additional information if necessary)

Report Submitted By		**Contact Date**
Name (print clearly)	Title:	
Vendor Address :	Telephone Number:	
Reviewed by Name:	Signature:	
Other Agencies/Individuals Notified/ Contact Name:	**Telephone #**	
Regional Center		
Licensing (DSS /DHS)):		
Parent/Guardian/Conservator:		
Physician/Hospital:		
Child/Adult Protective Services		
Long-Term Care Ombudsman		
Police/Sheriff:		
County Coroner:		
Other:		

Client Name: _____

Date: _____

Reporting Vendor/ Long -term Care Name:
License #:
Vendor Number:

Client Name: _____
Date: _____