WESTSIDE REGIONAL CENTER

Vendor/ Long-term Care Name: ________________________
Vendor Type: CCF: __ LTC: __ CPP/CRDP:__ SLS__ Day/ILS Other: __
Vendor Number: ______________

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1. Notify Westside Regional Center (WRC) of all special incidents within 24-hours verbal report, **(310) 258-4000.**
(Do not leave message for Service Coordinator (SC). *Speak* to the SC, Counselor On Duty (COD) or On-Call Manager
2. Submit written report within 48-hours, WRC SIR Fax 1-877-254-6903 or email to SIR@westsiderc.org
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 SIR follow up/ updates to WRC within 30-days

Consumer Name	Gender Identified	DOB:	UCI:	Date of Report
Check Applicable	Verbal: _____ Non- Verbal: ___	Ambulatory:____ Non-Ambulatory: ___	Conserved: Yes __ No__ By who? ___________	

Date of Incident:	**Date the vendor/other entity learned of the incident**:
Specific Location of Incident:	
Time of Incident:	
SPECIAL INCIDENTS CCR TITLE17 §54327	**Other Observations and Unusual events**
□ Death of any consumer (regardless of where or when) □ The consumer was a victim of a crime (regardless of where or when it occurred.) □ The consumer is missing and the vendor has filed a missing person report with a law enforcement agency □ COVID 19 Positive or COVID 19 reports symptoms	Behavioral Crisis episode: □ Use of restrictive behavior intervention/ physical containment , Chemical restraint drug used to control behavior (not to treat medical condition) I.D. Team Staffing within 24-Hours required per H&S Code 1180-1180.6 (Restraint/Seclusion) WIC §4659.2 □ Complete Post Emergency Restraint (PERR) form
Reasonably suspected abuse, exploitation or neglect: A MANDATED REPORT REQUIRED	**Other Behavior episode:**
□ Physical Abuse □ Sexual □ Fiduciary □ Psychological □ Physical Restraint □ Chemical Restraint □ Failure to provide: Medical care for physical and mental health needs; □ Failure to pPrevent malnutrition or dehydration; □ Protect from health and safety hazards □ Assisting personal hygiene or the provision of food, clothing or shelter or Exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or dependent adult.	□ Verbal aggression □ Aggressive act to self □ Aggressive act to consumer □ Aggressive act to staff □ Aggressive act to family/visitor □ Property damage □ Suicide episode: □ Attempt □ Threat
Unplanned / Unscheduled hospitalization due to:	**Other occurrence involving:**
□ Respiratory illness □ Seizure-related activity □ Cardiac-related activity □ Internal infection □ Diabetes-related □ Wound/ skin care □ Nutritional deficiencies □ Involuntary psychiatric admission	□ Alleged Violation of consumer's Rights □ Other sexual incident: ____________ □ Vehicular accident with injury □ Pregnancy □ Medical Emergency / **ER visit** □ Seizure □ Injury Unknown Origin □ Fire □ Other: ______________________
A serious injury or accident including:	Other Consumers/ Staff Present: Include name & relationship (list)
□ Laceration(s) requiring sutures or Staples □ Fractures □ Dislocations □ Burns, bites, puncture wounds, internal bleeding, or medication reactions requiring medical treatment *beyond first aid* □ **ANY** medications errors (submit Medication Error Diagnostic form) MD notified for instruction.	________________________________ ________________________________ Medical Treatment: ______________________ Where Administered:______________________ Type of Treatment: ______________________ Name of MD Treating: ____________________ Contact # of Treating MD:__________________

CONSUMER NAME: ______________________

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Description of Incident :Include possible cause of incident / who, what , when where, how & why Attach a separate page for additional information if necessary)
Immediate Action Take by Service Provider/ Staff (Vendor/Administrator/Licensee/Other
Plan To Prevent Further Occurrences

Report Submitted By (Print Name / Title		CONTACT DATE
	Contact name and #:	
Reviewed by:		Date
Other Agencies/Individuals Notified/ Contact Name:	**Contact name and #**	Date
Date the vendor/other entity notified the WRC of the incident	***Who* did you speak to:**	Date:
Vendoring Regional Center notified for all Title 17 reportable incidents		
Licensing (DSS /DHS)		
LA County Dept. of Public Health (LACDPH)		
Parent/Guardian/Conservator:		
Physician/Hospital:		
Child/Adult Protective Services: include n**ame & reference #**		
Police/Sheriff: report #		
Long-Term Care Ombudsman		
Disability Rights California per WIC §4659.2		
California Department of Development **(DDS)**		

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Additional Information/ Follow up Submission within 30 Days of initial SIR dated:

Submitted by: ____ Date __________________________

CONSUMER NAME: ___________________________