WESTSIDE REGIONAL CENTER

Vendor/ Long-term Care Name: _____

Vendor Number: _____

Vendor Type: CCF: ☐ LTC: ☐ CPP/CRDP ☐ SLS ☐ Day/ILS ☐ FMS: ☐ Other: ☐

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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 ***encrypted 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:

☐ 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

Other Observations and Unusual events:

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

☐ Physical Abuse
☐ Sexual
☐ Fiduciary
☐ Psychological
☐ Physical Restraint
☐ Chemical Restraint
☐ Failure to provide: Medical care for physical and mental health needs;
☐ Failure to Prevent 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.

Other Behavior episode:

☐ 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:

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

Other occurrence involving:

☐ Alleged Violation of consumer's Rights
☐ Other sexual incident: _____
☐ Vehicular accident with injury
☐ Pregnancy
☐ Medical Emergency /**ER visit (Title22)**
☐ Seizure
☐ Injury Unknown Origin
☐ Fire ☐ Other: _____

A serious injury or accident including:

☐ 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.

Other Consumers/ Staff Present: Include name & relationship (list)

_____

_____

Medical Treatment: _____

Where Administered: _____

Type of Treatment: _____

Name of MD Treating: _____

Contact # of Treating MD: _____

Participant 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	**Signature Required**	**CONTACT DATE**
	Contact name and #:	
Reviewed by:	**Signature Required**	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)**		
FMS Notified		

WESTSIDE REGIONAL CENTER

Vendor/ Long-term Care Name: _____

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Vendor Type: CCF ☐ LTC: ☐ PP/CRDI ☐ L ☐ Day/ILS ☐ FMS: ☐ Other: ☐

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

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Submitted by: _____ Date _____

Participant NAME: _____