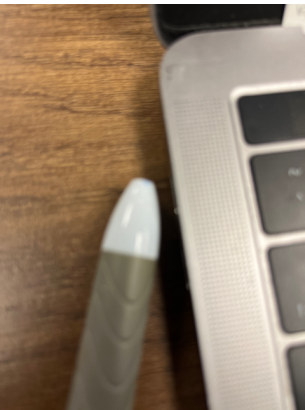


INCIDENT INVOLVED: ☒ Resident ☐ Visitor ☐ Staff ☐ Other

DATE OF INCIDENT (D/M/Y) 01 Nov 2024	Time 11:19 AM	LOCATION OF INCIDENT main floor	WITNESSED BY concierge
DATE OF DISCOVERY (D/M/Y) 01 Nov 2024	Time 11:20 AM	LOCATION OF DISCOVERY main gate	DISCOVERED BY concierge
TYPE OF INCIDENT <div><div><input checked="" type="checkbox"/> Fall <input type="checkbox"/> Fire <input type="checkbox"/> Security <input type="checkbox"/> Elopement <input type="checkbox"/> Aggressive Behavior <input type="checkbox"/> Other</div><div><input type="checkbox"/> Resident Abuse <input type="checkbox"/> Treatment <input type="checkbox"/> Loss of Property <input type="checkbox"/> Choking <input type="checkbox"/> Death</div></div>		SAFETY DEVICES IN USE BEFORE OCCURRENCE <div>Yes No N/A</div> <div>Fob was within reach <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Call bell within reach <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Caution signs in place <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> <div>Other</div>	OTHER WITNESSES? <div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Name:<u>ross</u></div> <div>Position:<u>server</u></div> <div>Name:<u>bill</u></div> <div>Position:<u>agm</u></div>
Condition At Time Of Incident <div><input type="checkbox"/> Oriented <input checked="" type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input type="checkbox"/> Other (Specify)</div>	Fall Assessment <div><input type="checkbox"/> Medication Change <input checked="" type="checkbox"/> Cardiac Medications <input type="checkbox"/> Mood Altering Medications <input type="checkbox"/> Visual Deficit <input type="checkbox"/> Relocation <input type="checkbox"/> Temporary Illness</div>	Ambulation <div><input type="checkbox"/> Unlimited <input checked="" type="checkbox"/> Limited <input type="checkbox"/> Required assistance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Other (Specify)</div>	Fire <div>Yes No</div> <div>Alarm pulled <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>False alarm <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Extinguisher used <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Resident or facility property damage <input checked="" type="checkbox"/> <input type="checkbox"/></div>
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:			
Add			

Attachments:-



NOTIFICATION			
INFORMED OF INCIDENT	INITIAL	PERSON NOTIFIED	NOTIFIED RESIDENT'S RESPONSIBLE PARTY
<input checked="" type="checkbox"/> Assistant General Manager	<u>s</u>	Family Doctor: <u>dr x</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> General Manager	<u>s</u>	Time: <u>11:22 AM</u>	Name:
<input checked="" type="checkbox"/> Risk Management Committee	<u>s</u>	Other: <u>dr y</u>	Date:
<input type="checkbox"/> Other		Time: <u>11:22 AM</u>	Time:

COMPLETED BY alice	POSITION concierge	DATE 01 Nov 2024 11:22 AM
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**FOLLOW UP** (For Management Use Only)

ISSUE (Problem)
FINDINGS (Gather Information)
POSSIBLE SOLUTIONS (Identify Solution)
ACTION PLAN
FOLLOW UP (Examine Result – Did the Plan work?)
