

INCIDENT INVOLVED:      ☒ Resident      ☐ Visitor      ☒ Staff      ☒ Other oth inc

DATE OF INCIDENT (D/M/Y)  23 Oct 2024	Time  02:48 PM	LOCATION OF INCIDENT  room	WITNESSED BY  mng
DATE OF DISCOVERY (D/M/Y)  23 Oct 2024	Time  02:48 PM	LOCATION OF DISCOVERY  room	DISCOVERED BY  mng
TYPE OF INCIDENT  <div><div><input checked="" type="checkbox"/> Fall <input checked="" type="checkbox"/> Fire <input checked="" type="checkbox"/> Security <input checked="" type="checkbox"/> Elopement <input checked="" type="checkbox"/> Aggressive Behavior <input checked="" type="checkbox"/> Other <u>other incident</u></div><div><input checked="" type="checkbox"/> Resident Abuse <input checked="" type="checkbox"/> Treatment <input checked="" type="checkbox"/> Loss of Property <input type="checkbox"/> Choking <input type="checkbox"/> Death</div></div>		SAFETY DEVICES IN USE BEFORE OCCURRENCE  Yes No N/A  Fob was within reach <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  Call bell within reach <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>  Caution signs in place <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>  Other <u>other safety</u>	
OTHER WITNESSES?  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  Name: <u>nm 1</u>  Position: <u>pos 1</u>  Name: <u>nm 2</u>  Position: <u>pos 2</u>			
Condition At Time Of Incident  <div><input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other (Specify)</div>	Fall Assessment  <div><input checked="" type="checkbox"/> Medication Change <input checked="" type="checkbox"/> Cardiac Medications <input type="checkbox"/> Mood Altering Medications <input type="checkbox"/> Visual Deficit <input checked="" type="checkbox"/> Relocation <input checked="" type="checkbox"/> Temporary Illness</div>	Ambulation  <div><input type="checkbox"/> Unlimited <input checked="" type="checkbox"/> Limited <input checked="" type="checkbox"/> Required assistance <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Walker <input checked="" type="checkbox"/> Other (Specify)  <u>other Ambulation</u></div>	Fire  Yes No  Alarm pulled <input checked="" type="checkbox"/> <input type="checkbox"/>  False alarm <input type="checkbox"/> <input checked="" type="checkbox"/>  Extinguisher used <input checked="" type="checkbox"/> <input type="checkbox"/>  Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/>  Resident or facility <input checked="" type="checkbox"/> <input type="checkbox"/>  property damage
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:			
Fact			

Attachments:-



NOTIFICATION
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<b>INFORMED OF INCIDENT</b>	<b>INITIAL</b>	<b>PERSON NOTIFIED</b>	<b>NOTIFIED RESIDENT'S RESPONSIBLE PARTY</b>
<input checked="" type="checkbox"/>	<u>agm</u>	Family Doctor: <u>doc</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Assistant General Manager	<u>gm</u>	Time: <u>02:50 PM</u>	Name: <u>RAO</u>
<input checked="" type="checkbox"/>	<u>rmc</u>	Other: <u>other notified</u>	Date: <u>23 Oct 2024</u>
General Manager	<u>oth</u>	Time: <u>02:50 PM</u>	Time: <u>02:50 PM</u>
<input checked="" type="checkbox"/>			
Risk Management Committee			
<input checked="" type="checkbox"/>			
Other <u>other notification</u>			
<b>COMPLETED BY</b> Rahi		<b>POSITION</b> developer	<b>DATE</b> 23 Oct 2024 02:50 PM

**FOLLOW UP** (For Management Use Only)

<b>ISSUE (Problem)</b>
Issue text
<b>FINDINGS (Gather Information)</b>
Findings text
<b>POSSIBLE SOLUTIONS (Identify Solution)</b>
Solutions text

<b>ACTION PLAN</b>
<b>Plan text</b>
<b>FOLLOW UP (Examine Result – Did the Plan work?)</b>
<b>Follow up text</b>