

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 <div><input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></div> Call bell within reach <div><input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> Caution signs in place <div><input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/></div> Other <u>other safety</u>	
OTHER WITNESSES? <div><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</div> 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><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></div>	Ambulation <div><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)</div> <u>other Ambulation</u></div>	Fire Yes No Alarm pulled <div><input checked="" type="checkbox"/> <input type="checkbox"/></div> False alarm <div><input type="checkbox"/> <input checked="" type="checkbox"/></div> Extinguisher used <div><input checked="" type="checkbox"/> <input type="checkbox"/></div> Personal injury <div><input type="checkbox"/> <input checked="" type="checkbox"/></div> Resident or facility <div><input checked="" type="checkbox"/> <input type="checkbox"/></div> property damage
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:			
Fact			

Attachments:-



NOTIFICATION

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

FOLLOW UP (For Management Use Only)

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

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