

INCIDENT INVOLVED:

☐ Resident

☒ Visitor

☐ Staff

☐ Other

DATE OF INCIDENT (D/M/Y) 14 Nov 2024	Time 06:21 PM	LOCATION OF INCIDENT hhj	WITNESSED BY cbj
DATE OF DISCOVERY (D/M/Y) 14 Nov 2024	Time 06:21 PM	LOCATION OF DISCOVERY gn	DISCOVERED BY vb
TYPE OF INCIDENT <div><div><input 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 type="checkbox"/> <input checked="" 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 type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Other</div>	OTHER WITNESSES? <div><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>Name:</div> <div>Position:</div> <div>Name:</div> <div>Position:</div>
Condition At Time Of Incident <div><input type="checkbox"/> Oriented <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input type="checkbox"/> Other (Specify)</div>	Fall Assessment <div><input type="checkbox"/> Medication Change <input 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 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 type="checkbox"/> <input checked="" type="checkbox"/></div> <div>False alarm <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Extinguisher used <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Resident or facility property damage <input type="checkbox"/> <input checked="" type="checkbox"/></div>
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:			

Attachments:-

NOTIFICATION			
<b>INFORMED OF INCIDENT</b>	<b>INITIAL</b>	<b>PERSON NOTIFIED</b>	<b>NOTIFIED RESIDENT'S RESPONSIBLE PARTY</b>
<input type="checkbox"/> Assistant General Manager		Family Doctor:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> General Manager		Time:	Name:
<input type="checkbox"/> Risk Management Committee		Other:	Date:
<input type="checkbox"/> Other		Time:	Time:
<b>COMPLETED BY</b> hj		<b>POSITION</b> cmk	<b>DATE</b> 14 Nov 2024 06:22 PM

FOLLOW UP (For Management Use Only)

<b>ISSUE (Problem)</b>
H
<b>FINDINGS (Gather Information)</b>
B

<b>POSSIBLE SOLUTIONS (Identify Solution)</b>
<b>B</b>
<b>ACTION PLAN</b>
<b>G</b>
<b>FOLLOW UP (Examine Result – Did the Plan work?)</b>
<b>W</b>