UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS : NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.

SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.

RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER
Ryan Family Care Home	123456789	(530) 613-4535

ADDRESS	CITY, STATE, ZIP
12285 Rio Oso Rd.	Auburn, CA 95602

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION
Goober Fish	12/12/2021	34	M	01/01/2020

TYPE OF INCIDENT

- ☐ Unauthorized Absence
- ☐ Aggressive Act/Self
- ☐ Aggressive Act/Another Client
- ☐ Aggressive Act/Staff
- ☐ Aggressive Act/Family, Visitors
- ☐ Alleged Violation of Rights

Alleged Client Abuse

- ☐ Sexual
- ☐ Physical
- ☐ Psychological
- ☐ Financial
- ☐ Neglect

- ☐ Rape
- ☐ Pregnancy
- ☐ Suicide Attempt
- ☐ Other

- ☐ Injury-Accident
- ☐ Injury-Unknown Origin
- ☐ Injury-From another Client
- ☐ Injury-From behavior episode
- ☐ Epidemic Outbreak
- ☐ Hospitalization

- ☐ Medical Emergency
- ☐ Other Sexual Incident
- ☐ Theft
- ☐ Fire
- ☐ Property Damage
- ☐ Other *(explain)*

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURIES:

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PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

MEDICAL TREATMENT NECESSARY? ☐ YES ☐ NO IF YES, GIVE NATURE OF TREATMENT:

WHERE ADMINISTERED:	ADMINISTERED BY:

FOLLOW-UP TREATMENT, IF ANY:

ACTION TAKEN OR PLANNED (BY WHOM AND ANTICIPATED RESULTS):

LICENSEE/SUPERVISOR COMMENTS:

NAME OF ATTENDING PHYSICIAN

	NAME AND TITLE	DATE
REPORT SUBMITTED BY:		
REPORT REVIEWED/APPROVED BY:	NAME AND TITLE	DATE

AGENCIES/INDIVIDUALS NOTIFIED *(SPECIFY NAME AND TELEPHONE NUMBER)*

☐ LICENSING_____ ☐ ADULT/CHILD PROTECTIVE SERVICES_____

☐ LONG TERM CARE OMBUDSMAN_____ ☐ PARENT/GUARDIAN/CONSERVATOR_____

☐ LAW ENFORCEMENT_____ ☐ PLACEMENT AGENCY_____