INCIDENT REPORT
DSS-3123 (Rev. 05/12)

Facility Name: _____ **County:** _____

Date of Incident:_____ **Time:**_____ **Regulations: 487.7(d)(1-13)**
488.7(b)(1-13)
Resident Name:_____ **490.7(d)(1-11)**

I. <u>Reportable Incidents to the Department's Regional Office</u>:

☐Resident's whereabouts were unknown for more than 24 hours

☐Resident assaults or injures, or is assaulted or injured by another resident, staff or others

☐Resident attempted or committed suicide (if resident died, must also check "resident death" below)

☐Complaint or evidence of resident abuse

☐Resident Death

☐A felony crime may have been committed by or against a resident

☐Resident behaved in a manner that directly impaired the well-being, care or safety of the resident or any other resident, or which substantially interferes with the orderly operation of the facility

☐Resident was involved in an accident on or off the facility grounds which resulted in such resident ***<u>requiring medical care, medical attention or services</u>***

II. <u>Non-Reportable Incidents are maintained on file in the facility's and/or resident's record</u>:

III. <u>Incident Description</u> (include injuries, type of first aid given and employee involvement (attach a separate statement of other participants and any witnesses):

IV. <u>Action Taken</u> (describe medical treatments and/or action taken):

V. <u>Identify individual(s) or agency(s) that provided care and location where care was provided</u>:

VI. Describe current status of the resident(s)/individual(s) involved:

_____ _____
Administrator/Operator's Signature **Date:**

VII. Resident's Description of Incident/Accident: Operator is required by law to include your description of the incident/accident, unless you object or decline. Use the space below for your comments, or if you do not wish to comment, check the following: ☐ **I do not wish to comment**

_____ _____
Resident Signature **Date:**

VIII. Reporting of Incident/Accident (check all that apply):

Individual and title of person reporting incident:_____

☐ NYS Department of Health Regional Office:_____ Date:_____

☐ Resident's Physician (identify)_____ Date:_____

☐Resident's Representative (identify):_____ Date:_____

If Required (refer to regulation)

☐Police:_____ Date:_____

☐State Commission on Quality of Care for the Mentally Disabled (if appropriate) Date:_____

☐Other (identify):_____ Date:_____

For DOH Internal Use:

Regional Office Staff Assigned:_____ **Review Date:**_____

Regional Office Action Taken (describe):_____

_____

Central Office Notified: ☐YES ☐NO Date:_____