WESTSIDE REGIONAL CENTER

Reporting Vendor/ Long-term Care Provider Name:

Vendor Type (check one): CCF: LTC: CPP/CRDP: SLS: OTHER:

Vendor Number:

Report to Regional Center
Special Incident Report and Other Observations and Events

INSTRUCTIONS

1. Notify Westside Regional Center (WRC) of all special incidents within 24-hours *verbal* report, (310) 258-4000
2. Submit *written* report within 48-hours, **WRC SIR Fax 1-877-254-6903 or email to sir@westsiderc.org**
3. Notify applicable licensing (CCL, DHS, APS, Ombudsman, Police) entity per regulations.
4. Notify responsible person, (i.e., parent, guardian, conservator) per requirements.
5. Submit SIR updates to WRC within 30-days

Consumer Name:	**Sex:**	**Date of Birth:**	**UCI Number**	**Date of Report:**
	☐M ☐F			

Check Applicable ☐Verbal ☐Non- Verbal ☐Ambulatory ☐Non-Ambulatory Conserved ☐ Yes ☐ No

Date of Incident:

Time of Incident:

Site of Incident:

SPECIAL INCIDENTS (TITLE 17, §54327)

☐ Death of a consumer (regardless of where or when)

☐ The consumer was a victim of a crime (regardless of where or when)

☐ The consumer is missing and the vendor has filed a missing persons report with a law enforcement agency

☐ **Reasonably suspected abuse, exploitation or neglect: MANDATED REPORT REQUIRED**

☐ Physical Abuse
☐ Sexual
☐ Fiduciary
Psychological
Physical Restraint
Chemical Restraint

☐ Failure to provide: Medical care for physical and mental health needs;
☐ Prevent malnutrition or dehydration;
☐ Protect from health and safety hazards;
☐ Assist in personal hygiene or the provision of food, clothing or shelter; or
☐ Exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or dependent adult.

☐ **Unplanned / Unscheduled hospitalization due to:**

☐ Respiratory illness
☐ Seizure-related activity
☐ Cardiac-related activity
☐ Internal infection
☐ Diabetes-related
☐ Wound/ skin care
☐ Nutritional deficiencies
☐ Involuntary psychiatric admission

A serious injury or accident including:

☐ Laceration(s) requiring sutures
☐ Fractures
☐ Dislocations
☐ Burns, bites, puncture wounds, internal bleeding, or medication reactions requiring medical treatment beyond first aid
☐ **ANY** medications errors (Complete Medication Error Diagnostic form)

OTHER OBSERVATIONS AND EVENTS

Behavioral Crisis episode:

☐ Use of restrictive behavior intervention/ physical containment , Chemical restraint drug used to control behavior (not to treat medical condition) **I.D. Team Staffing within 24-Hours required per H&S Code 1180-1180.6 (Restraint/Seclusion) WIC §4659.2**

☐ Complete Post Emergency Restraint (PER) form

Other Behavior episode:

☐ Verbal aggression
☐ Aggressive act to self
☐ Aggressive act to consumer
☐ Aggressive act to staff
☐ Aggressive act to family/visitor
☐ Property damage
☐ Suicide episode: ☐ Attempt ☐ Threat

☐ **Other occurrence involving**:

☐ Alleged violation of consumer's rights
☐ Other sexual incident:
☐ Sexual harassment
☐ Inappropriate sexual contact
☐ Earthquake
☐ Vehicular accident

☐ Pregnancy
☐ Medical Emergency
☐ Emergency room visit
☐ Seizure
☐ Injury Unknown Origin
☐ Fire
☐ Other:_______________________

Other Consumers/ Staff Present: (Include the full name and relationship)

Medical Treatment: (If yes, describe) ☐ Yes ☐ No

Where Administered?

Client Name: ______________________________

Date: ______________________________

WESTSIDE
REGIONAL CENTER

Reporting Vendor/ Long-term Care Provider Name: ______

______

Vendor Number: ______

(Attach a separate page for additional information if necessary)

Description of Incident (Include possible cause of incident / who, what , when where, how & why)
Immediate Action Take by Service Provider/ Staff (Vendor/Administrator/Licensee/Other)
Plan To Prevent Further Occurrences
Submit Follow-Up Plan within 30-days/ Comments

Report Submitted By:	**Title:**	**Contact Date**
Name :		
Vendor Address :	Telephone Number:	
Reviewed by Name:	Signature:	
Other Agencies/Individuals Notified/ Contact Name:	**NAME & Telephone #**	**Contact Date**
Regional Center		
Vendoring Regional Center notified for all Title 17 reportable incidents		
Licensing (DSS /DHS)):		
Parent/Guardian/Conservator:		
Physician/Hospital:		
Child/Adult Protective Services: include n**ame & reference #**		
Long-Term Care Ombudsman		
Police/Sheriff: report #		
Disability Rights California per **WIC §4659.2**		
California Department of Development **(DDS)**		

Client Name: ______
Date: ______