Facility Name: ___________________________ County: ___________________________

Date of Incident: __________________________ Time: __________  Regulations: 487.7(d)(1-13)
488.7(b)(1-13)  490.7(d)(1-11)

Resident Name: ___________________________

Resident level of care (circle all that apply): AH  EHP  ALR  EALR  SNALR  ALP

I. Reportable Incidents to the Department’s Regional Office: ** must fill out addendum to this report

☐ Resident 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; or
☐ Resident was involved in an accident on or off the facility grounds which resulted in such resident requiring medical care, medical attention, or services.

☐ Non-Reportable Incidents (maintained on file in the facility's and/or resident's record)

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

III. Immediate Action Taken: (describe medical treatments and/or action(s) taken)

IV. Action(s) Taken Upon QA Review (Systems Review)

V. Identify individual(s) or agency(s) that provided care and location where care was provided:
VI. Describe current status of 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: ____________________________ Date: ____________

☐ NYS Department of Health Regional Office: ____________________________ Date: ____________

☐ Resident’s Physician: (identify) ____________________________ Date: ____________

☐ Resident’s Representative: (identify) ____________________________ Date: ____________

If Required (refer to regulation)

☐ Police: ____________________________ Date: ____________

☐ The Justice Center for the Protection of People with Special Needs: ____________________________ Date: ____________

☐ Other (identify): ____________________________ Date: ____________
ADDENDUM TO ACF INCIDENT REPORT OF RESIDENT DEATH OR ATTEMPTED SUICIDE

| Resident Name | | |
|----------------|--------------------------------------------------------------------------------------------------|
| Resident Age   | Did resident receive aftercare OMH services? | |
| Death Due to:  | Suicide | Natural Causes | Accident | Homicide | Unknown |
| Date of Death  | (circle one) Estimated | Actual Date: |

**Location of the Death:**

Did the person die: In the facility | Outside the facility

If the person died outside the facility,
how many hours after leaving the facility did the person die: Less than or equal to 48 hours | More than 48 hours

If the person died outside the facility, indicate the location of death:

Hospital | Nursing Home | Hospice | Home/Family

Other (please specify)

Briefly Describe the Circumstances Surrounding the Death:

Date and Time Regional Office Notified:

Additional Comments: