

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: \_\_\_\_\_

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: \_\_\_\_\_

**For DOH Internal Use:** \_\_\_\_\_

**Regional Office Staff Assigned:** \_\_\_\_\_ **Review Date:** \_\_\_\_\_

**Regional Office Action Taken (describe):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Central Office Notified:**  YES  NO

**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 or 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: \_\_\_\_\_

\_\_\_\_\_

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