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: ________________________________

_________________________________ ________________________________