

Reporting Vendor/ Long -term  
Care Name: \_\_\_\_\_

License #: \_\_\_\_\_

Vendor Number: \_\_\_\_\_

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

**INSTRUCTIONS**

1. Notify Westside Regional Center of all special incidents within 24 hours, (310) 258-4000
2. Submit written report within 48 hours, WRC SIR Fax (310) 258-4222
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 update to Westside Regional Center within 30-days

<b>Consumer Name:</b>		<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>Date of Birth:</b>		<b>UCI Number</b>		<b>Date of Report:</b>											
Check Applicable		<input type="checkbox"/> Verbal	<input type="checkbox"/> Non- Verbal	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Non-Ambulatory	Conserved		<input type="checkbox"/> Yes	<input type="checkbox"/> No										
Date of Incident:																			
Time of Incident:																			
Site of Incident:																			
<b><u>SPECIAL INCIDENTS (TITLE 17, §54327)</u></b>					<b><u>OTHER OBSERVATIONS AND EVENTS</u></b>														
<input type="checkbox"/> Death of a consumer (regardless of cause or location)					<input type="checkbox"/> Alleged violation of consumer's right			<input type="checkbox"/> Pregnancy		<input type="checkbox"/> Medical Emergency									
<input type="checkbox"/> The consumer is missing and the vendor has filed a missing persons report with a law enforcement agency											<input type="checkbox"/> Other sexual incident:			<input type="checkbox"/> Emergency room visit					
<input type="checkbox"/> The consumer was a victim of a crime (regardless of location)															<input type="checkbox"/> Sexual harassment	<input type="checkbox"/> ANY medications errors			
					<input type="checkbox"/> Inappropriate sexual contact			<input type="checkbox"/> Seizure	<input type="checkbox"/> Injury Unknown Origin										
<input type="checkbox"/> Reasonably suspected abuse or exploitation:					<input type="checkbox"/> Suicide episode: <input type="checkbox"/> Attempt <input type="checkbox"/> Threat														
<input type="checkbox"/> Physical Abuse		<input type="checkbox"/> Psychological			<input type="checkbox"/> Behavioral episode:														
<input type="checkbox"/> Sexual		<input type="checkbox"/> Physical Restraint																	
<input type="checkbox"/> Fiduciary		<input type="checkbox"/> Chemical Restraint			<input type="checkbox"/> Verbal aggression														
<input type="checkbox"/> Reasonably suspected neglect:																			
<input type="checkbox"/> Failure to provide medical care					<input type="checkbox"/> Aggressive act to self														
<input type="checkbox"/> Failure to prevent malnutrition or dehydration										<input type="checkbox"/> Aggressive act to consumer									
<input type="checkbox"/> Failure to protect from health and safety hazard															<input type="checkbox"/> Aggressive act to staff				
<input type="checkbox"/> Failure to assist in personal hygiene or the provision of food, clothing or shelter																			
<input type="checkbox"/> Unplanned / Unscheduled hospitalization due to:					<input type="checkbox"/> Property damage														
<input type="checkbox"/> Respiratory illness		<input type="checkbox"/> Diabetes-related								<input type="checkbox"/> Use of restrictive behavior intervention (Restraint/Seclusion)*									
<input type="checkbox"/> Seizure-related activity		<input type="checkbox"/> Wound/ skin care			<b>I.D. Team Staffing within 24-Hours required</b>														
<input type="checkbox"/> Cardiac-related activity		<input type="checkbox"/> Nutritional deficiencies								<b>*H&amp;S Code 1180-1180.6 (Restraint/Seclusion)</b>									
<input type="checkbox"/> Internal infection		<input type="checkbox"/> Involuntary psychiatric admission			<input type="checkbox"/> Earthquake														
<input type="checkbox"/> A serious injury or accident including:										<input type="checkbox"/> Vehicular accident									
<input type="checkbox"/> Laceration(s) requiring sutures					<input type="checkbox"/> Fire														
<input type="checkbox"/> Fractures										<input type="checkbox"/> Other:									
<input type="checkbox"/> Dislocations					<b>Other Consumers/ Staff Present:</b> (Include the full name and relationship of any witness to the incident)														
<input type="checkbox"/> Burns, bites, puncture wounds, internal bleeding, or medication reactions requiring medical treatment beyond first aid																			
<b>Medical Treatment:</b> (If yes, describe) <input type="checkbox"/> Yes <input type="checkbox"/> No		Where Administered:			Administered by:														

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

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**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**

**Follow-Up Plan/ Comments**

(Attach a separate page for additional information if necessary)

**Report Submitted By**

Name (print clearly) \_\_\_\_\_ Title: \_\_\_\_\_  
Vendor Address : \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
Reviewed by Name: \_\_\_\_\_ Signature/ Date \_\_\_\_\_

**Other Agencies/Individuals Notified**

	Contact Name:	Contact Date	Telephone #	Report Number
Westside Regional Center:	_____	_____	_____	_____
Licensing (DSS /DHS):	_____	_____	_____	_____
Parent/Guardian/Conservator:	_____	_____	_____	_____
Physician/Hospital:	_____	_____	_____	_____
Child/Adult Protective Services:	_____	_____	_____	_____
Long-Term Care Ombudsman:	_____	_____	_____	_____
Police/Sheriff:	_____	_____	_____	_____
County Coroner:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

Client Name: \_\_\_\_\_  
Date: \_\_\_\_\_