

INCIDENT REPORT FORM: Initial Combined Initial and Final Follow up Info. Final
Please check only one box above.

Please complete Parts A & B for 24-hour notifications. Include Part C for 5 day and final reports. All incident reports/notifications may be submitted to toll free fax number **1-866-239-7553**.

Part A

Facility ID _____ Name of Facility _____

Address _____
Street City State Zip

Point of Contact Email _____

Incident Date _____ Incident Location _____

**Resident(s)/Client(s)/
Staff Involved** _____

Incident Type (For allegations against nurse-aides or nontechnical services workers, please include ODH Form 718)

- | | |
|--|---|
| <input type="checkbox"/> Certain Injuries (OAC 310:675-7-5.1(i)) | <input type="checkbox"/> Storm Damage |
| <input type="checkbox"/> Utility Failure (more than 8 hours) | <input type="checkbox"/> Fire |
| <input type="checkbox"/> Misappropriation of Resident Property | <input type="checkbox"/> Allegations of Neglect |
| <input type="checkbox"/> Allegations of Abuse/Mistreatment | <input type="checkbox"/> Injury of Unknown Source |
| <input type="checkbox"/> Death Other than by Natural Causes | <input type="checkbox"/> Missing Resident |
| <input type="checkbox"/> Communicable Disease (Call Infectious Disease (IDPR) for <u>initial outbreak</u> notification only at (405) 426-8710. <u>Updates not required for ongoing outbreak</u>). | |
| <input type="checkbox"/> Suspected Criminal Act* | <input type="checkbox"/> Physical Harm* |

*If Physical Harm and Suspected Criminal Act, indicate if Local Law Enforcement Agency contacted in the 'Notifications Made' box at the right.

Notifications Made (Check all that apply)

- | |
|--|
| <input type="checkbox"/> Physician |
| <input type="checkbox"/> Family |
| <input type="checkbox"/> Resident's Legal representative |
| <input type="checkbox"/> DHS: Adult Protective Services |
| <input type="checkbox"/> Local Law Enforcement |
| Agency Name: _____ |
| Date: _____ Time: _____ |
| <input type="checkbox"/> Appropriate Licensing Board |
| <input type="checkbox"/> Nurse Aide Registry (ODH Form 718 Attached) |
| <input type="checkbox"/> Attorney General |
| <input type="checkbox"/> Other _____ |

Part B

Description of Incident. Please include injuries sustained as well as measures taken to protect the resident(s) during investigation. (500 characters max) If additional pages are needed, see the optional page below.

Relevant Resident History. Please include relevant resident history (i.e. cognitive status, fall risk assessment, relevant care plan instructions prior to this incident, etc.) (500 characters max) If additional pages are needed, see the optional page below.

Part C

For 5 day and final reports, please include a summary of the investigation (include investigative actions, findings and causative factors) and corrective measures implemented to prevent recurrence. (500 characters max) If additional pages are needed, see the optional page below.

Failure to document credible protective/preventative measures at the time of initial reporting and/or failure to provide evidence of a thorough investigation with corrective measures on the final report may require the OSDH to perform an onsite visit to determine if acceptable measures are being taken to protect residents.

Person Completing Form

OPTIONAL PAGE. Use this page as needed to provide further information. (5,200 character max)
If additional space is required, please attach a supplemental document.