

# LONG TERM CARE ADMINISTRATION

Living Choice

Medically Fragile

## CRITICAL INCIDENT REPORT: EVALUATION

<b>Participant Name</b>			<b>SoonerCare ID</b>
<i>Last</i>	<i>First</i>	<i>MI</i>	
<b>Name of Person Reporting</b>			

### A. CRITICAL INCIDENT LEVELS AND EVENTS

Critical Incident Level	INCIDENT Please check box that describes incident.	Reporting Time Lines	Follow-Up Requirements
Level I – Urgent	<input type="checkbox"/> Sexual abuse <input type="checkbox"/> Lost or missing person <input type="checkbox"/> Questionable, unexpected or preventable death <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Neglect* <input type="checkbox"/> Physical abuse* <input type="checkbox"/> Exploitation*	Within 1 working day	<b>Investigation Required.</b>  Report on investigation required.
Level II – Serious	<input type="checkbox"/> Involvement with the criminal justice system <input type="checkbox"/> Restraint use <input type="checkbox"/> Medication error with adverse effects <input type="checkbox"/> Falls with injury	Within 2 working days	Evaluation required. <b>May require investigation.</b> If investigated, report on investigation required.
Level III – Significant	<input type="checkbox"/> Verbal abuse* <input type="checkbox"/> Hospitalizations <input type="checkbox"/> Emergency room visits <input type="checkbox"/> Other	Within 2 working days	Evaluation required. <b>May require investigation.</b> If investigated, report on investigation required.

\* OKDHS/APS is the lead investigative authority in the event of critical events regarding abuse, neglect or exploitation.

### B. DETAILS OF INCIDENT

Date and Time of Incident:	Date Agency Aware of Incident:
Witnesses to Incident:	Location of Incident:
Description of Incident:	
Action Taken and Outcome:	
Did the Incident result in a change in the agency's Continuous Quality Improvement Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes' – has the change been implemented? Please comment:	
Agency Investigation Required? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>**If Yes: <u>Submit Critical Incident Investigation Report</u></b>	
Who was notified about this incident? <input type="checkbox"/> OKHCA or Designee	<input type="checkbox"/> Supervisor/TC/CM <input type="checkbox"/> Law Enforcement <input type="checkbox"/> APS <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (list)

### C. SUPERVISORY REVIEW

Agency Supervisor has reviewed Critical Incident Report Evaluation: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Critical Incident Report Evaluation was reviewed? TC/CM Supervisor Signature:
Was Critical Incident a result of Back Up Plan failure? <input type="checkbox"/> Yes <input type="checkbox"/> No