Resident Incident Report

Complete within 24 hours of the incident. Attach additional pages as needed.

Prompt, factual, complete documentation protects your residents and your facility. Record only facts you observed or were told, and identify the source of any reported information. Do not include opinions, blame, or speculation.

1 · FACILITY INFORMATION

FACILITY NAME	DATE OF REPORT
FACILITY ADDRESS	
REPORT COMPLETED BY (NAME / TITLE)	PHONE

2 · INCIDENT DETAILS

DATE OF INCIDENT	TIME OF INCIDENT	AM / PM
EXACT LOCATION (ROOM, HALLWAY, DINING, EXTERIOR, ETC.)		

Type of incident (check all that apply)

☐ Fall, witnessed	☐ Fall, unwitnessed	☐ Medication occurrence
☐ Skin injury / wound	☐ Elopement / wandering	☐ Resident-to-resident
☐ Behavioral incident	☐ Choking / aspiration	☐ Equipment-related
☐ Visitor / third-party injury	☐ Property damage	☐ Other (describe below)

3 · PERSON(S) INVOLVED

RESIDENT NAME		ROOM #
DATE OF BIRTH	ADMISSION DATE	CODE STATUS
MOBILITY / COGNITIVE STATUS AT TIME OF INCIDENT (CARE-PLANNED STATUS)		

4 · DESCRIPTION OF INCIDENT

DESCRIBE WHAT HAPPENED IN FACTUAL, OBSERVABLE TERMS. INCLUDE WHAT THE RESIDENT WAS DOING BEFORE THE INCIDENT, POSITION FOUND, AND STATEMENTS MADE BY THE RESIDENT (IN QUOTES)

5 · INJURIES AND ASSESSMENT

Apparent injuries (check all that apply)

☐ No apparent injury	☐ Bruise / discoloration	☐ Skin tear / laceration
☐ Suspected fracture	☐ Head involvement	☐ Pain reported
☐ Change in condition	☐ Other (describe below)	

ASSESSMENT FINDINGS, VITAL SIGNS, AND NEURO CHECKS INITIATED (IF APPLICABLE)

6 · IMMEDIATE ACTIONS TAKEN

☐ First aid provided	☐ Physician notified	☐ 911 called
☐ Transferred to hospital	☐ Increased monitoring	☐ Environment secured

DESCRIBE ACTIONS TAKEN AND BY WHOM

7 · NOTIFICATIONS

PHYSICIAN NOTIFIED (NAME)	**DATE / TIME**
FAMILY / RESPONSIBLE PARTY NOTIFIED (NAME)	**DATE / TIME**

ADMINISTRATOR / DON NOTIFIED (NAME)	DATE / TIME

Determine whether this incident is reportable to your state licensing agency, ombudsman, or other authorities under applicable regulations, and document any required reports separately.

8 · WITNESSES

WITNESS 1 (NAME / ROLE)	PHONE
WITNESS 2 (NAME / ROLE)	**PHONE**

9 · FOLLOW-UP AND PREVENTION

CARE PLAN UPDATES, INTERVENTIONS ADDED, EQUIPMENT CHANGES, OR STAFF EDUCATION COMPLETED IN RESPONSE

10 · SIGNATURES

COMPLETED BY (SIGNATURE)	DATE
REVIEWED BY ADMINISTRATOR / DON (SIGNATURE)	**DATE**

Reminder: if this incident may give rise to a claim, report it promptly to your insurance carrier and notify Bedrock Global at 818-937-1827 or contact@bedrockglobalins.com. Late reporting can jeopardize coverage.