VALLEY MOUNTAIN REGIONAL CENTER
SPECIAL INCIDENT REPORT

COVID-19 Staff	Vendor Type			Vendor #	Date of Report
Vendor's Address	Community Services Liaison			Regional Center	

TYPE OF INCIDENT (Reportable Incidents in Bold)

___ **Suspected Abuse/Exploitation** ***(Limited to that which has occurred while under care/supervision of a vendor.)*** **Check type:**
- ___ **Physical**
- ___ **Sexual**
- ___ **Fiduciary**
- ___ **Emotional/Mental**
- ___ **Physical and/or Chemical Restraint**

___ **Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following (Check type):**
- ___ **Lacerations requiring sutures or staples**
- ___ **Puncture wounds requiring medical treatment beyond first aid**
- ___ **Fractures**
- ___ **Dislocations**
- ___ **Bites that break the skin and require medical treatment beyond first aid**
- ___ **Internal bleeding**
- ___ **Any medication errors**
- ___ **Medication reactions that require medical treatment beyond first aid.**
- ___ **Burns that require medical treatment beyond first aid**

___ **Victim of Crime** ***(Regardless of consumer's living arrangement or perpetrator.)*** **Check type:**
- ___ **Personal Robbery**
- ___ **Aggravated assault**
- ___ **Rape**
- ___ **Burglary**
- ___ **Larceny**
- ___ **Other (specify) _____**

___ **Suspected Neglect** ***(Limited to that which has occurred while under care/supervision of a vendor.)*** **Check type:**
- ___ **Failure to Assist in Personal Hygiene, Provision of Food, Clothing, Shelter**
- ___ **Failure to Prevent Malnutrition or Dehydration**
- ___ **Failure to Provide Medical Care**
- ___ **Failure to Protect from Health & Safety Hazards**
- ____ Exercise a degree of care that a reasonable person would exercise in a position of having the care and custody of an elder or a dependent adult.

___ **Any Unplanned or Unscheduled Hospitalization Due to the Following Conditions. Check type:**
- ___ **Respiratory illness**
- ___ **Seizure-related**
- ___ **Cardiac related**
- ___ **Internal infections**
- ___ **Diabetes/Diabetes related complications**
- ___ **Wound/skin care**
- ___ **Nutritional deficiencies**
- ___ **Involuntary psychiatric admission**

___ **Missing Person** ***(Complete only when reported to law enforcement and if consumer was under care/supervision of a vendor.)***

___ **Death** ***(Regardless of living arrangement, cause or perpetrator)***

Supplemental/Optional Reporting

___ Serious Injury/Accident Which Occurs While the Consumer is Under the Care and Supervision of Any Vendor and Results in One or More of the Following: Check type:
- ___ Injury-Accident
- ___ Injury-Unknown origin
- ___ Injury from seizure

___ Other Check type:
- ___ Violation of Rights
- ___ Pregnancy
- ___ Disease outbreak
- ___ Fire
- ___ Suicide attempt
- ___ Threatened suicide

Date of Report:

___ Injury from another consumer
___ Injury from behavior episode

___ Aggression Displayed by Consumer. Check type:
___ Aggressive act to self
___ Aggressive act to another consumer
___ Aggressive act to staff
___ Aggressive act to family/visitor

___ Medical emergency
___ Property damage
___ Other sexual incident—Not rape
___ Unauthorized absence–law enforcement not notified
X Other: **COVID 19 Positive**

Incident date	___ Definitive ___ Approximate	**Time of incident**	___ Definitive ___ Approximate
Date incident reported to Regional Center and to whom		**Medical Care/Treatment Required?** ___ Yes ___ No	

Relationship of alleged perpetrator to consumer

___ Unknown
___ Self
___ Vendor or Employee of Vendor
___ Non-Vendor or Employee of Non-Vendor
___ Another Consumer
___ Relative/Family Member
___ Individual known to consumer (Not a provider or another consumer)
___ Not applicable

Incident location

___Acute hospital–not ER
___Acute hospital–ER
___Day care/ Intervention program
___Psychiatric treatment center
___SNF
___Other _____
___Job site
___Out of home respite
___Community setting
___Home of family
___In transit
___Subacute or pediatric subacute
___Day program
___Consumer's residence
___Hospice
___Jail or related setting
___Public school
___Rehabilitation facility

Party/Entity responsible for consumer at time of incident

Vendor Name: _____
Vendor Type: _____
Vendor Number: _____

___Self/Spouse ___Residential

___Parent/Family ___Day Program

___Other: _____

Name: _____

Address: _____

City/Zip: _____

Telephone:_____

Other agencies notified

___Community Care Licensing
___Child Protective Services
___Parent/Guardian/Conservator
___Police/Law Enforcement
___Coroner
___DHS Licensing & Certification
___Adult Protective Services
___Long-Term Care Ombudsman
X Other: Local County Public Health Dept.
___Other: _____

Description of incident

Date of Report:

Specific preventative action taken or planned by the vendor:

Reporting Person's Name: _____

Signature: _____ Date: _____

(SIR template – revised 09/18/2007) ej