Kentucky Cabinet for Health and Family Services
Office of Inspector General – Division of Health Care

Long Term Care Facility – Self-Reported Incident Form

☐Initial Report ☐5 Day Follow up/Final Report ☐Combined Incident Report/Final Report

Please complete Parts A & B for 24-hour Initial notifications. Include Part C for 5 day Follow up/Final Reports.

Part A

Name of Facility _____

Address _____

Street City State Zip

Incident Date _____ Incident Location _____

Resident(s)/Client(s) Involved _____

Staff Involved _____

Required Incident Reports

- ☐ Fire
- ☐ Missing Resident/Elopement
- ☐ Injuries of Unknown source
- ☐ Allegations of Neglect
- ☐ Allegations of Abuse/Mistreatment
  - ☐ Physical Abuse
  - ☐ Sexual Abuse
  - ☐ Mental Abuse
  - ☐ Verbal Abuse
  - ☐ Seclusion
  - ☐ Misappropriation of Property

Optional Incident Reports

- ☐ Communicable Disease
- ☐ Outbreak of Infectious Disease
- ☐ Storm Damage
- ☐ Utility Failure (more than 4 hours)
- ☐ Care and Treatment
- ☐ Incident Involving Life Safety Code
- ☐ Death Other than by Natural Causes
- ☐ Other _____

Notifications(Check all that apply)

- ☐ Physician
- ☐ Family/Guardian
- ☐ Resident's Legal Representative
- ☐ DCBS
- ☐ Local Law enforcement
- ☐ Appropriate Licensing Board
- ☐ Attorney General
- ☐ Ombudsman

Other _____

Part B

Description of Incident. Please include injuries sustained as well as measures taken to protect the resident(s) during investigation. **Attach additional pages as necessary.**

Please include relevant resident history (i.e. cognitive status, fall risk assessment, relevant care plan instructions prior to this incident, etc.)

Part C

For 5-working day/final reports, please include a summary of the investigation (include investigative actions, findings and causative factors) and corrective measure implemented to prevent recurrence.
Attach additional pages as necessary.

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 an onsite visit to determine if acceptable measures are being take to protect residents.

_____ _____ _____

Reporting Party (type or print clearly) **Date** **Reporting Party's Contact Number**