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 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
- ☐ Exploitation/Misappropriation of Property
- ☐ Allegations of Abuse/Mistreatment
  - ☐ Serious Bodily Injury
  - ☐ Physical Abuse
  - ☐ Sexual Abuse
  - ☐ Mental Abuse
  - ☐ Verbal Abuse
  - ☐ Seclusion

Optional Incident Reports

- ☐ Communicable Disease
- ☐ Outbreak of Infectious Disease
- ☐ Storm Damage
- ☐ Utility Failure (more than 4 hours)
- ☐ Care and Treatment Concerns
- ☐ 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. (Limit of 500 characters 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.) (Limit of 500 characters attach additional pages as necessary)

Part C

For 5-working day/final reports, please include a summary of the investigation (include investigative actions, findings and causative factors) and corrective measures implemented to prevent recurrence. (Limit of 500 characters attach additional pages as necessary)

______________________________ __________ ______________________________

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

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Reporting Party's email Address