

SDS Critical Incident Report

In case of emergency, call 911 or appropriate local emergency services.

Within 24 hours or one business days of a reportable incident or notice of such an incident, fax this form to (907) 269-3648. For all incidents other than death, complete pages one and two; for reports of death, complete pages one and three.

A list of incidents requiring an SDS Incident Report follows. Please check all categories which describe the incident.

- | | |
|--|--|
| <input type="checkbox"/> Missing person | <input type="checkbox"/> Accident/incident with medical intervention |
| <input type="checkbox"/> Harm to self or others | <input type="checkbox"/> Medication error requiring medical intervention |
| <input type="checkbox"/> Use of restrictive intervention | <input type="checkbox"/> Law enforcement response |
| <input type="checkbox"/> Death of participant | <input type="checkbox"/> Other: _____ |

Participant information

Name: _____

Date of Birth: _____

Medicaid Number: _____

Program: Home and Community-Based Waiver Personal Care Services Grant Services General Relief

Service being provided at the time of the incident:

- | | |
|--|---|
| <input type="checkbox"/> Adult day | <input type="checkbox"/> Intensive active treatment |
| <input type="checkbox"/> Residential supported living (assisted living home) | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Day habilitation | <input type="checkbox"/> Specialized private-duty nursing |
| <input type="checkbox"/> Family habilitation home | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Supported living | <input type="checkbox"/> Meals |
| <input type="checkbox"/> Group home | <input type="checkbox"/> PCA |
| <input type="checkbox"/> Supported employment | <input type="checkbox"/> None |
| <input type="checkbox"/> Other _____ | |

Contact Information

Date of this report: _____

Date incident became known to the reporter: _____

Name of reporter: _____

Title of reporter: _____

Provider Identification Number/ Agency Name: _____

Provider agency contact person: _____

Telephone number: _____

Email: _____

Notifications (Please check other agencies and individuals you notified regarding this incident.)

- | | |
|--|---|
| <input type="checkbox"/> Police/law enforcement | <input type="checkbox"/> Assisted Living Home Licensing |
| <input type="checkbox"/> Adult Protective Services | <input type="checkbox"/> Long Term Care Ombudsman |
| <input type="checkbox"/> Office of Children's Services | <input type="checkbox"/> Guardian/Legal representative |
| <input type="checkbox"/> Care coordinator | |
| <input type="checkbox"/> Other: _____ | |

If this report is about the death of a participant, skip page two and fill out page three.

Name of Participant: _____

Incident information (Provide all information known; if not a direct observer; include sources of the information.)

Date of incident: _____ Time of incident: _____

Where did it happen?

Name of facility: _____

Address: _____

This location is a private residence an assisted living home/family habilitation home/group home
 a community setting other (describe) _____

Names of all persons present at the time of the incident:

What happened? (Describe the incident including circumstances or events leading to the incident.)

What did you or others do when it happened? (Describe actions taken in response to the incident.)

How will you or others help the participant now? (Describe plans for provider agency follow-up.)

Incident analysis

What do you think was the cause of the incident? (Describe contributing factors.)

What could be changed, or has been changed so a similar incident does not happen again?

Death of a Participant

Name of Participant: _____

Date of death: _____ Time of death: _____

Residence at time of death.

- a skilled nursing facility
- an assisted living home/family habilitation home/group home
- a private residence
- other (describe) _____

Location at time of death.

Name of facility: _____

Address: _____

This location is

- a hospital
- a skilled nursing facility
- an assisted living home/family habilitation home/group home
- a private residence
- a community setting
- other (describe) _____

What happened? (Describe the circumstances leading to the death.)

Who was present at the time of death or discovered the death?

Were there health or safety issues that contributed to the death?(Describe recent illnesses, hospitalizations, or accidents.)

Was there an emergency response?(Describe who called 911 or other emergency service and what was done for the participant upon arrival.)

Was the participant taken to an emergency room or clinic prior to death? If so, how was he/she transported?

- by emergency services/ambulance/ Medivac
- by family or other natural supports
- by provider staff or volunteer
- other: _____

Was the participant receiving any of the following at the time of death?

- Hospice services. Name of hospice: _____
- Do-Not-Resuscitate (DNR) order
- Comfort One enrollment