NEW YORK STATE DEPARTMENT OF HEALTH
Adult Care Facility/Assisted Living

Incident Report
DSS-3123 (Revised 05/12, 11/15)

Facility Name: _____ County: _____

Date of Incident: _____ Time: _____ Regulations: 487.7(d)(1-13)
488.7(b)(1-13)
490.7(d)(1-11)

Resident Name: _____

Resident level of care (circle all that apply): AH EHP ALR EALR SNALR ALP

I. Reportable Incidents to the Department's Regional Office: ** must fill out addendum to this report

- ☐ Resident whereabouts were unknown for more than 24 hours;
- ☐ Resident assaults or injures, or is assaulted or injured by another resident, staff, or others;
- ☐ Resident attempted or committed suicide (if resident died, must also check "resident death" below);**
- ☐ Complaint or evidence of resident abuse;
- ☐ Resident Death;**
- ☐ A felony crime may have been committed by or against a resident;
- ☐ Resident behaved in a manner that directly impaired the well-being, care, or safety of the resident or any other resident, or which substantially interferes with the orderly operation of the facility; or
- ☐ Resident was involved in an accident on or off the facility grounds which resulted in such resident **requiring medical care, medical attention, or services.**
- ☐ **Non-Reportable Incidents (maintained on file in the facility's and/or resident's record)**

II. Incident Description: (include injuries, type of first aid given, employee involvement, and attach a separate statement of other participants and any witnesses)

III. Immediate Action Taken: (describe medical treatments and/or action(s) taken)

IV. Action(s) Taken Upon QA Review (Systems Review)

V. Identify individual(s) or agency(s) that provided care and location where care was provided:

VI. Describe current status of resident(s)/individual(s) involved:

Administrator/Operator's Signature _____ Date: _____

VII. Resident's Description of Incident/Accident: Operator is required by law to include your description of the incident/accident, unless you object or decline. Use the space below for your comments, or if you do not wish to comment, check the following:

☐ **I do not wish to comment**

Resident Signature _____ Date: _____

VIII. Reporting of Incident/Accident: (check all that apply)

Individual and title of person reporting incident: _____

☐ NYS Department of Health Regional Office: _____ Date: _____

☐ Resident's Physician: (identify) _____ Date: _____

☐ Resident's Representative: (identify) _____ Date: _____

If Required (refer to regulation)

☐ Police: _____ Date: _____

☐ The Justice Center for the Protection of People with Special Needs: _____ Date: _____

☐ Other (identify): _____ Date: _____

For DOH Internal Use: _____

Regional Office Staff Assigned: _____ **Review Date:** _____

Regional Office Action Taken (describe): _____

Central Office Notified: ☐ **YES** ☐ **NO** **Date:** _____

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ADDENDUM TO ACF INCIDENT REPORT OF RESIDENT DEATH OR ATTEMPTED SUICIDE

Resident Name _____

Resident Age _____ Did resident receive aftercare OMH services? _____

Death Due to: _____ Suicide _____ Natural Causes _____ Accident _____ Homicide _____ Unknown

Date of Death **(circle one)** Estimated or Actual Date: _____

Location of the Death:

Did the person die: _____In the facility _____ Outside the facility

If the person died outside the facility,

how many hours after leaving the facility did the person die: _____ Less than or equal to 48 hours _____ More than 48 hours

If the person died outside the facility, indicate the location of death:

_____ Hospital _____ Nursing Home _____ Hospice _____ Home/Family

_____ Other (please specify) _____

Briefly Describe the Circumstances Surrounding the Death: _____

Date and Time Regional Office Notified: _____

Additional Comments: _____