form

Form:Incident Report

County of Ottawa

submitted by **Non-Patient** (id: N/A, dob: N/A)

Facility/Home Information

Name of Facility/Home	Your agency's name/Self Determination Placement (i.e., CMHOC/Holland MDT, CMHOC/Crisis, Hope Network/West Lake Cottage 2, Benjamin's Hope/House 1, Alliance/CLS, St. John's/Private Duty Nursing, Case Management of MI, etc.)
License Number	If you are reporting from a licensed Adult Foster Care home, include the license #
Facility Address	Your agency's address
Facility Phone	Your Agency's telephone #
Licensee Name	If you are reporting from a licensed Adult Foster Care home, include the appointed licensee's name

Person Directly Involved

Consumer Directly Involved	CMHOC Recipient's First and Last Name
CMHOC Case Number	CMHOC specific case number

Other Persons Involved/Witnesses

Name and Type (Other Consumer/Employee/Visitor)	List who was present and/or involved in the incident you are reporting on. Briana Fowler, CMHOC staff Anna Bednarek, CMHOC staff Recipient #111000

Facts of the Incident

Report Date	2022-08-30
Time (include AM/PM)	4:40 pm
Name of Employee Assigned to Consumer	Kristi Chittenden, CMHOC IT/Staff
Location of Incident (Kitchen, Yard, etc.)	CMHOC - Lobby of Building A
Explain What Happened/Describe Injury (if any)	Be very detailed. Give specifics. Leave out your emotion(s). * Who, What, when, where, and why is a good start ** ** If you used an approved physical management technique make sure to document the approved MANDT technique and how long you used it for ** Remember, people reading this Incident Report were most likely not present for the incident so it is important

	that you write clearly, with great detail, in order to provide an accurate snapshot of what happened.
Action taken by Staff/Treatment Given	What did you do to assist with/remedy the incident (i.e., went to the ER, called the police for assistance, called Poison Control, cleaned the wound and applied a bandage, etc.)
Corrective Measures Taken to Remedy and/or Prevent Recurrence	What did you do? (i.e. increased supervision, suspended services and issued a Notice of Rights, contacted the guardian, contacted my supervisor, filed a recipient rights complaint, called CPS/APS, called the police, etc.) Did you make an environmental modifications? (i.e., moved the furniture around, etc.)

Additional Treatment Received (Complete this section if applicable)

Name of Treating Physician / Health Care / Medical Facility / Hospital	Dr. ____ @ Holland Urgent Care
Date and Time Care Given	08/30/2022 @ 5:00 pm
Physician's Diagnosis of Injury, Illness or Cause of Death, if known	Recipient was diagnosed with a sprained left ankle, directed to take tylenol for pain, and follow-up with the primary care physician.

Person(s) Notified

People notified include name, agency, date and time for each contact. Examples include Recipient Rights, APS/CPS, LARA, First Responders, etc.	Supervisor on 08/30/2022 @ 5:30 pm Case Manager/Supports Coordinator on 08/30/2022 @ 5:35 pm (left a voicemail) CMHOC RN, PT, OT, Speech, etc. sent an email on 08/30/2022 @ 5:40 pm Office of Recipient Rights sent an email on 08/30/2022 @ 5:40 pm LARA - AFC Licensing Consultant on 08/30/2022 @ 5:45 pm (sent an email)

Signature

Name and Title	Sign your name and include your current employment/position title
Date Completed	2001-08-30