ADULT FAMILY HOME

DOCUMENT TEMPLATE LIBRARY

COMPLIANCE & OPERATIONS

Incident / Accident Report

[HOME NAME]

[Street Address]

[City, State ZIP]

[Phone] | License #: [License Number]

BASIC INFORMATION

Date of Incident: _____ **Time of Incident:** _____

Date Reported: _____ **Reported By:** _____

Location of Incident: ☐ Resident Bedroom ☐ Bathroom ☐ Living Room ☐ Dining Room ☐ Kitchen ☐ Hallway ☐ Yard / Outside ☐ Other: _____

Resident Involved: _____

Resident Date of Birth: _____ **Room Number:** _____

TYPE OF INCIDENT

Check all that apply:

☐ Fall (unwitnessed) ☐ Fall (witnessed) ☐ Medication error ☐ Injury ☐ Choking ☐ Elopement / wandering ☐ Behavioral incident ☐ Hospitalization ☐ Allegation of abuse / neglect ☐ Unexpected death ☐ Other: _____

SECTION 1 — DESCRIPTION OF INCIDENT

Describe exactly what happened (Who, What, When, Where, How). Stick to observed facts only — do not speculate or assign blame.

Was the resident alone at the time? ☐ Yes ☐ No — Staff present: _____

Names and roles of witnesses: _____

SECTION 2 — INJURIES & CONDITION

Injuries observed: ☐ None apparent ☐ Bruise ☐ Laceration ☐ Abrasion ☐ Swelling ☐ Fracture suspected ☐ Head injury ☐ Other: _____

Describe injuries in detail (location, size, appearance):

Resident's physical condition at time of discovery:

Resident's verbal response or complaint (if any):

SECTION 3 — IMMEDIATE ACTIONS TAKEN

- ☐ First aid administered — describe below
- ☐ 911 called — Time called: _____ Ambulance arrived: _____
- ☐ Resident transported to hospital — Name of facility: _____
- ☐ Resident monitored and remained at home — monitoring plan documented below
- ☐ Physician notified — Name: _____ Time: _____

Describe all immediate actions taken:

SECTION 4 — NOTIFICATIONS

Person Notified	Relationship	Date	Time	Method	Notified By
	Family / Guardian			☐ Phone ☐ In person	
	Attending Physician			☐ Phone ☐ Fax	
	State Hotline / Agency			☐ Phone ☐ Online	
	Other:				

Was state licensing notification required? ☐ Yes — Confirmation #: _____ ☐ No
Was Adult Protective Services (APS) notified? ☐ Yes — APS Report #: _____ ☐ No

SECTION 5 — FOLLOW-UP PLAN

What steps will be taken to prevent recurrence:

Will the care plan / ISP be updated as a result of this incident? ☐ Yes — Date updated: _____ ☐ No
Was a physician follow-up ordered? ☐ Yes — Appointment date: _____ ☐ No

SIGNATURES

Staff Completing Report — Printed **Signature** **Date / Time**

Name

		Date
Supervisor / Provider Review — Printed Name	**Signature**	

This form must be completed prior to the end of the reporting shift. Retain in resident file and incident log.