

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report –INITIAL REPORT**

(* = MANDATORY FIELD)

v06212013

Note, if incident involves one individual, an Individual Incident Report needs to be completed instead.

Initial Report: Filing Agency Information

***(1)** Filing Agency: _____

***(2)** Staff filling out Paper Incident Report: _____

(3) Staff Responsible for Incident Follow-up: _____

Initial Report: Incident Classification

***(4A)** Date Incident Discovered: _____ ***(4B)** Approximate Time Incident Discovered: _____
MM/DD/YYYY HH:MM AM/PM

***(5)** Do you know the date and/or approximate time that the incident occurred?

CHECK ONE Both Date Only Time Only Neither

Complete only if known

(5A) Date Incident Occurred: _____ **(5B)** Approximate Time Incident Occurred: _____
MM/DD/YYYY HH:MM AM/PM

***(6)** Did staff directly observe the incident? Yes No Unknown

***(7)** Who was responsible for the supervision of the individuals at the time of the incident?

Choose one from the following:

- | | |
|---|---|
| <input type="checkbox"/> Individuals | <input type="checkbox"/> Other Provider |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reporting Provider | <input type="checkbox"/> Unknown |

(8) If Reporting Provider, was supervision at the time of the incident being provided as assigned?

Yes No Unknown

(9) Responsible Site: _____

(10) Area Office with Primary Responsibility for the site: _____

**Commonwealth of Massachusetts - Department of Developmental Services
 Massachusetts Rehabilitation Commission
 Site-Level Incident Report - INITIAL REPORT (continued)**

***(11) Site-Level Incident Categories: CHECK ONE**

<p>(1) Fire</p> <ul style="list-style-type: none"> <input type="checkbox"/> Known Origin – Allegedly Started by Individual <input type="checkbox"/> Known Origin – Not Started by Individual <input type="checkbox"/> Source Unknown <p>(2) Suspected Mistreatment</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supports <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supervision 	<p>(3) Theft</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alleged Victim <p>(4) Transportation Accident</p> <ul style="list-style-type: none"> <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other <p>(5) <input type="checkbox"/> Emergency Relocation</p> <p>(6) <input type="checkbox"/> Other</p>
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- ***(12A)** Did the incident involve the ingestion of non-food substances? Yes No Unknown
- ***(12B)** Did the incident involve unauthorized use of drugs/alcohol? Yes No
- ***(12C)** Did the incident involve suicidal threat/ideation? Yes No
- ***(12D)** Did the incident involve non-compliance with a medical directive? Yes No
- ***(12E)** Did the incident involve a medication refusal? Yes No

* **Is there an Injury?** No

If You Answer This Question “Yes”, You Need To File an Individual Incident Report, Not A Site-Level Incident Report

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - INITIAL REPORT (continued)**

*(15) Is the Incident Location known? Yes No

(15A) Where did the incident occur? *CHECK ONE*

- | | | |
|--|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Individuals' Residence | <input type="checkbox"/> Day Service | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Family Residence | <input type="checkbox"/> Work Site | <input type="checkbox"/> Other |
| <input type="checkbox"/> Residential Setting-Other | <input type="checkbox"/> School | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Community | |

(15B) Location Detail: *CHECK ONE*

- | | | |
|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Bedroom | <input type="checkbox"/> Common Area | <input type="checkbox"/> Yard |
| <input type="checkbox"/> Dining Area | <input type="checkbox"/> Public Area | <input type="checkbox"/> Work Area |
| <input type="checkbox"/> Living Area | <input type="checkbox"/> Laundry Area | <input type="checkbox"/> Vehicle |
| <input type="checkbox"/> Kitchen | <input type="checkbox"/> Stairs or Stairwells | <input type="checkbox"/> Outdoor Area |
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Basement | <input type="checkbox"/> Other |

(15C) Site Location of Incident (address): _____

(15D) *IF NOT AT PROVIDER SITE, INFORMATION ABOUT INCIDENT LOCATION:*

Location Name/Description: _____

Location Name and address, if any: _____

Initial Report: Actions Taken To Protect Health, Safety, and Rights

*(16) Actions Taken to Protect Health, Safety and Rights: *Immediate actions taken to protect the individuals. Describe administrative, health/safety, treatment and other actions taken to address the incident to date.*

(17) Treatment Provided By: *CHECK ALL THAT APPLY*

- | | | |
|---|--|-------------------------------|
| <input type="checkbox"/> Staff (non licensed) | <input type="checkbox"/> PCA | <input type="checkbox"/> None |
| <input type="checkbox"/> LPN, RN, NP | <input type="checkbox"/> Other (<i>describe above</i>) | |

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - INITIAL REPORT (continued)**

Initial Report: Involved Parties

***(18)** People Involved with Incident: (ADD ADDITIONAL SHEETS AS NEEDED)

	*(18B) Involvement <i>SELECT ALL THAT APPLY</i>	*(18C) Relationship <i>SELECT ALL THAT APPLY</i>
(18A) Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
(18D) Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		

Initial Report: Notification

***(19A)** Was the On-Call person notified? Yes No

***(19B)** Name of On-Call person: _____

***(20A)** Has Executive Office of Elder Affairs been notified? (Only applies to individuals greater than 59 years old. Choose 'N/A' for all other individuals.) Yes-Have Notified No-Will Notify No N/A

***(20B)** Has DPPC Been Notified? Yes-Have Notified No-Will Notify No

***(20C)** Has DCF Been Notified? Yes-Have Notified No-Will Notify No N/A

(21) Has Family/Guardians Been Notified? Yes-Have Notified No-Will Notify No N/A

***(22)** Was Law Enforcement Involved? Yes No Unknown

***(23A)** Signature of the Staff filling out Paper Incident Report: _____

***(23B)** Position: _____

***(23C)** Telephone: () - ***(23D)** Date/Time of Report: _____
MM/DD/YYYY HH:MM AM/PM

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - INITIAL REPORT (continued)**

***(24A)** Name of Supervisor: _____

***(24B)** Position: _____

***(24C)** Signature of Supervisor: _____

(24D) Telephone: (_____) - _____ **(24E)** Date/Time of Review: _____
MM/DD/YYYY HH:MM AM/PM

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - FINAL REPORT (continued)**

Final Report: Additional Information

**(25) Incident Description: Any updated or corrected information from the Incident Description (Question 13) including dates, times, people involved, and relevant details prior to, during, and after the incident. Indicate the current status of the individuals. If law enforcement has been contacted please list details of actions taken by law enforcement.*

Final Report: Action Steps

***(26)** Are there Additional Action Steps for this Incident: Yes No Unknown

(26A) Action Step:	(26B) Targeted Completion Date: (MM/DD/YYYY)	(26C) Responsible Party: (Name and/or Position)

Final Report: Involved Parties

(27) People Involved with Incident:

CORRECT ONLY IF THERE ARE CHANGES FROM THE INITIAL REPORT. ADD ADDITIONAL SHEETS AS NEEDED

	*(27B) Involvement <i>SELECT ALL THAT APPLY</i>	*(27C) Relationship <i>SELECT ALL THAT APPLY</i>
(27A) Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
(27D) Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		
Involved Party Name:	<input type="checkbox"/> Eyewitness to Incident <input type="checkbox"/> Person who filled out paper report <input type="checkbox"/> Person who reported Incident <input type="checkbox"/> Provider/DDS Staff who discovered/first made aware of incident	<input type="checkbox"/> Reporting Provider Staff <input type="checkbox"/> Relative <input type="checkbox"/> Non-Reporting Provider Staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Individual/Consumer <input type="checkbox"/> General Public <input type="checkbox"/> Friend <input type="checkbox"/> Other
Telephone: () -		

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - FINAL REPORT (continued)**

Final Report: Verification of Time and Categorization

***(28)** Initial Report Information is correct to the best of my knowledge:

Yes, *IF YES, SKIP TO # 40A.*

No, *IF NO, DESCRIBE ANY UPDATED OR CORRECTED INFORMATION BELOW AND ANSWER ALL APPLICABLE QUESTIONS:*

***(29A)** Date Incident Discovered: _____ ***(29B)** Approximate Time Incident Discovered: _____
MM/DD/YYYY HH:MM AM/PM

***(30)** Do you know the date and/or approximate time that the incident occurred:

Both Date Only Time Only Neither

(30A) Date Incident Occurred: _____ **(30B)** Approximate Time Incident Occurred: _____
MM/DD/YYYY HH:MM AM/PM

***(31)** Site-Level Incident Categories: *CHECK ONE*

<p>(1) Fire <input type="checkbox"/> Known Origin – Allegedly Started by Individual <input type="checkbox"/> Known Origin – Not Started by Individual <input type="checkbox"/> Source Unknown</p> <p>(2) Suspected Mistreatment <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supports <input type="checkbox"/> Alleged Omission – Failure to Provide Needed Supervision</p>	<p>(3) Theft <input type="checkbox"/> Alleged Victim</p> <p>(4) Transportation Accident <input type="checkbox"/> Pedestrian <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other</p> <p>(5) <input type="checkbox"/> Emergency Relocation</p> <p>(6) <input type="checkbox"/> Other</p>
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***(32A)** Did the incident involve the ingestion of non-food substances? Yes No Unknown

***(32B)** Did the incident involve unauthorized use of drugs/alcohol? Yes No

***(32C)** Did the incident involve suicidal threat/ideation? Yes No

***(32D)** Did the incident involve non-compliance with a medical directive? Yes No

***(32E)** Did the incident involve a medication refusal? Yes No

*** Is there an Injury?** No

If You Answer This Question “Yes”, You Need To File an Individual Incident Report, Not A Site-Level Incident Report

**Commonwealth of Massachusetts - Department of Developmental Services
Massachusetts Rehabilitation Commission
Site-Level Incident Report - FINAL REPORT (continued)**

*(33) Staff filling out Paper Final Report: _____

*(34) Did staff directly observe the incident? Yes No Unknown

*(35) Who was responsible for the supervision of the individuals at the time of the incident?

Choose one from the following:

- | | |
|---|---|
| <input type="checkbox"/> Individuals | <input type="checkbox"/> Other Provider |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other |
| <input type="checkbox"/> Reporting Provider | <input type="checkbox"/> Unknown |

(36) If Reporting Provider, was supervision at the time of the incident being provided as assigned?

Yes No

*(37A) Was the On-Call person notified? Yes No

*(37B) Name of On-Call person: _____

*(38A) Has Executive Office of Elder Affairs been notified? (Only applies to individuals greater than 59 years old. Choose 'N/A' for all other individuals.) Yes-Have Notified No-Will Notify No N/A

*(38B) Has DPPC Been Notified? Yes-Have Notified No-Will Notify No

*(38C) Has DCF Been Notified? Yes-Have Notified No-Will Notify No N/A

(39) Has Family/Guardians Been Notified? Yes-Have Notified No-Will Notify No N/A

*(40) Was Law Enforcement Involved? Yes No Unknown

Final Report - Finalization

*(41A) Name of Person Finalizing Report: _____

*(41B) Position: _____

*(41C) Signature: _____

(41D) Telephone: (____) _____ - _____ (40E) Date/Time of Review: _____
MM/DD/YYYY HH:MM AM/PM