State of Illinois
Illinois Department of Public Health

# Long-Term Care Facility & IID - Serious Injury Incident and Communicable Disease Report

**Illinois Administrative Code 77, 300.690b), 330.780b), 340.1330b), 340.1510a)c),350.700b), 390.700b).** The facility shall notify the Department of any serious incident or accident and communicable disease. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. If reporting communicable disease, please complete only the applicable sections.

## General Information

Report Type ☐ Initial ☐ Final Incident Date: ____________ Facility Type ☐ SNF ☐ ICF ☐ SC ☐ CLF ☐ ICF/DD ☐ MCDD ☐ VA

Facility Name ______________________ Time of Incident ____________ Report Date ____________

Address ______________________ Contact E-mail ______________________

## Incident Category

☐ Drug Diversion

☐ Alleged Abuse ☐ Death related to an incident ☐ Resident to Resident Altercation

☐ Alleged Neglect ☐ Fall with physical harm or injury ☐ Severe Injury of Unknown Origin

☐ Communicable Disease ☐ Elopement with physical harm or injury ☐ Other ______________________

## Resident #1 Involved in Incident/Reportable Event

**Hospitalized** ☐

Name ______________________ Date of Birth ____________ Identified Offender ☐ Yes ☐ No **Deceased** ☐

☐ Victim ☐ Perpetrator ☐ N/A ☐ Male ☐ Female ☐ Ambulatory ☐ Wheelchair ☐ Transfer w/1 ☐ Transfer w/2 ☐ Mechanical Lift ☐ Bed Bound

Interviewable ☐ Yes ☐ No Informed Decisions ☐ Yes ☐ No Alert and Oriented ☐ 1 ☐ 2 ☐ 3 Capable of Communication ☐ Yes ☐ No

## Resident #2 Involved in Incident/Reportable Event

**Hospitalized** ☐

Name ______________________ Date of Birth ____________ Identified Offender ☐ Yes ☐ No **Deceased** ☐

☐ Victim ☐ Perpetrator ☐ N/A ☐ Male ☐ Female ☐ Ambulatory ☐ Wheelchair ☐ Transfer w/1 ☐ Transfer w/2 ☐ Mechanical Lift ☐ Bed Bound

Interviewable ☐ Yes ☐ No Informed Decisions ☐ Yes ☐ No Alert and Oriented ☐ 1 ☐ 2 ☐ 3 Capable of Communication ☐ Yes ☐ No

## Resident #3 Involved in Incident/Reportable Event

**Hospitalized** ☐

Name ______________________ Date of Birth ____________ Identified Offender ☐ Yes ☐ No **Deceased** ☐

☐ Victim ☐ Perpetrator ☐ N/A ☐ Male ☐ Female ☐ Ambulatory ☐ Wheelchair ☐ Transfer w/1 ☐ Transfer w/2 ☐ Mechanical Lift ☐ Bed Bound

Interviewable ☐ Yes ☐ No Informed Decisions ☐ Yes ☐ No Alert and Oriented ☐ 1 ☐ 2 ☐ 3 Capable of Communication ☐ Yes ☐ No

## Staff #1 Involved in Incident

Name ______________________ Position ______________________

Date of Birth ______________________ License Number ______________________

Retrained ☐ Yes ☐ No Suspended ☐ Yes ☐ No Terminated ☐ Yes ☐ No No Action Required ☐

## Staff #2 Involved in Incident

Name ______________________ Position ______________________

Date of Birth ______________________ License Number ______________________

Retrained ☐ Yes ☐ No Suspended ☐ Yes ☐ No Terminated ☐ Yes ☐ No No Action Required ☐

## Staff #3 Involved in Incident

Name ______________________ Position ______________________

Date of Birth ______________________ License Number ______________________

Retrained ☐ Yes ☐ No Suspended ☐ Yes ☐ No Terminated ☐ Yes ☐ No No Action Required ☐

## Incident Description

Assessment/ Test Date ____________ Assessment/ Test Performed by ____________ Title ____________ Time ____________

Hospital ER ☐ Yes ☐ No Time ____________ Admitted ☐ Yes ☐ No Diagnosis ____________

Law Enforcement Notified ☐ Yes ☐ No Police Investigator ____________ Investigator Phone ____________ Case Number ____________

Witness Name ____________ ☐ Resident ☐ Family ☐ Staff ☐ Other ____________

Witness Phone ____________

Witness Name ____________ ☐ Resident ☐ Family ☐ Staff ☐ Other ____________

Witness Phone ____________

**Detailed Incident Summary (Who, What, When, Where, Why)**
**For Communicable disease please add type of test, reason for testing and steps taken after positive result on test**

Did the investigation confirm ☐ Abuse ☐ Neglect ☐ Misconduct ☐ N/A

Name of Person Submitting Report ____________ Title ____________ Date ____________ Time ____________

********** IDPH Use Only **********

Date Reviewed ____________ Regional Reviewer ____________ IRI # ____________

Date Reviewed ____________ C/O Reviewer ____________

☐ ANT ☐ IDFPR ☐ LSC ☐ ISP ☐ APRT