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.

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

☐ Alleged Abuse
☐ Alleged Neglect
☐ Communicable Disease
☐ Drug Diversion
☐ Death related to an incident
☐ Fall with physical harm or injury
☐ Elopement with physical harm or injury
☐ Resident to Resident Altercation
☐ Severe Injury of Unknown Origin
☐ Other _____

Resident #1 Involved in Incident/Reportable Event

Hospitalized ☐ **Deceased** ☐

Name _____ Date of Birth _____ Identified Offender ☐ Yes ☐ No

☐ 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 ☐ **Deceased** ☐

Name _____ Date of Birth _____ Identified Offender ☐ Yes ☐ No

☐ 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 ☐ **Deceased** ☐

Name _____ Date of Birth _____ Identified Offender ☐ Yes ☐ No

☐ 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