NEW VENDOR SPECIAL INCIDENT REPORTING TRAINING

Updated 3/25/2024

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Special Incident Reporting

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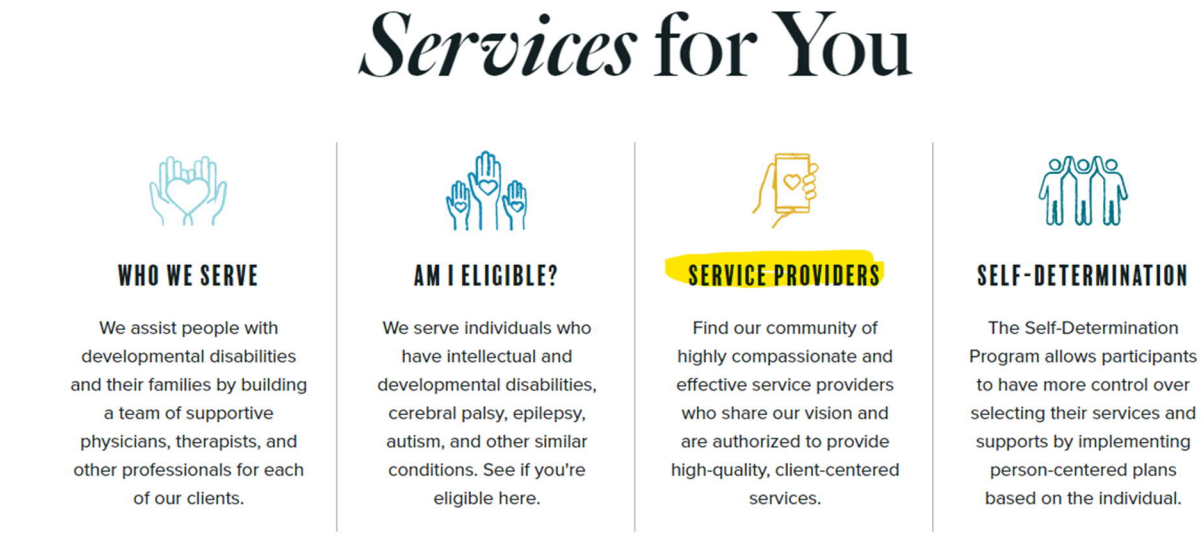
Directions on How to Access the Special Incident Report Forms on Alta California Regional Center's Website -Website address is www.altaregional .org

Special Incident Reporting (SIR) Forms/Documents

- From ACRC's Home Page Scroll down to Service Providers at the bottom of the page and click onto Service Providers.

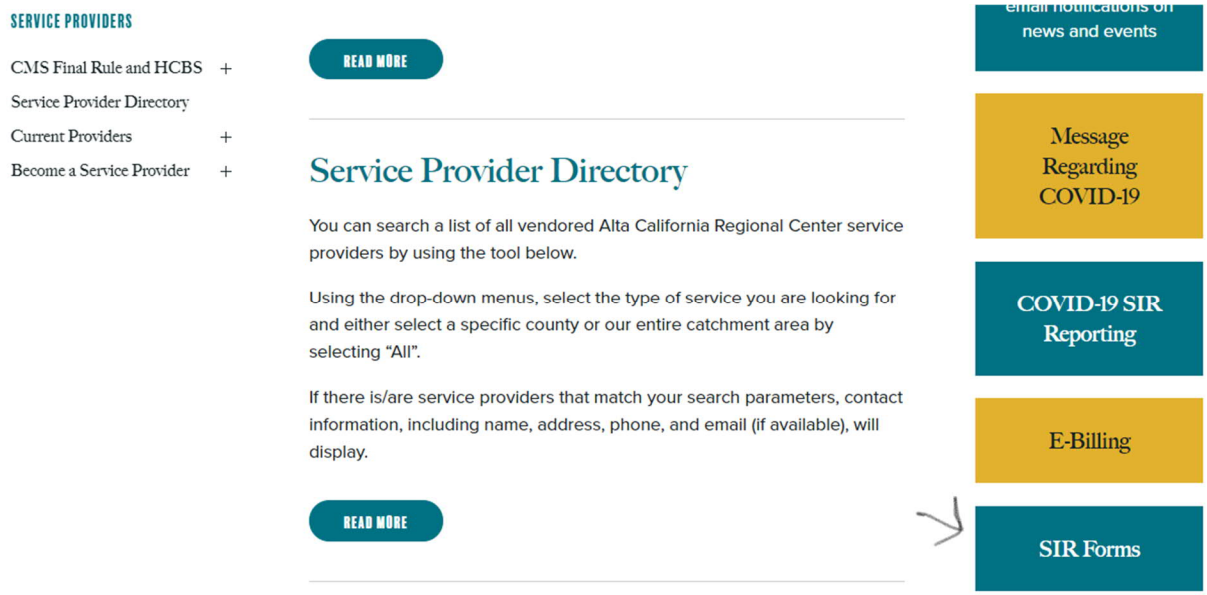


- Brings you to the page below:

- Scroll down to the bottom of the page; on the Right Side you will find SIR Forms

Updated on 7/07/21

Directions on How to Access the Special Incident Report Forms on Alta California Regional Center's Website -Website address is www.altaregional .org



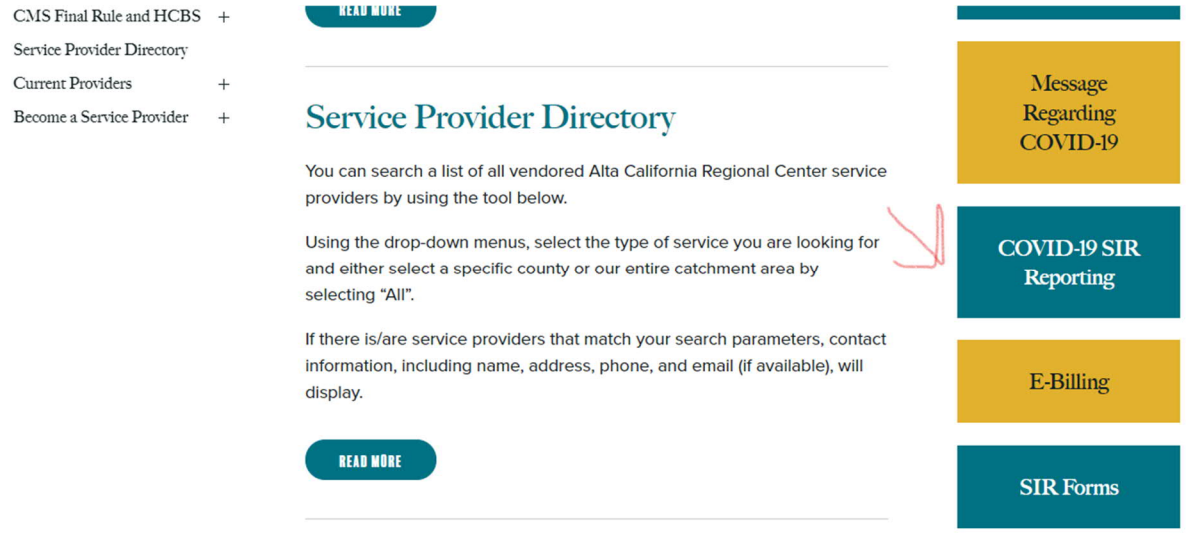
- Once the SIR or Death Report has been completed, either email or fax it the following:
  - Email: sdesk@altaregional.org
  - Fax 916 978-6619

For COVID 19 SIR Reporting

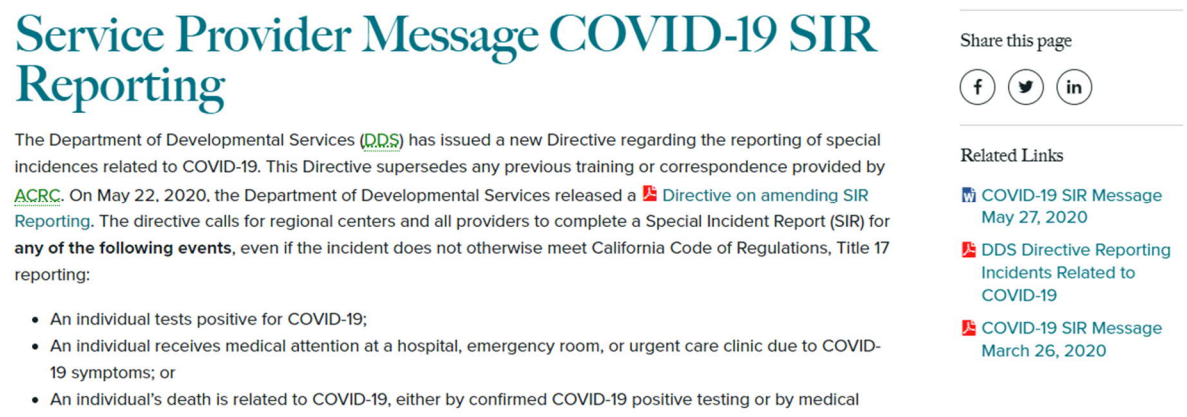
- From the Service Provider Page Click onto COVID-19 SIR Reporting instead of SIR Forms

Updated on 7/07/21

Directions on How to Access the Special Incident Report Forms on Alta California Regional Center's Website -Website address is www.altaregional .org



➢ Click on COVID -19 SIR Reporting



For the Post- Emergency Restraint Report Form

➢ From the Service Provider Page- Click on Service Provider Forms

Updated on 7/07/21

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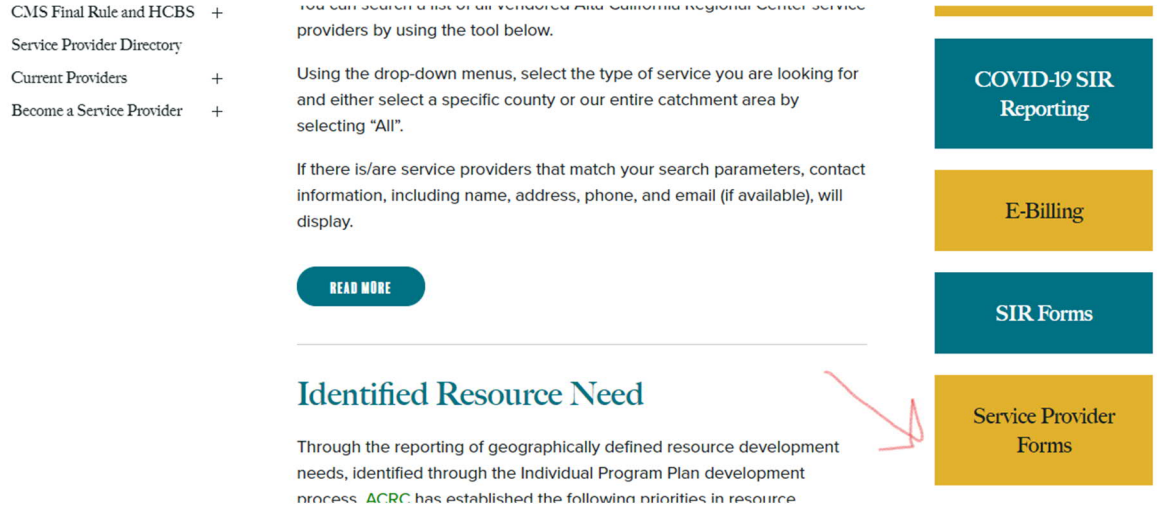
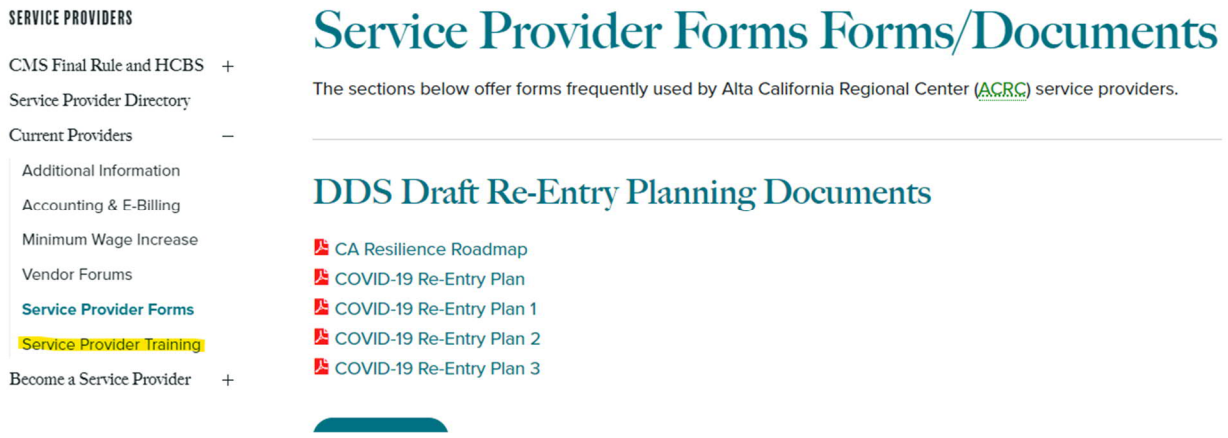


- Click on Service Provider Forms and scroll down to Post-Emergency Restraint Report Form:

New Vendor SIR Training Booklet:

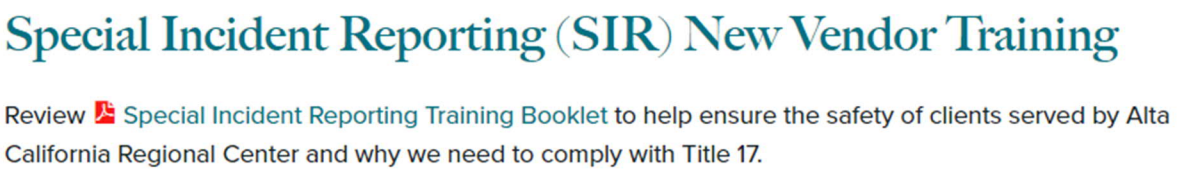
- The Training Booklet is located under Special Incident Reporting (SIR) Forms/Documents as shown above
- Also located under Service Provider Training
    - Select Service Provider Forms as shown above

Directions on How to Access the Special Incident Report Forms on Alta California Regional Center's Website -Website address is www.altaregional .org



- Click Service Provider Training

- Scroll down until you get to Special Incident Reporting (SIR) Training New Vendor Training



Under Vendored Care

Under Vendored Care: Title 17, Section (b) (1) reads:
(b) All vendors and long-term health care facilities shall report to the regional center:
(1) The following special incidents if they occurred during the time the consumer was receiving Services and Supports from any vendor or long-term health care facility.

RAP Protocol for Title 17, Section 54327(b) (1): "Under vendored Care"
A consumer was receiving service and supports from a vendor or long-term health care facility at the time when an incident occurred, if any of the following conditions is satisfied, and not otherwise.

1. If the client lived in a :
    a. Community Care Facility (CCF)
    b. Intermediate Care Facility (ICF)
    c. Skilled Nursing Facility (SNF)
    d. Supported Living Services (SLS)

Note that these residence types have 24/7 responsibility for care: Individuals in these types are always under vendored care.

2. If support staff were scheduled to be present at the time.

Note that incidents that are reportable if support staff were scheduled to be present at the time of the incident, even if they:
    a. Arrived after the incident
    b. Were late
    c. Did not arrive at all.

3. The vendor or long-term care facility was in fact, providing services and supports to the consumer at the time of the incident.

Long-Term Care Facility:
For purposes of reporting, any of the following count as long-term care facilities:
    a. Adult Day Health Care Programs (ADHC)
    b. Congregate Living Facilities (CLHF)
    c. Skilled Nursing Facilities (SNF)
    d. Intermediate Care Facilities (ICF)
    e. Intermediate Care Facilities/Developmentally Disabled (ICF/DD)
    f. Intermediate Care Facilities/ Developmentally Disabled Habilitative (ICF/ DDH)
    g. Intermediate Care Facility/ Developmentally Disabled-Nursing (ICF/ DDN)

The information on this document was taken from The Reporting Alignment Project Reporting Protocols which were developed on February 12, 2007 and updated July 2013. The Reporting Alignment Project follows Title 17 Section 54327(b)(1).

	Special Incident Reporting	
	Action	Documents
Who	Vendors and Long-term Health Care Facilities	
Why	To help ensure the safety of clients served by ACRC and need to comply with Title 17	Title 17 Regulations Sections 54327 (confirm the sections)
When	Special Incident Reporting • Vendors and Long-term Health Care Facilities shall report Special Incidents which occurred to an ACRC Client to the regional center as follows: o Notify the Assigned Service Coordinator immediately, but no later than 24 hours of the vendor, Long-term Health Care Facility learning of the incident. • Submit the Written Report (SIR) to the ACRC SIR Desk within 24 hours of the Vendor, Long-term Health Care Facility learning of the incident. • If the vendor, Long-term Health Care facility is a licensed facility then a report should also be filed with licensing agency. • If there is a suspicion of abuse or neglect then a mandated report is required to be filed with the appropriate protective agency (CPS, APS, Long-term Care Ombudsman, and or the Local Law Enforcement Agency) in addition to submitting an SIR to ACRC's SIR Desk.	• ACRC Special Incident Report, Form 552X • ACRC Death Report, Form 552D • Mandated Reporting Requirements Flow Chart
Where	All documents used are found used are found on the ACRC Website: www.altaregional.org	• Directions to Access Forms on Website

What	Title 17 section 54327(b) All vendors and long-term health care facilities shall report to the regional center the following: (1) The following special incidents if they occurred during the time the consumer was receiving services and supports from any vendor or long-term care facility: 1. Injuries Beyond First Aid a) Burns requiring medical treatment b) Medication Reactions c) Bites Break Skin d) Internal Bleeding e) Puncture Wounds 2. Serious Injury/ Accident a) Fractures b) Injury Accident –Dislocation c) Lacerations requiring sutures/staples d) Medication Error 3. Unauthorized absence a) Missing Person- law notified 4. Hospitalizations a) Involuntary Psych Admission b) Nutrition Deficiency c) Cardiac Care d) Diabetes e) Internal Infection f) Seizures g) Respiratory Illness h) Wound/Skin Care 5. Other Incidents a) Hospitalization-Other b) Choking Incidents c) Transportation Incidents d) Disease Outbreaks e) Physical Restraints Title 17 Section 54327 (b) All vendors and long-term health care facilities shall	• ACRC SIR Requirements Form-SIR • Under Vendored Care-SIR: this document describes what is meant by under vendored care.

	report to the regional center: (2) The following special incidents regardless of when or where they occurred: 1. Death 2. Victim of a Crime- (Law Enforcement required): a) Aggravated Assault b) Burglary c) Personal Robbery d) Larceny e) Rape/Attempted Rape 3. Suspected Abuse/Exploitation a) Physical b) Sexual c) Fiduciary d) Emotional / Mental e) Physical and /or Chemical Restraint 4. Suspected Neglect - Failure to: a) Provide medical care for physical and mental health needs b) Prevent malnutrition or dehydration c) Protect from health and safety hazards d) Assist in personal hygiene e) Provide food, clothing , shelter f) Provide care- Elder/Adult **5.** Other Incidents: a) Suicide Threat/Attempt b) Fire Setting c) Other Sexual Incident-Client is the aggressor d) Media Attention e) HIPAA Violations	

How	General SIR The Vendor or Long-term Health Care Facility completes the ACRC 552X-SIR form for incidents that meet the requirement and submits to ACRC's SIR Desk by email: sdesk@altaregional.org or fax (916) 978-6619.	General SIR • ACRC 552X ACRC Special Incident Report-SIR: This is the form used to complete a Special Incident Report and submit by email to SIR Desk in Outlook • Instructions for completing 552X Form by SC- Step-by-step instructions on how to complete the SIR form. • Flowchart- Steps to Reporting a Special Incident (SIR) to the Regional Center • Post Restraint Report (PRR) Death SIR • 552D ACRC Death Report
	Death of Client SIR When a client dies either the vendor or the SC completes the 552D ACRC Death Report.	
	SIR Follow-Up Documentation	
	Action	Documents
Who	Vendors and Long-term Health Care Facilities.	Title 17 Regulations Sections 54327
What	Information gathering to explain how the incident was resolved and how to prevent a repeat of the incident.	
When	After an incident occurred involving an ACRC Client.	
Where	Providing updates to ACRC Service Coordinator via e-mail or telephone call.	
Why	To protect the health and safety of the clients.	
How	The vendors and Long-term Care Facilities should discuss the Special Incident with the ACRC Service Coordinator to discuss how the incident was resolved and what the plan is to prevent future incidents.	• DDS Special Incident Follow-up Questions

SUPPLEMENTAL INFORMATION FOR TYPE OF SPECIAL INCIDENTS

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Injuries beyond First Aid: for an injury to be considered Treatment beyond First Aid means that the client was seen by a medical professional for the injury in question. *For Example,* if a vendor took a client to a physician for a burn, the incident is reportable to the regional center even if the physician decided not to treat the injury any further.

Types of Injuries beyond First Aid

- Puncture Wounds
- Bites that Break the Skin
- Internal Bleeding: *Bruises are a type of internal bleeding. If a client receives attention from any medical professional for the purpose of treating the bruise, an SIR is reported to the regional center.*
- Medication Reactions: *For medication reactions, including but not limited to allergic reactions to adverse effects of medications interacting with one another.*
- Burns Requiring Medical Treatment

Serious Injuries /Accidents

- Lacerations requiring sutures/ staples or glue
- Fractures
- Injury Accident-Dislocations

Medication Errors

Medication Error Categories:

Any medication error that occurred while a client was under vendored care regardless of the consequences.

- Receiving a prescription medication that was not prescribed.
- Receiving the wrong dose of any medication; this includes missed dose of prescription medications and wrong doses of over-the-counter medications.
- Not receiving prescribed medication within one hour of the prescribed time of day
- Not receiving prescribed medication by the proper route.
- Refusals by clients over the age of 14 are not reportable to DDS.

Definitions for Medication Error Categories:

- Missed Dose- prescribed medication was not given or administered.
- Wrong Dose-the incorrect dose of medication was administered (e.g., medication given was not at the prescribed dose)
- Wrong Medication-wrong medication was given or taken by the individual.
- Wrong Person-medication was administered to the wrong individual.
- Wrong Time-medication was given at the wrong time (i.e., outside of 1hour window for when it should have been given)
- Wrong Route- prescribed medication was given via wrong route (e.g., by injection rather than by mouth).
- Documentation Error (for use only in combination with other error) -error in documenting medication administration or prescription.

- Other- medication error not listed above.

Medical Attention -Definitions:

- Consulted RN/RPH/MD-vendor contacted a nurse, pharmacist, or doctor to consult about medical attention required.
- Consulted Poison Control- vendor contacted a Poison Control hotline to consult about attention or action required.
- Emergency Room/Urgent Care Visit-vendor sought emergency or urgent care (e.g., hospital, urgent clinic) for individual.
- Observe/Report-vendor closely observed individual after medication error and/or reported concerns as needed to medical doctor.
- None- vendor did not take any actions in response to error.
- Other- vendor action taken in response to error that is not listed above.

Missing Person-Law Enforcement Notified:

- The client is missing and a vendor or long-term health care facility has filed a formal missing person report or the vendor of long-term health care facility has described the client as missing in any way-not necessarily in a formal way to law enforcement.

Hospitalizations:

Any time a client is admitted to the hospital while under vendor care it must be reported to the regional center. (Hospitalizations are now referenced by diagnosis rather than what is not planned. How the SIR will be coded by the SIR Desk will depend on the treatment they received and their discharge diagnosis).

Hospitalization Categories:

- Respiratory Illness, including but not limited to asthma, tuberculosis; and chronic obstructive pulmonary disease;
- Seizure-related;
- Cardiac-related, including but not limited to congestive heart failure; hypertension and angina;
- Internal infections, including but not limited to ear, nose and throat , gastrointestinal , kidney, dental, pelvic or urinary tract infection;
- Diabetes, including diabetes related complications;
- Wound/skin care, including but not limited to cellulitis and decubitus;
- Nutritional deficiencies, including but not limited to anemia and dehydration; or
- Involuntary psychiatric admission.
- Hospitalization-Other: If a client is admitted to the hospital for any other reason.

Choking

- An SIR is required when a client has experienced a chocking incident.

SUPPLEMENTAL INFORMATION FOR TYPE OF SPECIAL INCIDENTS

Transportation Incidents

- An SIR is required when a client is in an accident while transported by a vendor or an SIR is required when the bus or taxi breaks down while the vendor is providing services to the client.

Disease Breakout

- An SIR is required when a disease outbreak occurs at a facility or program involving any ACRC consumers.
- These are confirmed cases and an SIR should be submitted for each client where there is confirmation of the outbreak.
- If a client has been exposed to a contagious disease but there is no confirmation that the client has contacted the disease, then contact then contact ACRC Community Services Department and work directly with them. If there is confirmation of disease then submit SIR.

Physical Restraints

- An SIR is required whenever a client is restrained. Please see protocol below:

  A Note on using restraints……
  - Due to risk for physical injury and /or emotional trauma, the use of restraints are considered procedures that may cause pain or trauma
  - All procedures that may cause pain or trauma must be reviewed and approved prior to implementation as outlined in Title 17: §§50800-50835.

Steps for Review and Approval Include:

1. Planning team discusses need for restrictive procedure and notifies all appropriate parties of the review process.
2. Planning team develops an "interim safety plan" while review process occurs.
3. Qualified professional (i.e., BCBA or Behavior Management Consultant) develops intervention plan.
4. Planning team reviews the proposed intervention plan and written informed consent received.
5. Client's primary care physician reviews proposed intervention plan.
6. Client's Service Coordinator reviews proposed intervention plan with ACRC's Behavior Modification Review Committee for Approval

- Vendor completes and submits Post –Emergency Restraint Report (PERR) to assigned Service Coordinator

Death of a Client

- Please complete the ACRC Death report when an ACRC client passes away regardless of the circumstances.

SUPPLEMENTAL INFORMATION FOR TYPE OF SPECIAL INCIDENTS

Victim of a Crime

- Robbery: a victim; including theft using a firearm, knife or cutting instrument or other dangerous weapons or methods which force or threaten

- Aggravated Assault: including physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon;

- Larceny: including the unlawful taking, carrying, leading or riding away of property, except motor vehicles, from the possession or constructive possession of another person;

- Burglary: including forcible entry; unlawful non-forcible entry; and attempted forcible entry of a structure to commit a felony or theft therein;

- Rape: including rape or attempted rape

Suspected Abuse/Exploitation

Protocol for Title 17 Section 54327(b)(1)(B)- Reasonably Suspected Abuse/exploitation including:

- Physical
- Sexual
- Fiduciary
- Emotional/mental or
- Physical and/or chemical restraint

Please refer to the *Mandated Reporting Flow Chart* on filing a report of suspected abuse.

Suspected Neglect

Protocol for Title 17 Section 54327(b)(1)(B):
Reasonably Suspected Neglect including failure to:

- Provide medical care
- Prevent malnutrition or dehydration
- Protect from health and safety hazards
- Assist in personal hygiene or the provision of food, clothing or shelter
- Exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult

Please refer to *Mandated Reporting Flow Chart* on filing a report of suspected neglect.

SUPPLEMENTAL INFORMATION FOR TYPE OF SPECIAL INCIDENTS

Arrests

- An SIR is required when a client is arrested or looks like the client may be arrested (i.e. has an upcoming court date due to a new law enforcement incident).

Suicide Threat/Suicide Attempt

- An SIR is required whenever a client makes either a suicide threat or suicide attempt regardless of the circumstances.

Fire Setting

- An SIR is required whenever a client starts a fire.

Other Sexual Incident-consumer is the aggressor

- An SIR is required whenever the client is the aggressor of a sexual incident.

Media Attentions

- An SIR is required whenever there is any media attention regarding an ACRC Client. DDS tracks this information and we are required to report it to DDS.

Multiple Incidents Reporting Requirements

- If a client experiences an incident in the morning and in the afternoon of the same day a similar incident occurred you can describe both occurrences on one SIR and submit to the regional center.
- If a consumer has two different incidents on the same day but the incidents are unrelated then two separated SIRs need to be submitted to the regional center.
- If an incident occurs today and then the same incident occurs tomorrow then two separate SIRs need to be reported to the regional center because they occurred on separate days.

DEPARTMENT OF DEVELOPMENTAL SERVICES
1215 O Street, MS 9-90
Sacramento, CA 95814
TTY: 711
(833) 421-0061

March 27, 2023

TO: REGIONAL CENTER EXECUTIVE DIRECTORS

SUBJECT: ENDING SPECIAL INCIDENT REPORTING FOR COVID-19 AND MPOX

Welfare and Institutions (W&I) Code section 4639.6 authorizes the Director of the Department of Developmental Services (Department) to issue directives to regional centers as the Director deems necessary to protect consumer rights, health, safety, or welfare, or in accordance with W&I Code section 4434. Regional centers must comply with any directive issued by the Director pursuant to this section.

Effective Monday, April 3, 2023, this Directive ends all COVID-19 and Mpox reporting requirements, through special incident reports and also about vaccination status information, by regional centers and service providers that previously were established by the Department. This Directive supersedes the directives issued September 27, 2022; March 10, 2022; May 22, 2020; and March 25, 2020 regarding reporting on these topics.

The federal public health emergency for Mpox ended on January 31, 2023. The state public health emergency for COVID-19 ended on February 28, 2023. The federal public health emergency for COVID-19 will expire May 11, 2023. Effective Monday, April 3, 2023, and in light of ongoing reporting requirements established for facilities licensed by the California Department of Public Health and California Department of Social Services, mandatory reporting to the Department through special incident reports regarding Mpox and COVID is ended. This includes reporting of COVID-19 and Mpox cases, hospitalizations and deaths specific to COVID-19. Reporting of vaccination status information also is ended. The SANDIS data system's ability to capture and report this information remains available for regional centers that wish to continue to use it.

Regional centers must share this Directive with all providers and are encouraged to share it with their staff. The Department is deeply grateful to the entire developmental services community for their longstanding efforts to protect the health of the individuals we serve. If you have any questions regarding this Directive, please contact Leslie Morrison at (916) 214-3706 or leslie.morrison@dds.ca.gov.

Sincerely,

NANCY BARGMANN
Director

cc: See next page.

"Building Partnerships, Supporting Choices"

DEPARTMENT OF DEVELOPMENTAL SERVICES
1215 O Street, MS 9-90
Sacramento, CA 95814
TTY: 711
(833) 421-0061

April 14, 2023

TO: REGIONAL CENTER EXECUTIVE DIRECTORS

SUBJECT: MONTHLY REPORTS FROM VENDORS TO DDS: INCIDENTS OF BEHAVIORAL RESTRAINTS, SECLUSION, AND INVOLUNTARY EMERGENCY MEDICATION

Welfare and Institutions Code section 4659.2(c) was amended last year by SB 188 (Chapter 49, Statutes of 2022) to identify additional entities that receive monthly information from specified regional center vendors regarding their use of restraint or seclusion. All regional center vendors that provide crisis or residential services or supported living services, long-term health care facilities, and acute psychiatric hospitals have been required to report restraint data on a monthly basis to Disability Rights California. This reporting continues to be in addition to required special incident reporting of restraint use pursuant to California Code of Regulations, Title 17 section 54327.

Effective May 1, 2023, reports from these vendors must be made to the Department of Developmental Services (Department). The Department will share those reports with the regional center providing services to the consumer (or to the vendoring regional center, if different) and with Disability Rights California. The monthly reports from these vendors continue to include the following information:

(A) The number of incidents of seclusion and the duration of time spent per incident in seclusion;

(B) The number of incidents of the use of behavioral restraints and the duration of time spent per incident of restraint;

(C) The number of times an involuntary emergency medication is used to control behavior; and

(D) The name, street address, and telephone number of the facility.

The Department has developed an online form for submission of this information. All regional center vendors that provide crisis or residential services or supported living services, long-term health care facilities, and acute psychiatric hospitals must submit information on the use of seclusion, behavioral restraint, or involuntary emergency medication, using the online form. Vendors are invited to contact the Department at RestraintReportingForm@dds.ca.gov if they would like to discuss an alternate method for submitting this information.

Regional centers must inform their vendors that provide crisis or residential services or supported living services, long-term health care facilities, and acute psychiatric hospitals that, effective May 1, 2023, these vendors are required to submit the information required above to the Department.

Vendors and regional centers with questions about this directive and reporting should contact the Department at RestraintReportingForm@dds.ca.gov.

Sincerely,

Original signed by:

NANCY BARGMANN
Director

cc: Regional Center Administrators
Regional Center Directors of Consumer Services
Regional Center Community Services Directors
Association of Regional Center Agencies
Pete Cervinka, Department of Developmental Services
Carla Castañeda, Department of Developmental Services
Brian Winfield, Department of Developmental Services
Ernie Cruz, Department of Developmental Services
Chris Gephart, Department of Developmental Services
Leslie Morrison, Department of Developmental Services
Jim Switzgable, Department of Developmental Services

Mandated Reporting Requirements Flow Chart – SIR
Alta California Regional Center

Mandated Reporting Requirements

Penal Code 11164-11174.3: Suspected Abuse or Neglect for Children:
The Child Abuse and Neglect Reporting Act is created with the intent and purpose to protect children from abuse and neglect, all persons participating in the investigation of the case shall consider the needs of the child victim and shall do whatever is necessary to prevent psychological harm to the child victim.
Any individual working with or behalf of a child or is providing services to a minor is considered a mandated reporter. This includes but is not limited to licensee/ administrator/staff of a licensed community care facility, licensing worker, employee of a child institution, teachers, teacher's aides, social workers, marriage/family therapists, and law enforcement.

W&I Code 15630-15632: Suspected Abuse or Neglect for Dependent Adults/Elder: Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or local law enforcement agency, is a mandated reporter.

When do I report?

- When you have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect.

- When you have been told by a minor, dependent adult or elderly person that he or she has experienced behavior, including an act or omission, constituting physical abuse, or neglect.

"Reasonable suspicion" is defined as in California Welfare and Institutions Code and California Penal Code.

- " Reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing , when appropriate , on his or her training and experience to suspect abuse or neglect.

What happens if I do not report abuse?

- Failure to report physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, is a misdemeanor, punishable by not more than six months in the county jail, by fine of not more than $1,000.00, or by both that fine and imprisonment.
- Any Mandated reporter who willfully fails to report any of the above, where that abuse results in death of great bodily injury, shall be punished by not more than one year in county jail, by a fine of not more than $5,000, or by both that fine and imprisonment.

What is your role in situations that involve suspicion of abuse / neglect?

- Ensure the appropriate Protective agencies have been notified and are investigating.
- Do not interview consumers, witnesses or alleged perpetrator.

- Do not notify the alleged perpetrator of the allegation against them.

What is considered physical abuse?
15610.63 "Physical Abuse" means any of the following:

- Assault, as defined in Section 240 of the Penal Code.
- Battery, as defined In Section 242 of the Penal Code
- Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
- Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
- Sexual assault, that means that any of the following:
    - Sexual battery, as defined in Section 243.4 of the Penal Code
    - Rape as defined in Section 261 of the Penal Code
    - Rape in concert, as described in Section 264.1 of the Penal Code
    - Spousal rape, as defined in Section 262 of the Penal Code
    - Incest, as defined in Section 285 of the Penal Code.
    - Sodomy, as defined in Section 286 of the Penal Code.
    - Oral copulation, as defined in Section 288a of the Penal Code.
    - Sexual penetration, as defined in Section 289 of the Penal Code.
    - Lewd or lascivious acts as defined in paragraph (2) of subdivision (b), of Section 288 of the Penal Code.
- Use of physical or chemical restraint of psychotropic medication under any of the following conditions:
    - For punishment
    - For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the instructions are given.
    - For any purpose not authorized by the physician and surgeon.

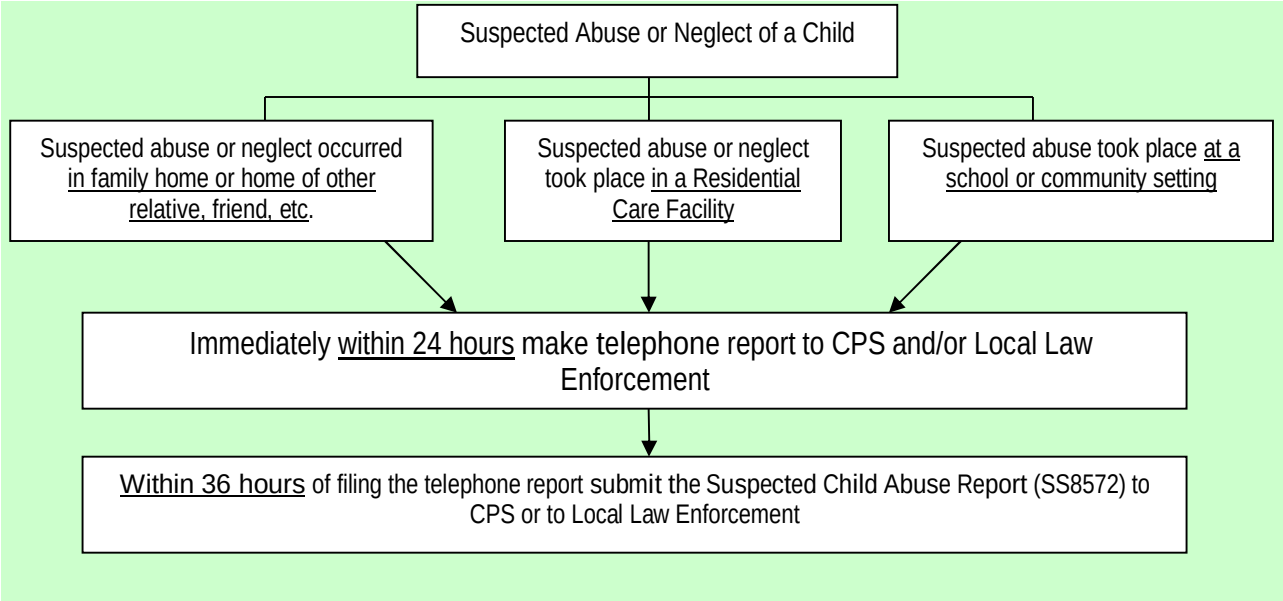
Welfare and Institution Code Sections 15630 and 15658 (a) (1):

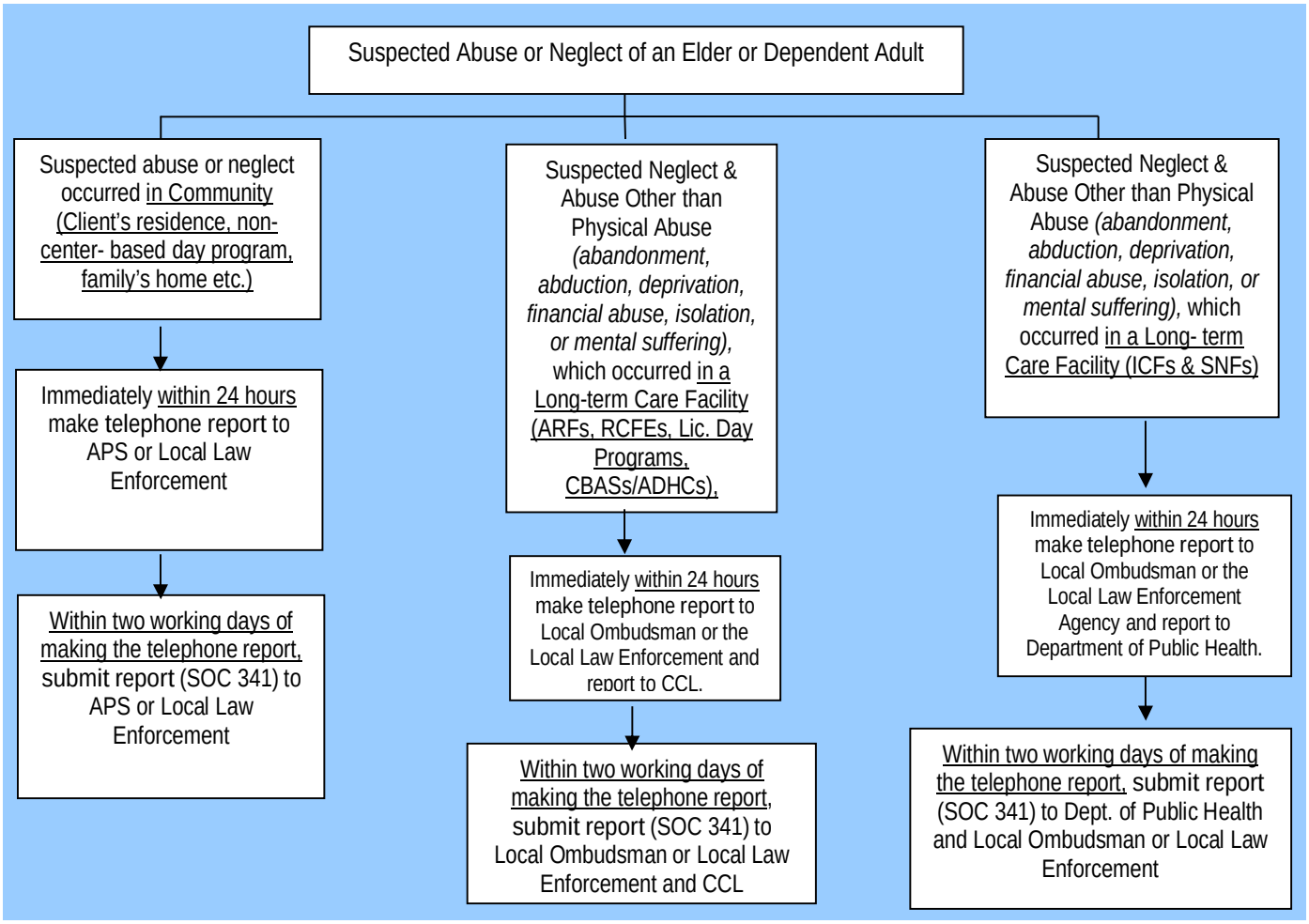
- Neglect means the negligent failure of an elder or dependent adult or any person having the care custody of an elder or a dependent adult to exercise that degree of self-care that a reasonably person in a like position would exercise.

Who reports the suspected abuse or neglect?

- Service Coordinators, Vendors, and Long- Term Health Care Providers are all Mandated Reporters and need to follow the laws for mandated reporting whenever there is a suspicion of abuse or neglect of a child, dependent adult or elder.
- The agency which either witnesses, obtained knowledge, or suspects the abuse or neglect of the child, dependent adult or elder should be the person responsible for making the mandated report.
- When making the report it should be reported to the local agency of where the suspected abuse or neglect occurred.
- Because there are different jurisdictions for the protective agencies depending on the age of the victim and the location of the incident please follow the guidelines below:

Mandated Reporting Requirements Flow Chart – SIR
Alta California Regional Center





Important Definitions related to AB 40-Yamada

1. Welfare & Institution Code Section 15610.67 definition of "Serious bodily injury": an injury involving extreme physical pain, substantial risk of death, or protracted loss of impairment of function of a bodily member, organ of mental faculty, or requiring medical intervention, including , but not limited to, hospitalization, surgery, or physical rehabilitation. Physical abuse that does not meet this definition is considered to be abuse with "no serious bodily injury".

2. Physical abuse that must be reported to law enforcement includes: assault, battery, sexual assault, and unreasonable physical constraint, improper use of a physical or chemical restraint or psychotropic drugs. (Welfare Institution Code Section 15610.63)

3. If other than physical abuse no change in law. Report by telephone and written report to either Ombudsman or Local Law Enforcement Agency immediately or as soon as practicably possible. Report in writing within two working days.

4. "Long-Term Health Care Facility" means both facilities licensed by Community Care Licensing (i.e. Adult Residential Facilities (ARF), Adult Residential Facilities for Persons with Special Needs (ARFPSHN); Adult Day Programs (including Licensed Activity Centers, Adult Development Centers, and Behavior Management Programs), Residential Care Facilities for the Elderly, (RCFE) and Community Based Adult Services (CBAS) (previously known as Adult Day Health Centers (ADHC) and by the Department of Public Health (i.e. Intermediate Care Facilities (ICF) and Skilled Nursing Facilities (SNF).

5. Who is not considered a long-term care facility? Any licensed children's programs; Community based or non-center-based programs (even if these serve dependent adults). Reports of abuse for these programs would go to local law enforcement and/ or Adult Protective Services (APS) /Child Protective Services (CPS), and not the Long-term Care Ombudsman

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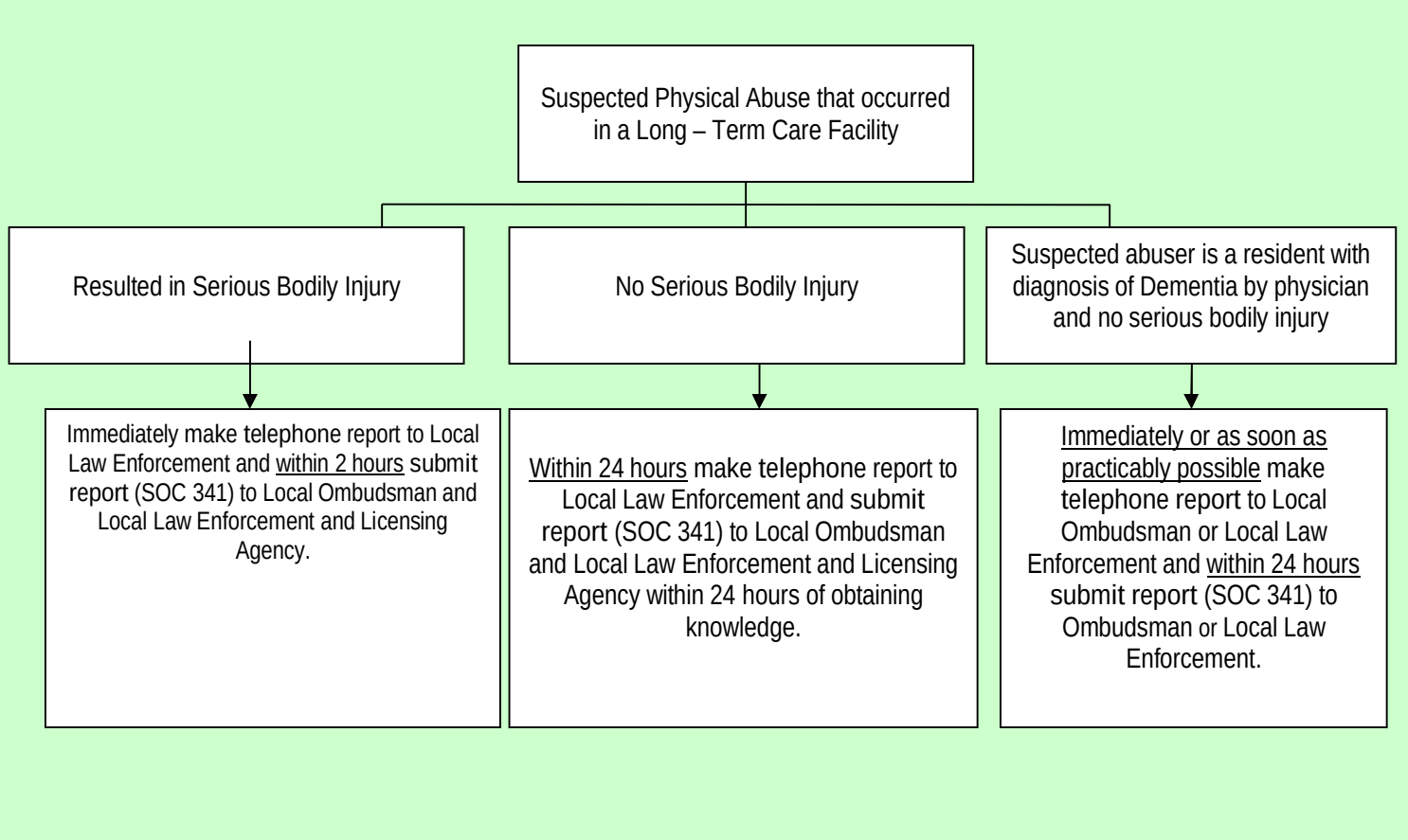

Contact Information for Mandated Reporters

Adult Protective Services			Child Protective Services		
County	Telephone	Fax	County	Telephone	Fax
Alpine	888 755-8099	530 694-2252	Alpine	888 755-8099	530 694-2252
Colusa	530 458-0280	530 458-2664	Colusa	530 458-0280	530 458-0492
El Dorado	530 642-4800	530 622-1543	El Dorado	530 642-7100 Placerville 530 573-3201 South Lake Tahoe	530 541-2803
Nevada	888 339-7248	530 274-3264	Nevada	530 273-4291	530 273-6941
Sacramento	916 874-9377	916 854-9341	Sacramento	916 875-5437	916 874-4002
Placer	888 886-5401	530 265-9376	Placer	916 872-6549	916 787-8915
Sierra	530 289-3720	530 993-6767	Sierra	530 289-3720	530 993-6767
Sutter	530 822-7227	530 822-7384	Sutter	530 822-7227	530 822-7384
Yolo	530 661-2955	530 661-2761	Yolo	530 669-2345	530 666-8468
Yuba	530 749-6471	530 749-6244	Yuba	530 749-6288	530 749-6801

Long Term Ombudsman			Licensing Contact Information		
County	Telephone	Fax	County	Telephone	Fax
Colusa- will identify as	530 898-5923	530 898-4870	Community Care Licensing	916 263-4700	916 263-4744

Passages					
El Dorado	530 642-4860	530 626-9060	Department of Public Health	916 263-5800	916 263-5840
Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba	916 376-8910	916 376-8914	Foster Care Licensing	916 875-5543	916 263-4744

Other Important Contact Numbers:		
Office of Client's Rights Advocacy	916 504-5944	Fax 916 504-5821
Medical Board of California	800 633-2322 916 263-2382	Fax 916 263-2435

Sheriff Departments:

County	Telephone	Address	County	Telephone	Address
Alpine	530 694-2231	14777 State Route 89 P.O. Box 278 Markleeville 96120	Placer	530 886-5375	2929 Richardson Dr. Auburn, CA 95603
Colusa	530 458-0200 colusasheriff.com	929 Bridge St. Colusa 95932	Sierra	530 289-3700	100 Courthouse Square First Floor P.O. Box 66 Downieville 95936
El Dorado	530 621-5655 (main office) 530 573-3000 (South Lake Tahoe Office)	300 Fair Lane Placerville 95667 or 1360 Johnson Blvd S. Lake Tahoe 96150; 4354 Town Center Dr. Suite 112, El Dorado Hills,CA	Sutter	530 822-7307 530 822-7813	1077 Civic Center Blvd. Yuba City, 95993
Nevada	530 265-1263 530 582-7842 (Truckee)	950 Maidu Avenue Nevada City 95959 10879 Donner Pass Road Truckee, CA96160	Yolo	530 666-8282	140 Tony Diaz Dr Woodland, CA 95776
Sacramento	916 874-5070	711 G Street Sacramento CA 95814	Yuba	530 749-7777	215 5th Street Marysville ; 5829 Feather River Blvd. Marysville; 16796 Willow Glen Rd Brownsville; and 1765 River Oaks Plumas, CA

Police Departments

City	Telephone	Address	City	Telephone	Address
Auburn	Non-emergency dispatch 530 823-4237 Fax 530 823-4202	1215 Lincoln Way Auburn, CA 95603	Roseville	916 774-5000	1051 Junction Blvd. Roseville, 95678
Citrus Heights	Non-Emergency 916 727-5500	6315 Fountain Square Dr. Citrus Heights, 95621	Sacramento	Records Department 916 808-0620 Head quarters 916 808-0800	Records Department 5770 Freeport Blvd. Sacramento, 95822 Head Quarters- Public Safety Center 5770 Freeport Blvd. Sacramento,95822
Davis	Non-Emergency 530 747-5400 Fax 530 747-7102	2600 5th Street Davis, CA 95618			

Elk Grove	Non-Emergency 916 714-5115	8380 Laguna Palms Way Elk Grove, CA		North Command 916 566-6401	North Command- William J. Kinney Police Facility 3550 Marysville Blvd. Sacramento, 95838
Folsom	916 355-7230 Fax 916 985-7643	46 Natoma St. Folsom, CA 95632		Central Command 916 808-4500	Central Command- Richards Police Facility 300 Richards Blvd. Sacramento, 95811
Galt	Non-Emergency 209 366-7000 Investigations 209 366-7010 Fax 209 366-7093	455 Industrial Drive Galt, CA 95632		South Command 916 277-6001	South Command- Joseph E. Rooney Police Facility 5303 Franklin Blvd. Sacramento, 95820
Lincoln	Non-Emergency 916 645-4040 FAX 916 645-8940	770 7th Street Lincoln, CA 95648	South Lake Tahoe	530 542-6100 Fax 530 541-7524	1352 Johnson Blvd. South Lake Tahoe, 96150
Marysville	Non-Emergency 530 749-3900 Investigations 530 749-3949 Fax 530 749-3990	316 6th Street Marysville 95901	Sutter Creek	209 267-5646	18 Main Street Sutter Creek, 95685
Nevada City	530 265-4700 Fax 530 265-9259	317 Broad Street Nevada City 95959	Truckee	530 550-2328	10183 Airport Rd. Truckee 96161
Placerville	Non-Emergency 530 642-5298 Fax 530 642-5258	730 Main Street Placerville 95667	West Sac	Non- Emergency 916 372-3375	550 Jefferson Blvd. Broderick 95605
Rancho Cordova	Non-Emergency 916 362-5115	2897 Kilgore Road. Rancho Cordova,95670	Winters	Non- Emergency 530 795-4561 Fax 530 795-3921	702 Main Street Winters 95694
Rocklin	Non-Emergency 916 625-5400	4080 Rocklin Road Rocklin 95677	Woodland	530 661-2411 FAX 530 662-5377	1000 Lincoln Ave. Woodland, 95695
Sacramento City Police Department	Non-Emergency Dispatch: 916 264-5471 Sacramento City PD Records fax: 916 808-0636 Sacramento City PD Tel: 916 808-0621 Sacramento City PD Family abuse and Investigation: 916 808-0650	5303 Franklin Blvd. Sacramento, CA	Yuba City	530 822-4661 Investigations530822-4675 Fax 530-822-3222	1545 Poole Blvd. Yuba City, 95993

Shared Information Reporting		
	Action	Documents
Who	ACRC Vendors and Long-term Health Care Facilities who serve ACRC Clients	• ACRC Shared Information Report • *ACRC Vendor Special Incident Reporting Requirements • ***Under Vendored Care
What	Shared Information report – Shared Information is a report of an occurrence provided by vendor and long-term health care facilities regarding a client that is neither DDS Reportable nor ACRC Best Practice Reportable. Shared Information Categories: 1. Routine seizures not requiring medical attention 2. Clients missing program for 3 consecutive days (unexcused absences) 3. Client falls-no injury or received basic first aid 4. Condition requiring medical intervention at one of the following locations: Emergency Rooms; Out-patient Care or Urgent Care Clinic **if the treatment they received is not listed on *" ACRC Vendor Special Incident Reporting Requirements" *** Under Vendored Care* 5. Pregnancy 6. Medication refusals-if client is age 14 or older 7. Minor injury-basic first aid 8. Injury-accident 9. Injury –from a behavior episode 10. Injury from another client 11. Injury –unknown (if not suspecting physical abuse) 12. **Aggressive act to another client 13. **Aggressive act to family 14. **Aggressive act to self 15. **Aggressive act to staff 16. Severe verbal threats 17. Drug /Alcohol Abuse 18. Community safety: (i.e. jumping out of a moving vehicle; j-walking; riding bike without helmet etc.) 19. Property damage 20. Theft by a client 21. Law Enforcement Involvement (Arrests should be reported as an SIR) 22. Bed bugs (If not suspecting neglect)	

	23. Report incidents on left column of *"ACRC Vendor Special Incident Reporting Requirements" that *** <u>did not occur</u> under vendored care. ***If no injuries were received by victim or client (alleged perpetrator) has not been arrested.*	
When	Shared Information should be reported by the vendor or long-term health care facility to the Service Coordinator either verbally or using the Shared Information form (whichever is determined most appropriate) within 48 hours. Exceptions are occurrences that take place on a regular basis such as behaviors or routine seizures. For these type of occurrences the Planning Team will determine the appropriate interval at which the Shared Information should be reported to the ACRC Service Coordinator.	
Where	Documentation is entered into the vendors and/or Long-term care facilities On-going Notes	
Why	Shared Information allows for Vendors to communicate with ACRC and collaboratively plan for the health and safety of the client.	
How	Vendors or Long-Term Health Care Facilities will call, email or submit incident details using the Shared Information form. Upon receipt, the SC reviews it to ensure it is not a DDS Reportable or Best Practice Reportable incident as well as contains adequate detail. SC may request additional information to be provided.	

Alta California Regional Center Special Incident Report

Please check the appropriate box below:

Report Submitted By: ☐ Service Coordinator ☐ Vendor ☐ Long-Term Health Care Facility

Report submitted by:	Title:	Telephone #:
Reporting Agency's Name:	Date Vendor or Other Entity Learned of the Incident:	Date Vendor or Other Entity Notified the Regional Center of the Incident:

Client Information:

Client's Name:	Sex: ☐ Male ☐ Female	UCI Number:
Date of Birth:	Date of Incident:	Time of Incident:
Conserved: ☐ Yes ☐ No ☐ Unknown	Self Determination Program: ☐ Yes ☐ No ☐ Unknown	

ACRC Special Incident Reporting Requirements: **Vendors or Long-Term Health Care Facilities are required to notify Service Coordinators and submit the written report (SIR) to the ACRC SIR Desk within 24-hours of learning of the incident.** It is ACRC's preference that all SIRS are typed and submitted to the SIR Desk e-mail at sdesk@altaregional.org. If you do not have access to e-mail you may fax it to 916-978-6619.

Mandated Reporting Requirements: For suspected child abuse or neglect the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall prepare written report within 36 hours of receiving the information concerning the incident (PC Section 11166(a)). For Suspected Abuse of Dependent Adults and Elderly the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall submit written report within 2 working days of making the report to the responsible agency(WIC Section 15610).

AB40 Assembly Bill: In September 2012 the Governor of California passed the AB40 law into effect which amends Sections 15630 and 15631 and adds 15610.67 to the Welfare and Institutions Code related to elder and dependent adult abuse:

Section 2 Section 15630 of the Welfare and Institutions Code is amended to read: (A) If the suspected or alleged abuse is physical abuse, as defined in Section 15610.63 and the abuse occurred in a long-term care facility, except a state mental health hospital or a state development center, the following shall occur:

(i) If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, and no later than within two hours of the mandated reporting observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(ii) If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(iii) When the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia, and there is no serious bodily injury, as reasonably determined by the mandated reporter, drawing upon his or her training or experience, the reporter shall report to the local ombudsman or law enforcement agency by telephone immediately or as soon as practicably possible, and by written report, within 24 hours.

Medical Information:

Medical Treatment Necessary: ☐ Yes ☐ No If yes, give nature of treatment:	
Administered by:	Location Administered:
Follow- up Treatment, if any:	

Alleged Perpetrator:

If reporting Suspected Abuse, Suspected Neglect and /or Victim of a Crime:
☐ Vendor, Employee of Vendor ☐ Employee of Non-vendor ☐ Relative/Family member ☐ Regional Center Client ☐ Self ☐ Unknown ☐ Other individual known to client ☐ Not Applicable

Location of Incident:

Location of Incident: ☐ Community Care Facility ☐ Long-Term Facility (ICF/SNF) ☐ Day Program ☐ Job Site ☐ Community Setting ☐ Consumer's Own Residence ☐ School ☐ Other:
Address:

Vendor Information:

Vendor at Time of Incident:	Staff Person in Charge at Time of Incident:	Vendor Telephone #:
Vendor Address:		
ACRC Vendor #:	Type of Facility: ☐ CCL ☐ DPH ☐ Foster Care Facility #:	

Agencies Contacted:

Agencies/Individuals Notified:	Name of Person Contacted:	Telephone Number:	Date of Contact:
☐ Service Coordinator:			
☐ Community Care Licensing			
☐ Department of Public Health Service			
☐ Parent/Guardian/Conservator			
☐ Physician/ Hospital:			
☐ Adult Protective Services			
☐ Child Protective Services			
☐ Long Term Care Ombudsman			
☐ Department of Developmental Services (DDS)-*Only for SB188 Reporting Requirements*			
☐ Other:			

Law Enforcement Information: (Please complete if Law Enforcement was contacted):

Agency Contacted:	Officer:	Badge #:	Telephone #:
Date of Contact:	Report #:	Comments:	

Residence Type:

Consumer Residence:
☐ Self/Spouse ☐ Parent/Family ☐ Residential (CCF/ICF/SNF) ☐ SLS ☐ Other:
Facility/Provider Responsible:
Name:
Address:
City/ZIP:
Phone Number:

Incident Information:

Type of Incident (Only Check Boxes that Apply):

☐ Disease Outbreak ☐ Sexual Incident-Client Aggressor ☐ Choking ☐ Fire Setting

☐ Suicide Attempts/Threats ☐ Client is Arrested ☐ Hospital Admission ☐ Media Attention

☐ Missing Person-Law Enforcement Notified ☐ Physical Restraint ☐ Transportation Incidents

☐ Death ☐ HIPAA Violation ☐ Other:

Suspected Abuse/Exploitation:
☐ Physical ☐ Sexual ☐ Fiduciary ☐ Emotional/Mental ☐ Physical or Chemical Restraint

Suspected Neglect and Failure to:
☐ Provide Medical Care for Physical or Mental Health Needs ☐ Prevent Malnutrition or Dehydration
☐ Protect from Health and Safety Hazards ☐ Assist in Personal Hygiene
☐ Provide Food, Clothing, & Shelter ☐ Provide Care Elder/Adult

Victim of a Crime (Law Enforcement <u>Must</u> be Contacted):
☐ Aggravated Assault ☐ Burglary ☐ Personal Robbery ☐ Larceny ☐ Rape/Attempted Rape

<u>Medication Error:</u> **(**Check all that apply)	**<u>Medical Attention for Medication Error:</u>** (Check all that apply)
☐ Missed Dose ☐ Wrong Dose ☐ Wrong Medication ☐ Wrong Person ☐ Wrong Time ☐ Wrong Route ☐ Documentation Error (for use in combination with another error) ☐ Other:	☐ Consulted RN/RPH/MD ☐ Consulted Poison Control ☐ Emergency Room/Urgent Care Visit ☐ Observed/Reported ☐ None ☐ Other:

<u>Injuries Beyond First Aid</u>: (*Received treatment by a medical professional)* ☐ Burns Requiring Medical Treatment ☐ Medication Reaction ☐ Bites Break the Skin ☐ Internal Bleeding- *(which includes bruising requiring medical treatment)* ☐ Puncture Wounds	**<u>Serious Injury/Accident:</u>** ☐ Fractures ☐ Injury Accident-Dislocation ☐ Lacerations req. Sutures/Staples/Glue

Description of Incident:

Description of Incident (Please describe the incident, including specific information leading up to the event, location, harm to client/others, persons involved in incident, who was notified when and by whom, etc.):
Action Taken/Planned (Include person responsible, and how incident was resolved):
What steps will be taken to prevent this incident from occurring again?

Instructions for Completing 552x Form

REMEMBER*: Vendors and Long-term Health Care Facilities should notify the regional center (Service Coordinator) of the special incident immediately, but not more than 24 hours of learning of the incident.*

And

Vendors and Long-term Health Care Facilities should submit written report (SIR) to the regional center (SIR DESK) within 24 hours of learning of the special incident.

Please review the instructions below to make sure the SIR you submit to the SIR Desk has included all of the necessary information and is complete

Incomplete SIRs cause a delay in processing and if received, the reporter of the incident will be contacted and required to submit a whole new "complete" SIR.

Submit complete SIR's to: SIR DESK
E-mail: sdesk@altaregional.org (preferred method)

Fax: (916) 978-6619 (use only if email is not available)

REPORTS SHOULD BE TYPED

Report Submitted by-Information:

1. Check the appropriate box indicating the person who is submitting the SIR. (Vendor or Long- Term Health Care Facility)

2. Report submitted by: The name of person submitting the SIR

3. Title: What is the position of person submitting the SIR (For Example, Program Director, Administrator, etc.?)

4. Telephone # (Vendors or Long –term Health Care Facilities add the best number for the SIR Desk to contact you for questions).

5. Reporting Agency's Name: (Vendors and Service Providers it should be the name of your agency)

6. Date Vendor or Other Entity Learned of the Incident: This is the date that the Vendor or any Service Provider working with an ACRC Client learned of the incident (Care Home, Supported Living, Independent Living Agency, Day Program, etc.)

7. Date Vendor or Other Entity Notified the Regional Center of the Incident: This the date the Vendor or any Service Provider of an ACRC client informed an ACRC staff

member of the incident. In most cases this would be reported to the Service Coordinator or the Client Services Manager who is assigned to the ACRC Client.

Client Information:

1. Client's Name: Provide client's first and last name (no nicknames). Complete name how it is written in all of client's documentation (i.e. referral packet).

2. Sex: Check if male or female.

3. UCI #: Provide client's unique client individual number (UCI).

4. Date of Birth: Provide client's date of birth.

5. Date of incident: Provide the date when incident occurred.

6. Time of Incident: Provide what time the incident occurred. If the time is approximate, write approx. after the time. If you do not know the time, write "unknown"

7. Conserved : Please indicate if the client is conserved yes, no , or unknown.

8. Self Determination Program: Please indicate if the client is participating in the Self-Determination Program; yes, no or unknown

Medical Information:

1. Check whether the client received medical treatment. If they received medical treatment provide the following information:

2. Location of the medical facility that the client was treated at.

3. What was the name of the medical professional who treated client? (For example, Jonathon Jones, M.D. at Kaiser on Morse Ave.

4. What is the follow up treatment? (For example: were they advised to schedule an appointment with their Primary Care Physician?)

Alleged Perpetrator:

If reporting suspected abuse, suspected neglect, or victim of a crime, indicate the relationship between the alleged perpetrator and the client. (For example, vendor, family, another client, etc.)

Location of Incident:

Check the appropriate box for the location where incident occurred. (For example, Day Program, Community Setting, Client's Residence, Community Care Facility, etc.) Include the physical address of the location.

Instructions for Completing 552x Form

Vendor Information:

1. Name of Vendor at the time of incident, or the vendor who was responsible at the time incident occurred.

2. The name of staff person who is in charge at the time the incident occurred.

3. Vendor's telephone number

4. Vendor's address (for care homes –address of facility; for day programs or other type of agencies the address of the vendored program.

5. ACRC vendor #: the number assigned to your agency or facility for your vendorization.

6. Type of Facility: If the facility is a licensed facility indicate who the licensing agency and the facility #

Agencies Contacted:

1. Check the box for all individuals that were notified of the incident and provide the following information

2. Name of person contacted, telephone number, date of contact

Law Enforcement Information:

If incident was reported to law enforcement then provide the following information:

1. Which law enforcement agency was contacted? (For example, Elk Grove Police Department, and Sacramento County Sheriff Department etc.).

2. Officer's name

3. Badge number

4. Officer's telephone number

5. Date of contact

6. Comments

Residence Type:

1. Check the appropriate box to client's living situation. (For example, if client lives with family or independently, at residential facility, or supported living.

2. Facility / Provider Responsible: If the client lives in a licensed facility, or receives supported living then indicate the name of facility or agency providing services. If the client lives with family then list names of the family/relatives residing with. If the client lives independently then can leave blank.

3. Name: List name of staff person who was responsible for client at the time of incident.

4. Address: The address of facility, supported living agency, or family/ relative

5. The telephone number for facility, supported living agency, or family/relative

Incident Information:

1. Check the boxes that apply for type of incident reporting
   a. Suspected Abuse / Exploitation: Please check the type of suspected abuse you are reporting.

   b. Suspected Neglect: Please check the type of suspected neglect that you are reporting

   c. For both Suspected Abuse and Suspected Neglect a mandated report must be completed and submitted with the SIR.

   d. Victim of a Crime: Please check the category you are reporting and confirm that a police report has been filed.

   e. Medication Errors: Please indicate the type of medication error that occurred.

   f. Medical Attention for Medication Error: Please check the appropriate box if the client received medical attention.

   g. Injuries beyond first aid: Please check the appropriate boxes if the client was seen/ assessed by a medical professional (For example, physician, nurse, paramedic, etc.

   h. Serious injury/accident: Please check the appropriate boxes which apply if the incident occurred under vendored care.

Description of Incident:

1. Document an incident in terms that are specific, observable and easily understood. Accurate documentation is written in simple language and is free of opinions, technical terms, jargon and obscure abbreviations.

2. A complete report is based on the points contained in a good newspaper story: Who, Where, When, What, How and Why? It should read clearly and make sense to someone who was not at the incident and/or is not familiar with the client.

3. When describing the incident makes sure it includes the following information:
   a. Who was involved with the incident?

i. If other clients were involved please refer to them by using their initials or client #1, client #2 etc., or UCI #'s.
ii. Provide first and last names of staff and their positions.
iii. Provide first and last names of representatives of other agencies and their title.

b. Where did the incident occur? Describe the location of the incident, be specific.

c. When did the incident occur?
   i. Provide the date and time of when the incident occurred.
   ii. Provide the date and time of when you were notified of the incident and how you learned of the incident.

d. How did the incident occur?
   i. Please provide what led up to the incident.
   ii. Provide the detailed information of what took place.
   iii. <u>For hospitalizations*:</u> it is important to include the following:

      1. When describing the incident on the Special Incident Report it is important that it is clear whether the client is treated in the Emergency Room and then returned to their living environment or if the client is actually admitted the hospital.

      2. The details of the treatment they received while in the hospital at the time of reporting the incident. For Psychiatric Hospitalizations whether a client was held on a 5150 and admitted or it they were assessed and then released.

      3. **When a client is admitted to the hospital it is important that medical records are requested; if you are with the client at the hospital please have them sign a release of information.*

   iv. <u>For Injuries:</u> please include the following information:

      1. Describe the type of injury the client sustained

      2. Describe the type of treatment the client received and where it was provided (i.e. Emergency Room or Urgent Care) and whether it was treated by a medical professional.

   v. <u>For Medication Errors:</u> please include the following information:
      1. A description of what led up to the medication error.
      2. A list of the medications (and dosages) involved in the medication error.

3. The description should describe what type of medication error took place (for example, missed error, wrong dose, wrong time, etc.)
4. Describe what medical attention was sought (for example contacted poison control, pharmacist, physician, etc.)
5. Were there any side effects due to the medication error?

Action Taken/ Planned:

Include person responsible, and how incident was resolved.

What steps will be taken to prevent this incident from occurring again?

What is the planning team's plan to prevent this type of incident to occur in the future?

Appendix- Special Incident Forms

Alta California Regional Center Death Report

Please check the appropriate box below:

Report submitted by: ☐ Service Coordinator ☐ Vendor ☐ Long-Term Health Care Facility

Report submitted by:	Title:	Telephone #:
Reporting Agency's Name:	Date Vendor or Other Entity Learned of the Incident:	Date Vendor or Other Entity Notified the Regional Center of the Incident:

Client Information:

Client's Name:	Sex: ☐ Male ☐ Female	UCI Number:
Date of Birth:	Date of Incident:	Time of Incident:
Conserved: ☐ Yes ☐ No ☐ Unknown	Self Determination Program: ☐ Yes ☐ No ☐ Unknown	

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Mandated Reporting Requirements: For suspected child abuse or neglect the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall prepare written report within 36 hours of receiving the information concerning the incident (PC Section 11166(a)). For Suspected Abuse of Dependent Adults and Elderly the mandated reporter is required to report the incident to the responsible agency immediately or as soon as practically possible by telephone and shall submit written report within 2 working days of making the report to the responsible agency(WIC Section 15610).

AB40 Assembly Bill: In September 2012 the Governor of California passed the AB40 law into effect which amends Sections 15630 and 15631 and adds 15610.67 to the Welfare and Institutions Code related to elder and dependent adult abuse:

Section 2 Section 15630 of the Welfare and Institutions Code is amended to read: (A) If the suspected or alleged abuse is physical abuse, as defined in Section 15610.63 and the abuse occurred in a long-term care facility, except a state mental health hospital or a state development center, the following shall occur:

(i) If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, and no later than within two hours of the mandated reporting observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(ii) If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

(iii) When the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia, and there is no serious bodily injury, as reasonably determined by the mandated reporter, drawing upon his or her training or experience, the reporter shall report to the local ombudsman or law enforcement agency by telephone immediately or as soon as practicably possible, and by written report, within 24 hours.

Medical Information:

Medical Treatment Necessary: ☐ Yes ☐ No If yes, give nature of treatment:	
Administered by:	Location Administered:
Follow- up Treatment, if any:	

Alleged Perpetrator:

If reporting Suspected Abuse, Suspected Neglect and /or Victim of a Crime:		
☐ Vendor, employee of vendor	☐ Employee of non-vendor	☐ Relative/family member
☐ Regional center client	☐ Self	☐ Unknown
☐ Other individual known to client	☐ Not Applicable	

Location of Incident:

Location of Incident: ☐ Community Care Facility ☐ Long-Term Facility (ICF/SNF) ☐ Day Program ☐ Job Site ☐ Community Setting ☐ Consumer's Own Residence ☐ School ☐ Other:
Address:

Vendor Information:

Vendor at Time of Incident:	Staff Person in Charge at Time of Incident:	Vendor Telephone #:
Vendor address:		
ACRC Vendor #:	Type of Facility: ☐ CCL ☐ DPH ☐ Foster Care Facility #:	

Agencies Contacted: Agencies Contacted:

Agencies/Individuals Notified:	Name of Person Contacted:	Telephone Number:	Date of Contact:
☐ Service Coordinator:			
☐ Community Care Licensing			
☐ Department of Public Health Service			
☐ Parent/Guardian/Conservator			
☐ Physician/ Hospital:			
☐ Adult Protective Services			
☐ Child Protective Services			
☐ Long Term Ombudsman			
☐ Department of Developmental Services (DDS)- *Only for SB188 Reporting Requirements*			
☐ Other:			

Law Enforcement Information: (Please complete if Law Enforcement was contacted):

Agency Contacted:	Officer:	Badge #:	Telephone #:
Date of Contact:	Report #:	Comments:	

Residence Type:

Consumer Residence:
☐ Self/Spouse ☐ Parent/Family ☐ Residential (CCF/ICF/SNF) ☐ SLS ☐ Other:
Facility/Provider Responsible:
Name:
Address:
City/ZIP:
Phone Number:

Category/ Type of Death:

Non-Disease Related-Check only boxes that apply:

☐ Abuse (Alleged) ☐ Accident/ Injury/ Trauma ☐ Acute Poison

☐ Catastrophic event – Fire, Flood, etc. ☐ Choking ☐ Error in Medication Administration

☐ Homicide ☐ Suicide ☐ Suspected Substance Abuse

☐ Other: ☐ Not Applicable

Disease Related: ☐ Predictable ☐ Anticipated ☐ Unanticipated

What was the Preliminary Cause of Death?

☐ DNR Order ☐ POLST ☐ Hospice Care ☐ Comfort Care ☐ Unknown

Medical Device Utilization: (Check if client was using for 6 months or longer)

☐ G/J /NG Tube ☐ Ventilator ☐ Ventriculostomy/ VP Shunt ☐ Pacemaker ☐ Dialysis

☐ Oxygen of CPAP ☐ Baclofen Pump ☐ Catherization ☐ TPN/IV ☐ Tracheotomy

☐ Vagus Nerve Stimulation (VNS) ☐ Other (Please Specify) :

☐ Not Applicable/ Does not use Medical Device

Care Characteristics: Please check all that apply:
☐ Under Care of Family ☐ Alone at Time of Death ☐ Under Care of Physician at Time of Death
☐ Within 30 days of Hospital Discharge ☐ Within 30 Days of Surgical Procedure
☐ Within 30 days of Medical Appointment ☐ Within 30 days of Emergency Room Visit
☐ End of Life Planning/ Hospice ☐ Use of Restrictive Procedure/Restraints
☐ Medical/Safety Equipment Malfunction ☐ Death Involved Suspected or Confirmed Criminal Activity
☐ Other (Please Specify) :

Description of Incident:

Description of Incident: Please provide a brief summary of the details that led to the client's death:
Action Taken/Planned (Include person responsible, and how incident was resolved):
What steps will be taken to prevent this incident from occurring again?

DDS Special Incident Report (SIR) Questions

Q#	**Question.** For each request/question, please explain your response (provide relevant dates, details, etc.).
	Incident Category All SIRs
1	Confirm the incident date; vendor and regional center transmission dates for accuracy.
2	Was SIR reported in a timely manner by the vendor and the regional center?
3	If SIR was not reported timely, why and what action was taken to address reporting timeliness?
4	Track and confirm any action to be taken, i.e., staff training, QA investigations, follow-up appointments, discharge plans, change in medications; also was there an existing behavior plan and was the plan revised?
5	Provide an update (outcomes) regarding the regional center's interaction with the vendor.
6	Did the regional center and/or vendor focus on staff training, and/or procedures to mitigate a reoccurrence of the incident?
7	Were there actions taken against staff involved in the incident?
8	Are staff training needs identified?
9	Is the regional center satisfied with the action/outcomes taken by the vendor?
10	What action(s) were taken to reduce the risk of this incident type occurring again?
11	[CCL ONLY] Was CCL contacted about the incident? Why or why not?
12	Are any other investigative agencies involved (e.g., APS, law enforcement, ombudsman, etc.)?
	Medication Error
13	What were the medication(s) and time(s) missed?
14	How long did consumer go without the prescribed medication(s)?
15	Were the prescribing doctor(s) notified of the medication issue? If so, what were the recommendations/orders?
16	What date were the consumer's medication(s) (re)filled?
17	Were the medications (re)filled in a timely manner?
18	On what date did the consumer continue medications as prescribed?
19	Was there a follow-up appointment/meeting? What was the date? What was the result (new services, change in medication)?
20	What are the current medications and why are they prescribed?
21	Did the consumer need to go to the physician? If so, when? Any follow-up scheduled?
22	Did consumer go to the ER?
23	Was consumer admitted to the hospital?
24	SIR should reflect when the consumer is/was released (from the ER, hospital or psych facility) and whether there were any specific recommendations for treatment/ discharge plans upon release.
25	What steps will the vendor take to ensure that the consumer's medications are (re)filled timely?
26	What other actions will the provider take to reduce medication errors?
27	Were there any funding/insurance issues?
28	What was the reason insurance did not cover the consumer's medication(s)?
29	When was the provider notified of insurance funding issue?
30	What action(s) did the provider take knowing that insurance would not cover the medication?
31	When was the regional center notified about the insurance issue?
	Injury
32	Was treatment received at the hospital?
33	Was the consumer admitted into a hospital because of the incident?
34	What was the discharge date?
35	What were the discharge orders?
36	What are the date(s) of any follow-up appointments for this incident?

37	With whom were the follow-up appointments?
38	What are the outcomes of follow-up appointments?
39	What is the health status as of <Date>?
40	Did the consumer require any new or modified services/supports because of the incident? If so, what were they?
Suspected Abuse	
41	Was APS notified of the incident?
42	Any recommendations by APS?
43	What was the result of the APS/police investigation (substantiated, unfounded, inconclusive), if shared with you?
44	Any recommendations or services offered by law enforcement?
45	Will the consumer continue to reside in the same residence?
46	If moving, when and where?
47	Other than relocation, will the consumer require any new or modified services/supports because of the incident?
48	If so, what are the new or modified services/supports?
49	What actions, if any, were taken against the alleged perpetrator?
50	Any recommendations, CAP, letters, technical assistance, etc., by the regional center?
51	What will the regional center to do to assist the vendor? When?
52	Is the regional center investigating the incident? Outcomes?
Psych. Hospitalization	
53	Admission and discharge dates?
54	What was the diagnosis received at the hospital?
55	What was the treatment received at the hospital?
56	Any changes to the consumer's medication regimen?
57	If so, what specific changes to the consumer's medication regimen?
58	What are the discharge orders?
59	What are the date(s) of any mental health or psychiatric follow-up appointments for this incident?
60	With whom were the follow-up appointments?

61	Outcomes of follow-up appointments?
62	What is the mental health and/or behavioral status update as of <DATE>?
63	Did the consumer require any new or modified services/supports because of this incident?
64	If so, what are the new or modified services/supports?
65	What will the regional center to do to assist the provider? Dates?
66	Are planning team meetings scheduled regarding this incident? Dates? Outcomes?
67	Will the regional center and provider be reviewing the consumer's current behavior plan? Why or why not? Dates? Outcomes? Recommendations?
Medical Hospitalization	
68	What was the treatment received at the hospital?
69	How was the consumer transported to the hospital?
70	Was the consumer admitted into a hospital because of this incident?
71	What was the discharge date?
72	What are the discharge orders?
73	What are the date(s) of any medical follow-up and with who?
74	Outcomes of follow-up medical appointments?
75	What is the health status as of <DATE>?
76	Did the consumer receive a diagnosis at the hospital because of this incident?
77	Were there any changes to the consumer's medication regimen?

78	Were there any changes to the consumer's health care plan? Why or why not?
79	What is the consumer's usual frequency of seizures? Have seizures increased?
80	Was the consumer's physician notified of the seizure?
81	Were any specific tests ordered (e.g. anticonvulsant blood levels, EEG, head CT scan, etc.)?
82	Was there any obvious precipitating cause for the incident, such as forgetting to take medications, observed fevers, etc.?
Victim of Crime	
83	Was police contacted? When?
84	What was the result of the police investigation?
85	Was the suspect identified?
86	What actions were taken against the alleged perpetrator?
87	Has the consumer been referred to victim-witness assistance by law enforcement?
88	Did the consumer receive any new or modified services/supports because of this incident?
Rights Violation	
89	RESTRAINT - Was the restraint used in this incident approved in the consumer's behavior plan? If not, please explain what the regional center and provider will do to address this incident.
90	Is staff training planned because of this incident? If so, please provide a date and outcomes of the training.

POST RESTRAINT REPORT (PRR)
(Emergency Intervention Process)

File with SIR Tracking #

Client Name: UCI#: D.O.B.:

Vendor Name: Vendor #:

Date of Restraint:

Date Post Restraint Report (PRR) Completed:

Date Restraint was reported to Disability Rights:

In the event a restraint procedure was used to stop a client from harming themselves or others, or other continuous and dangerous behavior, a verbal Special Incident Report (SIR) is to be made within 24 hours of incident. A written SIR and this POST RESTRAINT REPORT (PRR) must be completed by the ***Direct Care Staff and Administrator*** *involved in the incident and returned to the SIR Desk (sdesk@altaregional.org) within 48 hours.*

Incidences of restraint will be reviewed by the Behavior Modification Committee at Alta California Regional Center. Additional information regarding the restraint may need to be provided to complete that review.

To be completed by Direct Care Staff:

Description of the Restraint

Location where the incident took place that resulted in restraint (i.e. day program, care home etc.):

Did the client's behavior (that resulted in restraint) present an imminent danger of serious injury to self or others? ☐ Yes ☐ No

**Serious injury means any significant impairment of the physical condition as determined by qualified medical personnel (SB 130, 1180.1 (g)) and requires immediate medical attention*

What serious injury to self or others did the client do or attempt to do prior to the restraint? (Check all that apply)

☐ Burn ☐ Laceration ☐ Bone fracture ☐ Substantial hematoma ☐ Injury to internal organ(s)

☐ Other (Explain)

Does the client have any known physical or psychiatric conditions that would place the client at risk during a restraint (i.e. asthma, obesity, prior history of trauma [for example, sexual or physical abuse], cardiac problems, prior or current injury to limb being held, anxiety). Please explain:

POST RESTRAINT REPORT (PRR)
(Emergency Intervention Process)

Describe in detail the facts and circumstances leading to the use of the restraint (attach additional paper if necessary):

Please describe what the behavior looked like:

What happened immediately after the restraint?

Were other clients present at the time of the incident immediately preceding the restraint? Yes ☐ No ☐
If yes, how many other clients were present at the time of the incident?

What were the other clients directed to do at the time of incident, please describe:

Identify and describe the type of techniques used during the incident:

☐ Standing ☐ Escort/Transport Techniques (i.e. Single Sunday Stroll, Double wrist triceps procedure, etc.)

☐ Seated ☐ Wall or floor assisted/Immobilization Techniques (i.e. supine, prone, etc.) Other:

Start Time of Restraint: End Time (of restraint):

Describe the techniques utilized:

If an immobilization technique was used, was a mat utilized prior to implementing the procedure?
☐N/A ☐ Yes ☐No (if no, explain)

***NOTE: If an immobilization technique was used, an ID Team meeting will be required.**

What is the date of the meeting?

Please describe what area(s) on the body the client was touched during the restraint. (i.e. upper left and upper right arm)

What type of de-escalation actions, interventions and/or techniques were used by staff member prior to the restraint?

Additional Precautions Taken (check all that apply and list staff member who did the following):

☐ Ensured client airway unobstructed (no items covering face, no pressure on client torso or back)
☐ Continuous assessment and observation of client breathing and circulation
☐ Client hands NOT placed behind back

Is there a behavior plan in place for this client? ☐ Yes ☐ No Date of Behavior Plan:

Does the client have a behavior intervention plan that includes proactive and non-physical reactive strategies? Yes ☐ No ☐

Does the behavior intervention plan include the use of restraints?

POST RESTRAINT REPORT (PRR)
(Emergency Intervention Process)

Were the following post-crisis strategies performed, and what were the results?

Yes ☐ **No** ☐ Client was checked for any injuries, including minor injuries, that may have occurred and appropriate medical care was obtained if needed (explain details):

Yes ☐ **No** ☐ The environment was inspected and potentially dangerous items were removed or cleaned up, including items that may have been used as a weapon (explain details):

Yes ☐ **No** ☐ Client was not able to return to appropriate activities after the emergency restraint (explain details):

Debriefing after the incident:
This should occur within 24 hours between staff and supervisor and should include the following:

- *Assessment of the factors leading up to the assault crisis*
- *Examination of the choice of interventions*
- *The biological, psychological , social and behavioral impact of the intervention on the client*
- *Steps to reduce the potential for future assault crises*

Explain any, and all, post-crisis de-briefing techniques used related to the restraints:

Client Debriefing:

What does the client identify the antecedent to be? (Use client's own words if possible):

List alternatives to avoid escalation in future:

Staff Member(s) involved in restraint:

What does the involved staff member identify as the antecedent to the incident that led to the restraint:

List alternatives to avoid escalation in future:

This report was completed by:

Signature: Position or Title:

(Print Name) Date:

Direct Care Staff Signature: Position or Title:

(Print Name) Date:

Direct Care Staff Signature: Position or Title:

(Print Name) Date:

Created on 6/2018
File e-chart: SIR

POST RESTRAINT REPORT (PRR)
(Emergency Intervention Process)

To be completed by Administrator:

Date staff member(s) were interviewed

Do you assess that the client's behavior warranted the restraint?

Did the staff utilize the least restrictive behavioral supports as indicated in the client's Behavior Intervention Plan? Please explain:

How many staff members were involved in the crisis intervention? Include their names also.

Are staff restraint certifications up to date (as outlined by program)? Yes ☐ No ☐

If yes, what was the date of the training for staff member(s) involved?

Which certification does the staff who did the restraint possess?

☐ Professional Crisis Management (PCMA) ☐ Professional Assault Crisis Training (ProAct)

☐ Crisis Prevention Institute (CPI) ☐ Other:

Who developed the behavior plan for this client? (Name and credentials of individual)

Will the behavior plan be changed as a result of the restraint used in this incident?

☐ Yes ☐No

What are the planned changes? If no changes to behavior plan, what other modifications and/or actions will be taken to prevent likelihood that restraint will be used for future occurrences (staff training, protective equipment, etc.)?

Did Staff member follow the protocol prior to incident? ☐ Yes ☐No (*If no, please explain)*

Did Staff member follow the protocol after the incident? ☐ Yes ☐No (*If no, please explain)*

Describe interactions between staff member and client post-restraint.

A copy of the Special Incident Report and this PRR report was provided to your agency behavior analyst or consultant. ☐ Yes ☐ No

Administrator Signature: Position or Title:

(Print Name) Date:

Created on 6/2018
File e-chart: SIR

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip		TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE

PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	TELEPHONE ( )		
OTHER RELEVANT INFORMATION			

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE

T
REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE
O BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.
COMPL

A. VICTIM Check box if victim consents to disclosure of information (Ombudsman use only - WIC 15636(a))

NAME (LAST NAME, FIRST NAME)
NAME (LAST NAME, FIRST NAME)

AGE
AGE

DATE OF BIRTH
DATE OF BIRTH

SSN

GENDER
M F

ETHNICITY

LANGUAGE (✓ CHECK ONE)
NON-VERBAL ENGLISH OTHER

ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)
CODE

CITY

ZIP

TELEPHONE
( )

PRESENT LOCATION (IF DIFFERENT FROM ABOVE)
CODE

CITY

ZIP

TELEPHONE
( )

ELDERLY (65+) DEVELOPMENTALLY DISABLED MENTALLY LIVES ALONE
ILL/DISABLED PHYSICALLY DISABLED UNKNOWN/OTHER LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ *Check if* *Self-Neglect*

NAME OF SUSPECTED ABUSER

ADDRESS

CITY

ZIP CODE

TELEPHONE ( )

CARE CUSTODIAN (type) _____ PARENT SON/DAUGHTER OTHER _____

HEALTH PRACTITIONER (type) _____ SPOUSE OTHER RELATION _____

GENDER
GENDER

ETHNICITY
ETHNICITY

AGE
AGE

D.O.B.
D.O.B.

HEIGHT
HEIGHT

WEIGHT
WEIGHT

EYES
EYES

HAIR
HAIR

C. REPORTING PARTY *Check appropriate box if reporting party waives confidentiality to:* ✓ All ✓ All but victim ✓ All but perpetrator

NAME

SIGNATURE

OCCUPATION

AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW ABUSE IS KNOWN
RELATION TO VICTIM/HOW ABUSE IS KNOWN

STREET
STREET

CITY
CITY

ZIP CODE
ZIP CODE

TELEPHONE
TELEPHONE
( )

E-MAIL ADDRESS

D. INCIDENT INFORMATION - Address where incident occurred

DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

OWN HOME ANOTHER | COMMUNITY CARE FACILITY NURSING FACILITY/SWING | HOSPITAL/ACUTE CARE BED | HOSPITAL | HOME OF OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY)

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL (e.g. assault/battery, constraint or deprivation, chemical restraint, over/under medication)
b. SEXUAL
c. FINANCIAL
d. NEGLECT (including Deprivation of Goods and Services by a Care Custodian environment)
e. ABANDONMENT
f. ISOLATION
g. ABDUCTION
h. PSYCHOLOGICAL/MENTAL
i. Other _____

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. PHYSICAL CARE (e.g. personal hygiene, food, clothing, shelter)
b. MEDICAL CARE (e.g. physical and mental health needs)
c. HEALTH and SAFETY HAZARDS (e.g. risk of suicide, unsafe environment)
d. MALNUTRITION/DEHYDRATION
e. FINANCIAL SELF-NEGLECT (e.g. inability to manage one's own personal finances)
f. OTHER _____

__ NO PHYSICAL INJURY __ MINOR MEDICAL CARE __ HOSPITALIZATION __ CARE PROVIDER REQUIRED __ DEATH __ MENTAL SUFFERING
__ SERIOUS BODILY INJURY* __ UNKNOWN __ OTHER (SPECIFY) _____

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? DOES THE ALLEGATION INVOLVE A SERIOUS BODILY INJURY (see definition in section "Reporting Responsibilities and Time Frames" within the General Instructions)? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*

CHECK IF MEDICAL, FINANCIAL (ACCOUNT INFORMATION, ETC.), PHOTOGRAPHS, OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE *(family, significant others, neighbors, medical providers, agencies involved, etc.)*

NAME	RELATIONSHIP
ADDRESS	TELEPHONE ( )

H. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE *(If unknown, list contact person)*

NAME IF CONTACT PERSON ONLY CHECK			RELATIONSHIP
ADDRESS	CITY	ZIP CODE	TELEPHONE ( )

I. TELEPHONE REPORT MADE TO APS Law Enforcement Local Ombudsman Calif. Dept. of State Hospitals Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	TELEPHONE ( )	DATE/TIME DATE/TIME

J. WRITTEN REPORT **Enter information about the agencies receiving this report. If the abuse occurred in a LTC facility and resulted in Serious Bodily Injury*, please refer to "Reporting Responsibilities and Time Frames" in the General Instructions. Do not submit report to California Department of Social Services Adult Programs Division.**

AGENCY NAME	ADDRESS OR FAX	Date Mailed	Date Faxed
AGENCY NAME	ADDRESS OR FAX	Date Mailed	Date Faxed
AGENCY NAME	ADDRESS OR FAX	Date Mailed	Date Faxed

K. RECEIVING AGENCY USE ONLY Telephone Report Written Report

1. Report Received by | Date/Time

2. Assigned Immediate Response Ten-Day Response No Initial Response (NIR)
Not APS Not Ombudsman No Ten-Day (NTD)

Approved by Assigned to (optional)

3. Cross-Reported to CDPH-Licensing & Cert.; CDSS-CCL; Local Ombudsman; Bureau of Medi-Cal Fraud & Elder Abuse; Calif. Dept. of State Hospitals; Law Enforcement; Professional Licensing Board; Calif. Dept. of Developmental Services; APS; Other (Specify) Date of Cross-Report

4. APS/Ombudsman/Law Enforcement Case File Number

SOC 341 (3/15)

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. **Abuse** means any treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. **Neglect** means the negligent failure of an elder or dependent adult or of any person having the care or custody of an elder or a dependent adult to exercise that degree of self-care or care that a reasonable person in a like position would exercise. **Elder** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names,

   however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES AND TIME FRAMES:

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

*__Serious bodily injury__ means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury, report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential Internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:

- If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
- If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.

- For all other abuse, mandated reporters shall report by telephone or through a confidential Internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an Internet report shall be sent to adult protective services or law enforcement within two working days.

REPORTING PARTY DEFINITIONS

Mandated Reporter (WIC Section 15630 (a)) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.

Care Custodian (WIC Section 15610.17) means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing are or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code; (b) Clinics; (c) Home health agencies; (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services; (e) Adult day health care centers and adult day care; (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders; (g) Independent living centers;
(h) Camps; (i) Alzheimer's Disease Day Care Resource Centers; (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code; (k) Respite care facilities; (l) Foster homes; (m) Vocational rehabilitation facilities and work activity centers; (n) Designated area agencies on aging;
(o) Regional centers for persons with developmental disabilities; (p) State Department of Social Services and State Department of Health Services licensing divisions; (q) County welfare departments; (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys; (s) The Office of the State Long-Term Care Ombudsman; (t) Offices of public conservators, public guardians, and court investigators; (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities; or (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness; (v) Humane societies and animal control agencies; (w) Fire departments; (x) Offices of environmental health and building code enforcement; or (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

Health Practitioner (WIC Section 15610.37) means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

Any officer and/or employee of a financial institution is a mandated reporter of suspected financial abuse and shall report suspected financial abuse of an elder or dependent adult on form SOC 342, "Report of Suspected Dependent Adult/Elder Financial Abuse".

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine (WIC Section 15630(h)).

Officers or employees of financial institutions are mandated reporters of financial abuse (effective January 1, 2007). These mandated re- porters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter, to the party bringing the action.

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).

(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court - ordered conservatorship because of a mental illness or dementia.

(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency or agencies, the reporter shall send the written report to the designated agencies (as defined under "Reporting Responsibilities and Time Frames"); and keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS DIVISION.

ACRC Shared Information Report

Client Information:

Client's Name:	Sex: ☐ Male ☐ Female	UCI Number:
Date of Birth:	Date of occurrence:	Time of occurrence:

Location of the Occurrence:

☐ Community Care Facility ☐ Long-Term Health Care Facility (ICF/SNF) ☐ Day Program ☐ Job Site ☐ Community Setting ☐ Client's Own Residence ☐ Public School ☐ Other:
Address:

Description of Occurrence:

Please describe the occurrence, including specific information leading up to the event, location, harm to client/others , persons involved, who was notified when and by whom, etc.:

Report submitted by:

Report Submitted by:	Title:	Telephone #:
Agency Name:	Report submitted to:	Date Submitted:

Important Note: This Report should be submitted directly to the assigned ACRC Service Coordinator and not to the SIR Desk. This form should be used to report a type of occurrence which is listed on the Shared Information Sheet only.