

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
Long Term Care Assessment and Survey Program / Complaint Unit
P. O. Box 367
Trenton, NJ 08625-0367

Hotline: 1-800-792-9770, Select #1
Fax: 609-943-4977 or 609-633-9060

REPORTABLE EVENT RECORD/REPORT

Please answer all questions fully and address only one event per report.

Today's Date (MM/DD/YY)	Date of Event (MM/DD/YY)	Time of Event
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM

Was This a Significant Event?	Was Significant Event Called In?	Date (MM/DD/YY)	Time
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="checkbox"/> AM <input type="checkbox"/> PM

Full Name of Facility

Street Address

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Facility Telephone Number	Facility License Number	Provider ID Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Person Reporting	Title
<input type="text"/>	<input type="text"/>

Type of Facility:

- Assisted Living or Comprehensive Personal Care Home
- Adult/Pediatric Day Health Services
- ICF/MR
- Nursing Home
- Residential
- Sub-Acute Care
- Other, Specify:

Exact Location of Incident:

**REPORTABLE EVENT RECORD/REPORT
(Continued)**

Type of Incident:

- | | |
|--|---|
| <input type="checkbox"/> Elopement | <input type="checkbox"/> Involuntary Relocation |
| <input type="checkbox"/> Environmental Emergency | <input type="checkbox"/> Medication Error |
| <input type="checkbox"/> Financial Exploitation | <input type="checkbox"/> Resident Care |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Resident-to-Resident Abuse |
| <input type="checkbox"/> Interruption of Service | <input type="checkbox"/> Staff-to-Resident Abuse |
| <input type="checkbox"/> Involuntary Discharge | <input type="checkbox"/> Unexpected Death |
| <input type="checkbox"/> Other, Specify: | |

Resident Name

Unit and Room Number

Date of Birth

Narrative:

1) Describe the event, to include timeframes/risk factors related to the incident/event (relevant resident Dx):

2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? For example, chair alarm and/or lap buddy in place.

- Yes No If Yes, please describe:

3) What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:

**REPORTABLE EVENT RECORD/REPORT
(Continued)**

Nurse Aide Involvement:

If the event is an allegation of abuse, neglect, or misappropriation of resident funds by a nurse aide, please provide the certification number and certificate expiration date. For a nurse aide with no certification, please provide the Social Security Number.

Name	Certification Number	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Notifications:

MD, Specify:

OOIE (Ombudsman), Specify Date: Time: AM PM

Other, Specify:

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Reviewed By: (Surveyor ID Number and Initials)

Date (MM/DD/YY)

Other Review: (ID Number and Initials)

Date (MM/DD/YY)

Disposition:

- Pending
- No Action
- Complaint Investigation

Referral, Specify:

Closed, Specify Date Closed:

Comments: