

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

Hotline: 1-800-792-9770, Select #1  
Off Hour Emergencies: 609-392-2020  
Fax: 609-633-9060 or 609-633-9087

**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

ID 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:

**FOR NJDHSS USE ONLY**

**Reviewed By:** (Surveyor ID Number)  Date (MM/DD/YY)

**Other Review:** (ID Number)  Date (MM/DD/YY)

**Disposition:**

Pending

No Action

Complaint Investigation

Referral, Specify:

Closed, Specify Date Closed:

**Comments:**