New Jersey Department of Health
Division of Health Facility Survey and Field Operations
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: 609-633-9060 or 609-943-4977

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 ☐AM ☐PM

Was This a Significant Event? ☐ Yes ☐ No

Was Significant Event Called In? ☐ Yes ☐ No

Date (MM/DD/YY)

Time ☐AM ☐PM

Full Name of Facility

Street Address

City

State

Zip Code

Facility Telephone Number

Facility License Number

Provider ID Number

Person Reporting

Title

Type of Facility:

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

Exact Location of Incident:

REPORTABLE EVENT RECORD / REPORT
(Continued)

Type of Incident:

- ☐ Elopement
- ☐ Environmental Emergency
- ☐ Financial Exploitation
- ☐ Injury
- ☐ Interruption of Service
- ☐ Involuntary Discharge
- ☐ Involuntary Relocation
- ☐ Medication Error
- ☐ Resident Care
- ☐ Resident-to-Resident Abuse
- ☐ Staff-to-Resident Abuse
- ☐ Unexpected Death
- ☐ 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

Notifications:

☐ MD, Specify:

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

☐ Other, Specify:

FOR NJDOH USE ONLY

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: