SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Initial Report

Report Type:

☐ 2 hour initial ☐ 24 hour initial ☐ Licensure ☐ Certification

Date: _____

Facility: _____

Address: _____

Phone #: _____

Certified Bed: ☐ yes ☐ no

Resident's Name: _____

DOB: _____

Room #: _____

Additional Resident Information (as applicable): _____

_____

Type of Reportable Incident:

☐ physical abuse
☐ verbal abuse
☐ sexual abuse
☐ attempted suicide
☐ bone or joint fracture
☐ patient death
☐ mental abuse
☐ neglect
☐ fire
☐ involuntary seclusion
☐ medication error (with adverse reactions)
☐ elopement
☐ misappropriation of resident property
☐ crimes against residents
☐ severe hematoma, laceration, or burn requiring medical or hospitalization
☐ hospitalization as a result of accident/injury
☐ injury involving use of restraints
☐ injury of unknown source

Name of Alleged Perpetrator: _____

Date/Time of Reportable Incident: _____

Brief Description of Reportable Incident:

DPH
Healthcare Quality
2100 Bull Street, Columbia, SC 29201
Voicemail: 1-800-922-6735 Fax: 803-545-4292

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

0268-ENG-DPH
Instructions for Completing

PURPOSE:

This form is used for all facility reported incidents for Healthcare Quality. Healthcare Quality is required through state law, regulation, and policy to have documentation of all facility reported incidents. This form serves as that documentation

ITEM BY ITEM INSTRUCTIONS:

1. **Report Type:** Put a check next to the type of report that is being filled out.
2. **Date:** The date the form is being submitted.
3. **Facility:** Enter the permitted facility's official or legal name. Do not use a colloquial or abbreviated name.
4. **Address:** The existing South Carolina facility address.
5. **Phone #:** The current facility phone number and any needed extensions.
6. **Resident's Name:** Name of the resident involved in the incident.
7. **DOB:** Resident's date of birth that was involved.
8. **Room #:** Room number of the resident involved.
9. **Certified Bed:** Select yes or no if the involved resident occupies a certified bed.
10. **Type of Injury:** List the type of injury inflicted upon the resident.
11. **Type of Alleged Abuse:** Put a check next to the type of alleged abuse if that was the type of incident selected at the top of the form.
12. **Name of Alleged Perpetrator:** State the name of the person who caused the injury or incident.
13. **Date/Time of Reportable Incident:** What time and day did the incident occur?
14. **Brief Description of Reportable Incident:** Provide a brief statement describing the events that occurred.

Attach other supporting documentation if needed and additional sheets as necessary. Please attach copied of all applicable interview, witness statements, and any other applicable documents.

OFFICE MECHANICS AND FILING:

This form will remain as a part of Healthcare Quality's files in accordance with Federal CMS retention regulations and guidelines.