



## Paper Event Form

### General Event Type (select one)

<input type="checkbox"/> Fall Circle: alleged      assumed      witnessed Person was (choose one): able to get up on their own, lowered to the floor, observed on the floor, observed on the mat/bed extension, other:	<input type="checkbox"/> Medication/Fluid Error -List Drug Name and dosage:	
<input type="checkbox"/> Lab/Diagnostic Test	<input type="checkbox"/> Good Catch	<input type="checkbox"/> Deficiency by DOH F or Above
<input type="checkbox"/> Safety/Security/Conduct	<input type="checkbox"/> Environment	<input type="checkbox"/> Safety Concern Event
<input type="checkbox"/> Diagnosis/Treatment	<input type="checkbox"/> Complaint/Grievance	<input type="checkbox"/> Concern Report
<input type="checkbox"/> Skin/Tissue	<input type="checkbox"/> Reportable Request for Medical Record	<input type="checkbox"/> Care/Service Coordination
<input type="checkbox"/> Missing/Damaged Items – Describe item:	<input type="checkbox"/> Covid-19 – Reason for testing:	<input type="checkbox"/> Call Response Event – Name of Person who called 911, if applicable:
<input type="checkbox"/> Elopement/Wandering Time Reported Missing: _____ Time Resident was located: _____  Where was resident located: _____ Date Located: _____  Who Located the resident: _____ Has the resident eloped before: _____  Assessed as wander/elopement risk: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure      Was elopement prevention care planned: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure		

### Classification of Person Affected (select one)

<input type="checkbox"/> Resident/Client/Member (Circle Level of Care below):		
Adult Day Services	Assisted Living/Personal Care	Adult Foster Care
Independent/Residential Living	In-Service Member/In Home Care	Skilled Nursing/Healthcare
<input type="checkbox"/> Affiliate/Provider/Childcare		<input type="checkbox"/> Location/Person Not Applicable
<input type="checkbox"/> Volunteer		<input type="checkbox"/> Visitor/Guest

### If there was an Injury, complete this section

**Degree of Injury**

<input type="checkbox"/> No Injury, no treatment required	<input type="checkbox"/> Slight Injury, no treatment required	<input type="checkbox"/> Mild Injury, First Aid Required
<input type="checkbox"/> Moderate Injury, Treatment Required	<input type="checkbox"/> Possible Injury, Sent to ER/Hospital	<input type="checkbox"/> Severe Injury, Treatment/Hospitalization Required
<input type="checkbox"/> Death		

Location of Injury on Body:

**Nature of Injury (circle)**

Abrasion, adverse reaction, aggravation of pre-existing condition, allergic reaction, anaphylaxis, bite-animal, bite-human, bite-insect, bleeding/hemorrhage, blister, blister-friction, bruise/contusion, burn, cardiopulmonary arrest, chipped tooth, crush, death, dehiscence, dislocation, eardrum puncture, electrocution, emotional distress, excoriation, exposure to body fluids, exposure to other, hazardous material, foreign body, fracture, head injury, hypoglycemia, hypotension, infection, inflammation, laceration/cut/tear, loss of consciousness, loss of limb/appendage/amputation, no injury, open lesion, other skin disease/disorder, others, pain, poisoning, possible, fracture, puncture, rash, respiratory condition/distress, scald, scratch, soft tissue injury, strain/sprain, swelling



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<b><u>For Skin/Tissue Events, please select</u></b>			
<input type="checkbox"/> Condition worsened	<input type="checkbox"/> No apparent change	<input type="checkbox"/> No apparent change in condition	<input type="checkbox"/> Unsure
<b><u>MD/NP Examination</u></b>			
<input type="checkbox"/> Declined	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
<input type="checkbox"/> Yes: Findings:			

<b>Equipment Involved/Malfunction</b>			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please list:	

<b>Person Information</b>				
Last Name:		First Name:		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (optional):		
<b><u>Mental Status at the time of the event (please choose one):</u></b>				
<input type="checkbox"/> agitated	<input type="checkbox"/> alert/oriented	<input type="checkbox"/> cognitive impairment	<input type="checkbox"/> comatose	<input type="checkbox"/> combative
<input type="checkbox"/> confused	<input type="checkbox"/> disoriented	<input type="checkbox"/> sedated	<input type="checkbox"/> Unknown/unable to determine	
<b><u>Ambulatory Status at Time of the Event (please choose one):</u></b>				
<input type="checkbox"/> unlimited	<input type="checkbox"/> unlimited with assistive device		<input type="checkbox"/> limited with person assist	<input type="checkbox"/> non-ambulatory

<b>Event Details</b>				
Event Date:		Event Time:		
Shift	<input type="checkbox"/> Day	<input type="checkbox"/> Evening	<input type="checkbox"/> Night	<input type="checkbox"/> not applicable/unknown
General Location/Event Location (please be as specific as possible – complete as though you are creating this in PEER)				
Prepared By:	Entered Date:	Reported Date:	Reported Time:	
<b><u>Name of Reporter:</u></b>				
<input type="checkbox"/> Affiliate	<input type="checkbox"/> Agency Rep	<input type="checkbox"/> CNA/STNA/GNA	<input type="checkbox"/> Companion/Aide	
<input type="checkbox"/> Employee (general)	<input type="checkbox"/> Family	<input type="checkbox"/> LPN	<input type="checkbox"/> Manager/Dept Head	
<input type="checkbox"/> Med Aide	<input type="checkbox"/> Nurse	<input type="checkbox"/> Other	<input type="checkbox"/> PCA	
<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Physician - Attending	<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Provider Employee	
<input type="checkbox"/> Resident/Member/Client	<input type="checkbox"/> Resident Assistant	<input type="checkbox"/> Responsible Party/Guardian	<input type="checkbox"/> RN	
<input type="checkbox"/> Student nurse	<input type="checkbox"/> Visitor	<input type="checkbox"/> Volunteer		
Witness Name:	Witness Phone:	Witness Type (use list above):		



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## Specific Event Details:

Specific Event Type or Call Response Sub-type:

### Safety Precautions at time of the event:

### Contributing Factors:

### Immediate Actions Taken:

**Description of Environment, if checked:**

### Reported Event Severity

- Security Level 0-Good Catch/Potential Harm/Damage
- Security Level 1-No Harm/Damage
- Security Level 2-Temporary Minor Harm/Damage
- Security Level 3-Serious Injury/Damage
- Security Level 4 – Death
- Security Level 5 – Elopement/Wandering Event
- Security Level 6 – Level F Deficiency or greater
- Severity Level 7- Suicide of resident
- Severity Level 8- Assault, Rape, Homicide of Res.
- Security Level 9 – Stage 3 or 4 Pressure Ulcer
- Security Level 10 – Reportable Request for Records

### **Event Description:**

Briefly describe the event that occurred or unsafe condition: