## COMPLETE ALL SECTIONS OF REPORT

## Lake County Board of Developmental Disabilities/Deepwood

## UI/MUI REPORTING FORM CONFIDENTIAL

Agency Name or ider: Independent Provider Name

Individual Name:	Name of	Individua	1-No Nicknames	Reporting Prov
	A 1 1		The second second	

Individual Address: Address where individual resides Complete one report for each incident or injured individual. Report should be completed immediately.

PART I Completed by employee who disc	overed the incident		
	dent or report day of inci	dentorreport Bid Outhor n □Tues □Wed D. Witnessed? Pri □ Sat □Sun OYes O No	
E. Others involved (Aggressor, Victim or Other) ODODD#	tims and/or aggressor	ODD#	
Specific Location and address where incident occurred::  EXACT PIOCE INCIDENT OCCURRED COLORED (e.g. ARC @ AB Dining Room)		re incident occurred o	or —
Describe incident in detail including preceding or contributing every esolution of the incident ( Use supplemental form if more space is	ents/action, identification of parties (use staff	names) involved in the incident and the	
Before the incident: What was no		are the incident	
occured	J		
During the incident: ISE Specifics t	o describe what he	appened include	-
Staff names for other individ	duals-use terms in	ke Individual 1'	
	tive words. Do not	give opinions.	
only facts. Do not collaboration	with others to wir	ite the report.	
give all information. Write	legibly or use elec	tronic LIR form.	
			-
		al a la N	
After the incident: DESCRIDE FESC	olution to the inci	<u>oent</u>	
Nere there witnesses (besides yourself)? ☐Yes ☐No (if all	aged abuse/peglect use ODODD# instead of	name for any individual served as witness	es)
Vitness' Name: Name of Witness	Title: Title of with		
Vitness' Name:	Title:		
Signature: Signature of person writing	Date Completed:	portmode time reportir	ary)
Print Name: Name of Derson writing rei		n writing report	
NOTIFICATION Name of manager or Manager (name) pers. reported to in		me of notification 	
Med Pers .: ( name) number if message 16	C+Date://	Time::( Military)	
PART II Completed by LPN, RN or <u>STAFF</u> if no nurse av			
If nursing available, stop here: Nurse  H. Severity of inju Completes. If no Nurse, Staff  □ 1. No appare		<ul><li>I. First aid/treatment given by:</li><li>□ 1. None</li></ul>	<b>3</b> €
Complete.   2. Minor (ten	porary injury/illness; no further	☐ 2. Staff ☐ 3. RN/LPN	
☐ 1 None/NA ☐ 3 Moderate /	i) Injury/illness not serious; requiring	☐ 4. Physician	2
2. Bruise Scratch/abrasion medical atten		5. Other: if selected specify who	3,
3. Airway ☐ 10. Puncture ☐ 4. Severe ( se	erious injury/illness requiring medical	J. Required Emergency	
5 Burn irritation status)	l/or resulting in change in physical	Services? O Yes	
6. Exposure 12. teeth 5. Death		O No	
To cold/neat ☐ 13. Unable to K. For medication/		☐ 7. Transcription error	
□ 8. Head □ 14 Other □ 2. Incorrect med	lication   5. Incorrect individual	□ 8. Stray pills	
LIL 3 Incorrections	age 0 6. Omission	OVISE QUALIA DIE	
lumpleted by nurse or staff/inde	Page 1 decisions	2017	7
Use Attachment A of LCBDD po	licy for definitions		

## COMPLETE ALL SECTIONS OF REPORT

INDIVIDUAL NAME: INDIVIDUAL'S Name shape of injury PART II Contd. Completed by LPN, RN or STAFF if no nurse available. L. Assessment/Treatment (Military) time of assessment/ Time: **FIGHT** Describe involvement with incident/treatment Complete in objective terms. Do not speculate Document assessment methods used laximans terms. Describe any treatment given recommendation for further treatment and an directions for monitoring or care Signature: Signature of person completing Part I Date and time part I completed

Military

Military (Military) Print Name: Name of Derson completing Part I Title: Title of person completing Part I PART III M. NOTIFICATION: LIST NAME OF PERSON SPOKEN TO ( IF MESSAGE LEFT-LIST PHONE NUMBER) Notified by: DATE TIME **Print Name** Superintendent Reporting Line (Board operated programs only x5113) (military) Physician: (military) Director of Nursing: (military) □Family □Guardian (Check all that apply): (military) derson who MUI Reporting Line (350-5253): (military) mode the Residential Provider: U.S.P. the program/onvider name (military) notification Day Program: AND name of Derson notified (military) Child Protective Services (350-4000): If Individual 15 under 21 and (military) Law Enforcement: If an alreaded criminal act (military) SSA: (e-mail UIR@lakebdd.org) (military) Other: (military) Fax 350-5143 or e-mail: IA@lakebdd.org (military) (FOR MUIS ONLY) PART IV Completed by Manager Potential Major Unusual Incident Yes No All potential MUIs require notification to the MUI reporting line 440-350-5253 (LAKE) N. Type of incident ( See procedure): POGE 17 OF LCBDD O. One sentence summary of incident: Brief summary of incident and outcome for the individual P. Immediate actions taken to ensure health/welfare (e.g. removed staff from duty, sent individual to ER): List actions taken (not notifications Q. Possible causes and contributing factors for the incident: What is believed to have caused or contributed to the incident. Can make reasonable speculations based on known facts and history of the involved parties R. Preventative Measures (Specific actions, by whom): What actions have/will be taken to the and prevent the incident from repeating itself if a future action, include the target date date and time manager completed Signature: Signature of manager completing Date Completed: Time (Military) Print Name: Name of manager completing Title: Title of manager completing

Depict location and