



Paper Event Form
(to be used during system downtime)

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		
<u>Location of Injury on Body:</u>		
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		



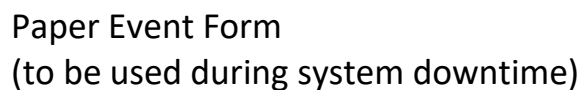
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For Skin/Tissue Events, please select			
<input type="checkbox"/> Condition worsened	<input type="checkbox"/> No apparent change	<input type="checkbox"/> No apparent change in condition	<input type="checkbox"/> Unsure
MD/NP Examination			
<input type="checkbox"/>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

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

Person Information				
Last Name:		First Name:		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth (optional):		
Mental Status at the time of the event (please choose one):				
<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	
Ambulatory Status at Time of the Event (please choose one):				
<input type="checkbox"/> unlimited	<input type="checkbox"/> unlimited with assistive device	<input type="checkbox"/> limited with person assist	<input type="checkbox"/> non-ambulatory	

Event Details			
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:
Name of Reporter:			
<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):	



Specific Event Type or Call Response Sub-type:

Contributing Factors:

Description of Environment, if checked:

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

Briefly describe the event that occurred or unsafe condition:

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.