



Executive Office of Elder Affairs
 Assisted Living Certification Unit
www.mass.gov/elder

Incident Reporting

If **ALR Dynamics** is unavailable, then
 (1) fax report to (617) 222-7461
 (2) add Incident Report to ALR Dynamics when system is available

Individual

ALR Name	Date of Incident
Submission date	Time of Incident

Type of Incident: circle/check **Incident Type**, and then circle the **Detailed Type** below.

<input type="checkbox"/> Fall	Witnessed	Unwitnessed	
<input type="checkbox"/> Elopement	Resident Located	Whereabouts unknown	
<input type="checkbox"/> Death	Anticipated	Unanticipated	
<input type="checkbox"/> Medication Issue	Med omission Issue	Med Administration Issue	Med Theft
<input type="checkbox"/> Allegation of Abuse, Neglect, or Exploitation	Physical	Emotional	Sexual
	Neglect of self or by others	Non-Financial – Theft (not related to medications)	Financial Exploitation
<input type="checkbox"/> Acute Health or Behavioral Emergency	Injury	No Injury	

Resident Type (circle):	Traditional	SCR	SCR Other <i>(e.g. Behavioral or intellectual disability)</i>
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Incident Narrative Note: please do **not** include any Personally Identifiable Information on this paper Incident Report (i.e. no Resident name or DOB, please).

Who was contacted? (circle)

Police

EMT

Family

Physician

Protective Services

Submitted by (Name)	Submitter Phone	Submitter Email
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Facility-wide

ALR Name	Date of Incident
Submission date	Time of Incident

Incident Facts: For each of the five (5) questions below, circle the correct answer.

1. Number of Residents Affected	0-10	11-25	26-50	51-75	76 or more
2. Number of Units Affected	0-10	11-25	26-50	51-75	76 or more
3. Areas Affected	Traditional AL	SCR	AL & SCR		
4. Duration of Displacement (defined as greater than 8 hours)	No displacement	8 to 24 hours	24 to 36 hours	36 to 72 hours	4 days or more
5. Arrangement	Return to Family	Remain onsite at ALR	Transferred to Licensed Health Facility	Other (Specify in Narrative)	

Incident Narrative *Note: please do *not* include any Personally Identifiable Information on this paper Incident Report (i.e. no Resident name or DOB, please).*

Outside Parties contacted? (*circle*)

Fire Department (local) **Board of Health** (local) **MassMAP** (Command Center) **State Authority** (specify in Narrative) **Other Party** (specify in Narrative)

Submitted by (Name)	Submitter Phone	Submitter Email
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