310_675-7-12.1 Internal facility incident reports

(a)

Incident defined. An incident is any accident or unusual occurrence where there is apparent injury or where injury may or may not have occurred. The incident report shall cover all unusual occurrences within the facility, or on the premises, affecting residents, and incidents within the facility or on the premises affecting visitors or employees.

(b)

Incident records. Each facility shall maintain an incident report record and shall have incident report forms available.

(c)

Incident report format. The incident report shall include, at a minimum: the date, location and type of incident; parties notified in response to the incident; description of the incident; the relevant resident history; summary of the investigation; and name of person completing the report.

(d)

Incident report preparation. At the time of the incident, the administrator, or the person designated by the facility with authority to exercise normal management responsibilities in the administrator's absence, shall be notified of the incident and prepare the report. The report shall include the names of the persons witnessing the incident and their signatures where applicable.

(e)

Incident records on file. A copy of each incident report shall be on file in the facility.

(f)

Incident in clinical record. The resident's clinical record shall describe the incident and indicate the findings on evaluation of the resident for injury.

(g)

Incidents: reviewers. All incident reports shall be reviewed by the director of nursing and the administrator and shall include corrective action taken where health and safety are affected.