STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
ADHC/CBAS INCIDENT REPORT
CDA 4009 (REV 10/2020)

Center Name:	
NPI:	
Name/Title of Person Completing Report:	
Incident Date:	Report Date:

Section I – Incident Information

Complete this section once only, even if multiple participants were affected. Report only adverse events that occur at the center or in transit to or from the center.

A. Nature of Adverse Event

Unusual Occurrences in Environment or Facility (Report within 24 Hours)

Fire	☐	Catastrophes or Major Accidents	☐
Flood	☐	Equipment or Utility Failures resulting in closures	☐
Explosion	☐	Poisoning	☐
Earthquake	☐	Other	☐
Epidemic outbreaks reportable to local or state public health officials			☐

Death, Serious Injury, and Unusual Incidents (Report within 48 Hours)

Death	☐	Unexplained absence & inability to make contact	☐
Serious injury	☐	Protected Health Information Security Breach	☐
Abuse	☐	Participant missing from center	☐
Other	☐		

Summary/Additional Information. Briefly describe adverse event and center's response.

B. Center Response (select all that apply):

- Called 911 ☐
- Completed *Report of Suspected Dependent Adult/Elder Abuse (SOC 341)* ☐
- Initiated 5150 ☐
- Closed center ☐
- Coordinated with:
- *Emergency Contact(s)* ☐
- *Authorized Representative(s)/Conservator* ☐
- *Personal Health Care Provider(s) "PHCP"* ☐
- *Managed Health Care Plan(s)* ☐
- *County Public Health* ☐
- *County Mental Health* ☐
- Other (specify below) ☐

C. Notification Submitted (select all that apply):

- California Department of Aging, CBAS Branch ☐
- California Department of Public Health, Licensing District Office (enter District office below) ☐

_____

- Managed Health Care Plan(s) ☐
- Emergency Contact(s) ☐
- Authorized Representative(s)/Conservator ☐
- Local Long-Term Care Ombudsman ☐
- Adult Protective Services ☐
- Regional Center(s) ☐
- Law Enforcement ☐
- County Public Health ☐
- County Mental Health ☐
- Personal Health Care Provider(s) "PHCP" ☐

Section II – Participant Information

Complete Sections II.A. and II.B. below for <u>each</u> participant affected by the adverse event. Use additional space provided to report multiple participants. For center-wide adverse events that did not result in participant harm do not complete Section II.

A. Participant Identifying Information

Name:

CIN:

Age:

Gender:

Enrollment Date:

Managed Care Plan:

B. Participant Status/Outcome at Time of Report (select all that apply)

- Transported for medical treatment ☐
- Transported home ☐
- Hospitalization ☐
- ER visit ☐
- Discharged from center ☐
- Nursing home placement ☐
- Death ☐
- Other ☐

If "Other" selected above, please specify:

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A. Participant Identifying Information	
Name:	
CIN:	
Age:	
Gender:	
Enrollment Date:	
Managed Care Plan:	
B. Participant Status/Outcome at Time of Report (select all that apply)	
Transported for medical treatment Transported home Hospitalization ER visit Discharged from center Nursing home placement Death Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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Name:
CIN:
Age:
Gender:
Enrollment Date:
Managed Care Plan:
B. Participant Status/Outcome at Time of Report (select all that apply)
Transported for medical treatment ☐ Transported home ☐ Hospitalization ☐ ER visit ☐ Discharged from center ☐ Nursing home placement ☐ Death ☐ Other ☐
If "Other" selected above, please specify:

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If "Other" selected above, please specify:	