

Special Incident Reporting

Harbor Regional Center
Manager of Rights and Quality Assurance (MRQA)

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Learning Goals

- Special Incident Reporting responsibilities
- Mandated Reporting requirements
- Process of reporting an incident
- Updates on revised SIR Regulations
- New SIR Form for Service Providers

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Reporting Requirements

- Title 17: All vendors and long-term health care facilities are required to report special incidents to regional centers
- All service providers are mandated by law to report reasonably suspected abuse or neglect to the appropriate agencies, as well as regional center

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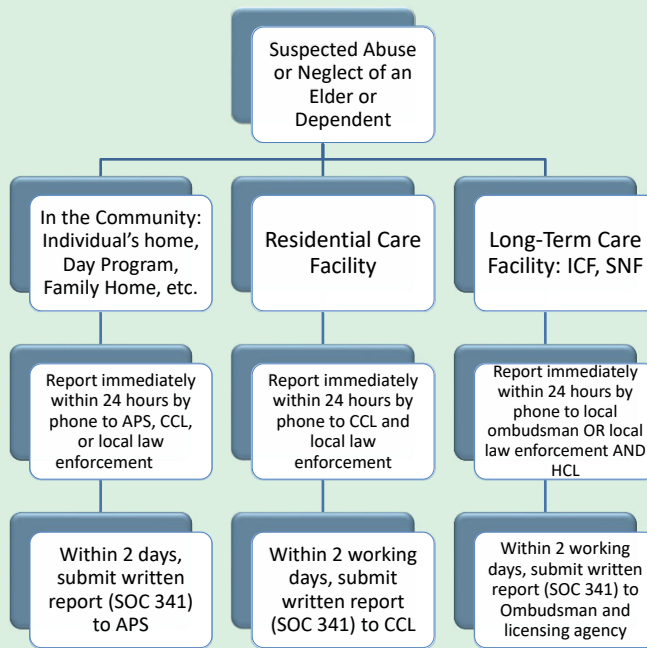
Why report? It's the law!

When to report?

- You have knowledge of/or are witness to abuse or neglect
- "Reasonable suspicion"
- Report immediately or as soon as possible

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Mandated Reporting



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TIMELINE



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REPORTABLE INCIDENTS

ALL INDIVIDUALS

ALL INDIVIDUALS UNDER THE CARE AND SUPERVISION OF A SERVICE PROVIDER

Death

Victim of a Crime

Abuse or Neglect reported to APS, CPS, Law Enforcement, Long Term Care Ombudsman

Admitted to Hospital or ER visits

Serious Injury

Missing Person

Medication Error

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UPDATED SIR REGULATIONS



- Take effect May 1, 2026
- New reporting requirements
- Aligns with HCBS requirements

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HARBOR REGIONAL CENTER Special Incident Report For Harbor Vendors and Long-Term Care Facilities

Instructions for provider Special Incident Reporting (Cal. Code of Regulations Title 17, § 54327)

1. Verbally notify Harbor within 24 hours of incident by calling the assigned Service Coordinator or SCOD
2. Submit written SIR within 48 hours of the incident by email: sirs@harborcc.org
3. Notify the appropriate licensing agency according to Title 22 regulations, if applicable
4. Notify authorities (APS, CPS/CFWB, LTC Ombudsman, Law Enforcement) per mandated reporting requirements for SIRs involving a victim of crime and/or an allegation of abuse or neglect

Individual's Name: _____ UCI #: _____ DOB: _____ Age: _____
 Service Coordinator: _____ Vendor #: _____ Vendor Name: _____
 Incident Date: _____ Incident Time: _____ AM _____ PM _____ Unknown _____
 Date Vendor LEARNED of Incident: _____ Date Vendor CALLED Harbor: _____
 Date Vendor submitted WRITTEN Report: _____
 Incident Location: _____ *Red boxes require a response – indicate N/A if not applicable

1. INCIDENT TYPES (S) – CHECK ALL THAT APPLY

<input type="checkbox"/> Death <input type="checkbox"/> Medication Error <small>(Please fill out Section 7)</small> <input type="checkbox"/> Missing Person <input type="checkbox"/> Missing Person –Police Notified <input type="checkbox"/> Victim of a Crime <input type="checkbox"/> Aggravated Assault <input type="checkbox"/> Burglary <input type="checkbox"/> Larceny <input type="checkbox"/> Personal Robbery <input type="checkbox"/> Rape or Attempted Rape <input type="checkbox"/> Simple Assault <input type="checkbox"/> Battery <input type="checkbox"/> Fraud <input type="checkbox"/> Identity or Credit Theft <input type="checkbox"/> Attempted or Actual Homicide or <input type="checkbox"/> Manslaughter <input type="checkbox"/> Stalking <input type="checkbox"/> Hate Crime <input type="checkbox"/> Human Trafficking <input type="checkbox"/> Injury From <input type="checkbox"/> Accident <input type="checkbox"/> Another Individual Served <input type="checkbox"/> Behavior Episode <input type="checkbox"/> Unknown Origin <input type="checkbox"/> Suspected Abuse/Exploitation <small>(Please fill out Section 8)</small> <input type="checkbox"/> Alleged Violation of Rights <input type="checkbox"/> Emotional/Mental Abuse <input type="checkbox"/> Financial Abuse <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Physical/Chemical/Mechanical <input type="checkbox"/> Restraint <input type="checkbox"/> Exploitation <input type="checkbox"/> Verbal <input type="checkbox"/> Isolation	<input type="checkbox"/> Suspected Neglect Including Failure To: <small>(Please fill out Section 6)</small> <input type="checkbox"/> Assist w/ Personal Hygiene <input type="checkbox"/> Prevent Malnutrition/Dehydration <input type="checkbox"/> Protect From Health/Safety Hazard <input type="checkbox"/> Provide Care - Elder/Adult <input type="checkbox"/> Provide Food/Clothing/Shelter <input type="checkbox"/> Provide Medical Care <input type="checkbox"/> Prevent TWO or more falls within 30 days <input type="checkbox"/> Abandonment <input type="checkbox"/> Provide for Mental Health Needs <input type="checkbox"/> Medical Treatment – Beyond First Aid <small>(Please fill out Section 6)</small> <input type="checkbox"/> Bites That Break The Skin <input type="checkbox"/> Burns <input type="checkbox"/> Choking <input type="checkbox"/> Condition Requiring Medical Intervention <input type="checkbox"/> Emergency Room Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Internal Bleeding <input type="checkbox"/> Laceration Requiring Sutures/Staples/Dermabond <input type="checkbox"/> Puncture Wounds Requiring Treatment <input type="checkbox"/> Injury Resulting from Seizure <input type="checkbox"/> Bruising/Contusion/Hematoma (include size and location) <input type="checkbox"/> Pressure Injury Stage 2 or Unstageable <input type="checkbox"/> Any Head Injury/Concussion Requiring medical attention	<input type="checkbox"/> Unplanned/Unscheduled Hospitalization Due To: <small>(Please fill out Section 6)</small> <input type="checkbox"/> Cardiac-related <input type="checkbox"/> Diabetes-related <input type="checkbox"/> Seizure-related <input type="checkbox"/> Intestinal Infection <input type="checkbox"/> Dental-related <input type="checkbox"/> Nutritional Deficiency <input type="checkbox"/> Respiratory Illness <input type="checkbox"/> Wound/Skin Care <input type="checkbox"/> Bowel Obstruction <input type="checkbox"/> Involuntary Psychiatric Hospitalization <input type="checkbox"/> Voluntary Psychiatric Hospitalization <input type="checkbox"/> Behavior <input type="checkbox"/> Aggressive Act Involving A Weapon <input type="checkbox"/> Aggressive Act To Another Individual <input type="checkbox"/> Aggressive Act To Family/Visitors <input type="checkbox"/> Aggressive Act To Self <input type="checkbox"/> Aggressive Act To Staff <input type="checkbox"/> Arrests <input type="checkbox"/> Drug/Alcohol Abuse <input type="checkbox"/> Community Safety <input type="checkbox"/> Fire Setting <input type="checkbox"/> Psych Emergency Team/No Hospitalization <input type="checkbox"/> Property Damage <input type="checkbox"/> Severe Verbal Threats <input type="checkbox"/> Suicide Threat <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other <input type="checkbox"/> Disease Outbreak <input type="checkbox"/> Other Sexual Incident/Pregnancy <input type="checkbox"/> Extended ER visit lasting 5 days or more <input type="checkbox"/> Other
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Death, Medication Error, Missing Person

Death

Medication Error
(Please fill our Section 7)

Missing Person

Missing Person –Police Notified

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Victim of Crime

Victim of a Crime

- Aggravated Assault
- Burglary
- Larceny
- Personal Robbery
- Rape or Attempted Rape
- Simple Assault
- Battery
- Fraud
- Identity or Credit Theft
- Attempted or Actual Homicide or Manslaughter
- Stalking
- Hate Crime
- Human Trafficking

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Reasonably Suspected Abuse

Suspected Abuse/Exploitation

(Please fill out Section 8)

- Alleged Violation of Rights
- Emotional/Mental Abuse
- Financial Abuse
- Physical Abuse
- Sexual Abuse
- Physical/Chemical/Mechanical Restraint
- Exploitation
- Verbal
- Isolation

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Reasonably Suspected Neglect

Suspected Neglect Including Failure To:

(Please fill out Section 8)

- Assist w/ Personal Hygiene
- Prevent Malnutrition/Dehydration
- Protect From Health/Safety Hazard
- Provide Care - Elder/Adult
- Provide Food/Clothing/Shelter
- Provide Medical Care
- Prevent TWO or more falls within 30 days
- Abandonment
- Provide for Mental Health Needs

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Medical Treatment

Medical Treatment – Beyond First Aid

(Please fill out Section 6)

- Bites That Break The Skin
- Burns
- Choking
- Condition Requiring Medical Intervention
- Emergency Room
- Dislocation
- Fracture
- Internal Bleeding
- Laceration Requiring Sutures/Staples/Dermabond
- Puncture Wounds Requiring Treatment
- Injury Resulting from Seizure
- Bruising/Contusion/Hematoma (Include size and location)
- Pressure Injury Stage 2 or Unstageable
- Any Head Injury/Concussion Requiring medical attention

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Unplanned Hospitalizations/ ER Visits

Unplanned/Unscheduled Hospitalization Due To:

(Please fill out Section 6)

- Cardiac-related
- Diabetes-related
- Seizure-related
- Internal Infection
- Dental-related
- Nutritional Deficiency
- Respiratory Illness
- Wound/Skin Care
- Bowel Obstruction
- Involuntary Psychiatric
Hospitalization
- Voluntary Psychiatric
Hospitalization

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Behavior

Behavior

- Aggressive Act Involving A
Weapon
- Aggressive Act To Another
Individual
- Aggressive Act To Family/Visitors
- Aggressive Act To Self
- Aggressive Act To Staff
- Arrests
- Drug/Alcohol Abuse
- Community Safety
- Fire Setting
- Psych Emergency Team/No
Hospitalization
- Property Damage
- Severe Verbal Threats
- Suicide Threat
- Suicide Attempt

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Other Incidents

Other

- Disease Outbreak
- Other Sexual Incident Pregnancy
- Extended ER visit lasting 5 days or more
- Other

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Page 2 of SIR Form

- Additional agency notifications
- Description of incident
- Preventative action
- Risk mitigation
- Actions taken as an agency

2. AGENCIES NOTIFIED AND/OR INVOLVED <small>(Check off all that apply. If selected, please complete all fields.)</small>				
	Contact Name	Date Notified	Phone #	Report #
<input type="checkbox"/> Community Care Licensing (DSS)				
<input type="checkbox"/> Health Care Licensing (DHS)				
<input type="checkbox"/> Parent/Guardian/Conservator				
<input type="checkbox"/> Law Enforcement				
<input type="checkbox"/> Adult Protective Services				
<input type="checkbox"/> Child Protective Services / CFWB				
<input type="checkbox"/> Long-Term Care Ombudsman				
<input type="checkbox"/> Other				

3. DESCRIPTION OF INCIDENT
(who/what/where/when/why, description of perpetrator, treatment administered, transported to hospital etc.)

4. SPECIFIC PREVENTATIVE ACTION TAKEN/PLAN TO PREVENT REOCCURRENCE
(new or modified services/supports/equipment, follow-up care, next planning team meeting etc.)

5. ACTION(S) TAKEN BY VENDOR IN RESPONSE TO SPECIAL INCIDENT

<input type="checkbox"/> Staff Training	<input type="checkbox"/> Staff Terminated	<input type="checkbox"/> Planning Team Meeting	<input type="checkbox"/> Referral to Clinical Services
<input type="checkbox"/> Staff Suspended	<input type="checkbox"/> Policies Revised	<input type="checkbox"/> Review/Revise Behavioral Plan	<input type="checkbox"/> Other: <input type="text"/>

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Page 3 of SIR Form

- Hospitalizations and ER Visits
- Medication Errors
- Alleged abuse/neglect
- Reporting party

6. FOR HOSPITALIZATIONS & ER VISITS NOT APPLICABLE

Hospital Name: _____ Admission Date: _____
 Diagnosis (if available): _____
 Discharge Date (if available): _____ Discharged To (if available): _____
 Follow-up needed after discharge (i.e. PT, specialist appointment) (if available): _____
 Does client require any support/equipment daily? _____
 Medication Changes (if applicable): _____

7. FOR MEDICATION ERRORS NOT APPLICABLE

Type of Medication Error (check all that apply)

Missed Dose Wrong Medication Wrong Time Documentation Error
 Wrong Dose Wrong Person Wrong Route Medication Refusal

Name and dosage of medication(s):
(Only list medications related to this SIR incident)

Any adverse reactions? _____
 Day(s) affected by medication error: _____ Time medication was to be given: _____ AM PM
 Primary Care Physician (MD, NP, PA, or Psychiatrist) notification (name & date): _____

8. FOR SUSPECTED ABUSE OR NEGLECT NOT APPLICABLE

Name of Alleged Perpetrator: _____ Age: _____
 Has this person previously abused/neglected the client? Y/N: _____ If yes, when was last incident? _____
 Relationship to Individual: Another Individual Served Relative/Family Member Vendor/Employee of Vendor
 Other Person Known to Individual Unknown Other: _____
"If individual required medical attention due to abuse/neglect, please fill out Section 6 "Hospitalization & ER visit" above"
 Witness Name: _____ Address: _____ Phone #: _____

9. REPORT SUBMITTED BY

Name: _____ Title: _____
 Vendor Name: _____ Vendor Email: _____
 Date Completed: _____ Telephone #: _____

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How to Submit a SIR

Please use this standardized format when submitting SIRs

- **E-mail Subject Line:** SIR UCI of individual (SIR 1234567)
- **E-mail Body:** "This SIR is for (Individual) and (UCI Number)"

SIR E-mail Address: SIRS@harborrc.org

SIR form can be found on the Harbor website: www.harborrc.org

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Helpful Tips

- Ensure vendor number is correct
- Ensure the name and UCI number is correct
- Review form before submitting
- Submit to the SIRS inbox, not just SC or PRS
- Use the 48 hours to gather enough information
- Get rid of the old forms!
- When in doubt, report

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LIC 624

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

UNUSUAL INCIDENT/INJURY REPORT

INSTRUCTIONS: NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.
SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.
RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY: _____ FACILITY FILE NUMBER: _____ TELEPHONE NUMBER: _____
ADDRESS: _____ CITY, STATE, ZIP: _____

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

TYPE OF INCIDENT

<input type="checkbox"/> Unauthorized Absence	<input type="checkbox"/> Alleged Client Abuse	<input type="checkbox"/> Rape	<input type="checkbox"/> Injury-Accident	<input type="checkbox"/> Medical Emergency
<input type="checkbox"/> Aggressive Act/Self	<input type="checkbox"/> Sexual	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Injury-Unknown Origin	<input type="checkbox"/> Other Sexual Incident
<input type="checkbox"/> Aggressive Act/Another Client	<input type="checkbox"/> Physical	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Injury-From another Client	<input type="checkbox"/> Theft
<input type="checkbox"/> Aggressive Act/Staff	<input type="checkbox"/> Psychological	<input type="checkbox"/> Other	<input type="checkbox"/> Injury-From behavior episode	<input type="checkbox"/> Fire
<input type="checkbox"/> Aggressive Act/Family, Visitors	<input type="checkbox"/> Financial		<input type="checkbox"/> Epidemic/Outbreak	<input type="checkbox"/> Property Damage
<input type="checkbox"/> Alleged Violation of Rights	<input type="checkbox"/> Neglect		<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Other (explain)

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTICIPENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURY)

PERSONS WHO OBSERVED THE INCIDENT/INJURY

DATE AND SIGNATURE BY ALL FOUR PARTIES (INCLUDE RESIDENTS' SIGNATURES)

LIC 624 (4/95) OVER

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SOC 341a

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDER

NOTE: RETAIN IN EMPLOYEE/VOLUNTEER FILE

NAME	
PERSON	FACILITY

California law **REQUIRES** certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California

SOC 341A (3/15)
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If You **SEE** Something, **SAY** Something

To report a complaint or concern regarding any licensed care facility, contact the Hotline at:

1-844-LET-US-NO

(1-844-538-8766)

**IN THE EVENT OF AN EMERGENCY
CALL 9-1-1**

You may also contact us at LetUsNo@dss.ca.gov or by mail:

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

California Department of Social Services
 Community Care Licensing Division
 Centralized Complaint and Information Bureau
 744 P Street
 Sacramento, CA 95814

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Additional Resources

Harbor's Website: www.HarborRC.org

- "Vendor Guidelines for Special Incidents Pursuant to Title 17"
- "Special Incident Report for Harbor Vendors and Long-Term Care Facilities"

Reporting Abuse

- Adult Protective Services - (877) 477-3646
- Local Ombudsman - (310) 394-9871
- Child Abuse Hotline - (800) 540-4000

DDS Website:

<https://www.dds.ca.gov/transparency/risk-management-mitigation/>

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Q & A



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