



Incident Report

ADULT CARE FACILITIES/OAC RULE 3701-20-19

Facility Name: _____

Facility ID: **OHL** _____ License ID: _____

Name of Resident(s) Involved: _____

Date: _____ Time: _____ Place: _____

Other Person(s) Involved: _____

Describe what happened: _____

Probable cause: _____

Care provided or measures taken: _____

Who was notified (name, title, date, time)? _____

Signature: _____ Date: _____

Outcome/Disposition: _____

Plan to prevent reoccurrence: _____

Signature: _____ Date: _____

Date Manager Reviewed: _____