



## Initial Report

Report Type:

2 hour initial     24 hour initial     Licensure     Certification

Date: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Certified Bed:**    yes    no

**Resident's Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Room #:** \_\_\_\_\_

**Additional Resident Information (as applicable):** \_\_\_\_\_

- |   |  |  |
|---|--|--|
| Type of Reportable Incident:                    | <input type="checkbox"/> mental abuse                              | <input type="checkbox"/> misappropriation of resident property                                     |
| <input type="checkbox"/> physical abuse         | <input type="checkbox"/> neglect                                   | <input type="checkbox"/> crimes against residents  |
| <input type="checkbox"/> verbal abuse           | <input type="checkbox"/> fire                                      | <input type="checkbox"/> severe hematoma, laceration, or burn requiring medical or hospitalization |
| <input type="checkbox"/> sexual abuse           | <input type="checkbox"/> involuntary seclusion                     | <input type="checkbox"/> hospitalization as a result of accident/injury                            |
| <input type="checkbox"/> attempted suicide      | <input type="checkbox"/> medication error (with adverse reactions) | <input type="checkbox"/> injury involving use of restraints  |
| <input type="checkbox"/> bone or joint fracture | <input type="checkbox"/> elopement                                 | <input type="checkbox"/> injury of unknown source  |
| <input type="checkbox"/> patient death          |  |  |

**Name of Alleged Perpetrator:** \_\_\_\_\_

Date/Time of Reportable Incident: \_\_\_\_\_

Brief Description of Reportable Incident:

**DHEC**  
**Healthcare Quality**  
**2600 Bull Street, Columbia, SC 29201**  
**Voicemail: 1-800-922-6735 Fax: 803-545-4292**

**SOUTH CAROLINA DEPARTMENT OF  
HEALTH AND ENVIRONMENTAL CONTROL**

**DHEC FORM 0268**  
Instructions for Completing

PURPOSE:

This form is used for all facility reported incidents for Healthcare Quality. Healthcare Quality is required through state law, regulation, and policy to have documentation of all facility reported incidents. This form serves as that documentation

ITEM BY ITEM INSTRUCTIONS:

1. **Report Type:** Put a check next to the type of report that is being filled out.
2. **Date:** The date the form is being submitted.
3. **Facility:** Enter the permitted facility's official or legal name. Do not use a colloquial or abbreviated name.
4. **Address:** The existing South Carolina facility address.
5. **Phone #:** The current facility phone number and any needed extensions.
6. **Resident's Name:** Name of the resident involved in the incident.
7. **DOB:** Resident's date of birth that was involved.
8. **Room #:** Room number of the resident involved.
9. **Certified Bed:** Select yes or no if the involved resident occupies a certified bed.
10. **Type of Injury:** List the type of injury inflicted upon the resident.
11. **Type of Alleged Abuse:** Put a check next to the type of alleged abuse if that was the type of incident selected at the top of the form.
12. **Name of Alleged Perpetrator:** State the name of the person who caused the injury or incident.
13. **Date/Time of Reportable Incident:** What time and day did the incident occur?
14. **Brief Description of Reportable Incident:** Provide a brief statement describing the events that occurred.

Attach other supporting documentation if needed and additional sheets as necessary. Please attach copied of all applicable interview, witness statements, and any other applicable documents.

OFFICE MECHANICS AND FILING:

This form will remain as a part of Healthcare Quality's files in accordance with Federal CMS retention regulations and guidelines.