Nevada DHCFP Serious Occurrence Report

Service Type: ☐ **PCS** ☐**ISO** ☐**PAS** ☐**Homemaker** ☐**ADHC** ☐ **COPE** ☐ **Other:**
Recipient Eligibility: ☐**FE Waiver** ☐**ID Waiver** ☐**PD Waiver** ☐**FFS** ☐**Non Medicaid**

Recipient's Name: Last: **First:**		**Medicaid ID #:**
Recipient DOB:		**Date of Occurrence:**
Billing Provider NPI or API #:	**Servicing Provider NPI or API #:**	**Place of Occurrence:**
Full Name of Person Reporting:	**Date of Discovery:**	**Relationship to Recipient (PCA/Family/Friend/Peer/Staff/Roommate/Case Manager):**
Provider Name:		
Supervisor of Person Reporting:		**Provider Region:** ☐**North** ☐**South** ☐**Rural**
☐**UNPLANNED HOSPITAL VISIT/ER**	**Name of Facility:**	
Reason: ☐Injury (please complete injury section) ☐Illness ☐Pain ☐Psychiatric/Behavioral		
MEDICAL INTERVENTION REQUIRED FOR: ☐Injury ☐ Fall ☐ No Visible Signs of Injury/Injury of Unknown Origin		
Suspected Type of Injury: ☐Bruise ☐Abrasion/cut ☐Fracture/dislocation ☐Sprain/strain ☐Swelling/edema ☐Skin Tear ☐ Pain Location: ☐Other (please note):		
Person(s) Involved in Injury: ☐Self-Accident ☐Self-Inflicted (non accident) ☐Family Member ☐Roommate ☐Staff Member ☐ Peer ☐Other (please note):		
Was provider/staff at the residence at the time of this incident? ☐Yes ☐No		
Could the fall or injury have been prevented? ☐Yes ☐No How?		
Was the fall or injury intentional? ☐Yes ☐No If yes, how?		
☐ **PHYSICAL, VERBAL, EMOTIONAL, SEXUAL ABUSE OR HARASSMENT** (to or from recipient) *Note: All state laws regarding authority notification must be followed, if applicable*		
Type of Incident: ☐Neglect ☐Self Neglect ☐Physical Abuse (fill out injury section above if applicable) ☐Verbal Abuse ☐Sexual Harassment ☐Sexual Abuse ☐Isolation		
Victim: ☐Recipient ☐Staff Member ☐Other (name and relationship to the recipient):		**Perpetrator**: ☐Family Member ☐Staff Member ☐Recipient ☐Other (name and relationship to the recipient:
☐**SUICIDE THREAT** Medical or Police Contacted ☐Yes ☐No If yes, when?		
☐**SUICIDE ATTEMPT** Medical or Police Contacted ☐Yes ☐No If yes, when?		
☐**CRIMINAL ACTIVITY** resulting in police report or arrest ☐ **YES** ☐ **NO** If yes, CASE # TYPE		
☐**LEGAL INVOLVEMENT** including possible lawsuits Explanation:		

☐ **THEFT** ☐ **EXPLOITATION**

Type: ☐Money Amount: ☐ Property: ☐ Medication ☐ Other:
Perpetrator:

☐**MEDICATION ERROR**

☐Wrong Medication ☐ Wrong Dose ☐ Wrong Person ☐ Wrong Time of Administration ☐ Skipped Dose ☐ Other (explain)

☐**LOSS OF CONTACT** with recipient
Duration of time:

☐**ELOPEMENT** of any recipient residing in a 24-hour service setting

☐**RECIPIENT DEATH**
Date of Death:
Death was: ☐ Explained/Expected ☐ Unexplained/Unexpected
Where was the recipient when the death occurred?
History of services provided to the recipient by provider. Include information about the length of time and frequency of contact with the recipient:
What were the circumstances and the cause of death (be specific with as much detail as possible):
Was death certificate or coroner's report ordered? ☐ Yes ☐ No If yes, whom was it ordered from:
Was death certificate or coroner's report received? ☐ Yes ☐ No If yes, who received it:
(Please attach any documentation received pertaining to the death)

☐**OTHER CATEGORY**
☐HIPAA Violation
☐Major Property Damage
☐Auto Accident involving recipient
☐Staff Injury/Illness/Accident requiring Medical Attention
☐Environmental Incident requiring Emergency assistance
☐Death of unpaid caregiver
☐ Other occurrence not identified:

☐**Action Taken to Protect and Reduce Future Risk** ☐ N/A (If no action taken or needed)

EPS/CPS Notified?	☐Yes ☐No	Date:	Name:	Phone:
Law Enforcement Notified?	☐Yes ☐No	Date:	Name:	Phone:
Guardian/Responsible Person Notified?	☐Yes ☐No	Date:	Name:	Phone:
State Staff or Waiver Personnel Notified?	☐Yes ☐No	Date:	Name:	Phone:
Health Care Quality and Compliance Notified	☐Yes ☐No	Date:	Name:	Phone:
Is there a pending or ongoing investigation?	☐Yes ☐No ☐ Unknown			
Were there any witnesses?	☐Yes ☐No ☐ Unknown			

COMMENTS/DETAILS: (who, what, when, where, event #, etc.)