Nevada DHCFP Serious Occurrence Report

			aker			
Recipient's Name: Last: First:		N	Medicaid ID #:			
Recipient DOB:			Date of Occurrence:			
Billing Provider NPI or API #: Servicing Provider NP API #:		P P	Place of Occurrence:			
Full Name of Person Reporting:	Date of Discovery:	(F	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			me 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 intention PHYSICAL, VERBAL, EN			R HARASSMENT (to or from recipient) Note: All state			
Taws 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): □Recipient □Other (name and relationship to the recipient): □Staff Member □Recipient □Other (name and relationship to the recipient): □Staff Member □Recipient □Other (name and relationship to the recipient): □Staff Member □Staff Member □Recipient □Other (name and relationship to the recipient): □Staff Member □Staff Member □Recipient □Staff Member □Recipient □Staff Member □Staff Member □Recipient □Staff Member □Staff Member □Recipient □Staff Member □Recipient □Staff Member □Staff Member □Staff Member □Staff Member □Recipient □Staff Member □Staff Member □Recipient □Staff Member □Staff						
□SUICIDE THREAT Medical or Police Contacted □Yes □No If yes, when?						
SUICIDE ATTEMPT Medical or Police Contacted CRIMINAL ACTIVITY result yes, CASE # TYPE LEGAL INVOLVEMENT in	ulting in police report or arr		YES NO			
Explanation:						

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☐ THEFT ☐ EXPLOITATION						
Type : Money Amount: \$ Perpetrator:	• • • • • • • • • • • • • • • • • • • •					
MEDICATION ERROR						
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?		Date:	Name:	Phone:		
Law Enforcement Notified?						
	Yes No		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.)						

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