

MEDICAID FORM RELEASE MEMO

TO: FRM Distribution
FROM: Publications Control
SUBJECT: **Nevada DHCFP Serious Occurrence Report Form A**

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The following is for your information and action. Attached please find the new or revised form to be used. The actual form may vary in size, color, type of paper or printing method. Please update your FRM log and Forms Manual.

- NEW FORM/BULLETIN
- REVISED FORM: Destroy old version after new stock is received.
- SUPPLY is being sent to all using offices.
- REVISED FORM: Use old version until supply is exhausted.
- Revised FORMS CONTROL INDEX
- SUPERSEDED: Form/date _____, FRM _____
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PURPOSE:

The Original form, NMO-3430-E has been split into two independent forms. One for an individual to report serious occurrences (now known as form NMO-3430A) and one for state case managers to complete when following up on a reported serious occurrence (form NMO-3430B). The purpose of this form, NMO-3430 is to collect objective and factual data regarding identified serious occurrences and must be completed by any individual who becomes aware of a serious occurrence.

Definition:

1. **Serious Occurrence:** any actual or alleged event or situation that relates a significant risk of substantial or serious harm to the safety or well being of a recipient of the above mentioned programs.

Reportable serious occurrences include:

- ✓ Suspected physical abuse, verbal abuse or sexual harassment;
- ✓ Neglect of the recipient;
- ✓ Medical or medication errors;
- ✓ Exploitation;
- ✓ Theft;
- ✓ Injuries requiring medical intervention;
- ✓ Medical Emergency;
- ✓ Suicide Attempts
- ✓ Any event which is reported to Child and Elder Protective Services or law enforcement agencies;
- ✓ Death;
- ✓ Loss of contact with the recipient for three consecutive scheduled days.

INSTRUCTIONS:

1. Any person who becomes aware of a serious occurrence must report the occurrence by completing the serious occurrence report. Service providers, MFP transition coordinators, and case managers do not have to report a serious occurrence that has already been reported by the provider, but do have to report serious occurrences not previously reported.
2. The serious occurrence report must be completed within 24 hours of discovery by the individual who discovered the event.
3. The form must list only objective data and facts. Do not include opinions in the report. The form's function is to relay the honest actual facts of the occurrence. A narrative may be attached to the form.
4. Providers who initiate serious occurrence reports must retain a copy in the recipient's chart or a separate serious occurrence folder and send a copy to the appropriate agency as listed below.
5. Any person who fills out the form must choose only one event, not multiple events. The description of the event can include the cause. If there are multiple events, then each event must have a separate form. For example: If an individual dies as a result of a medication error, an assault or a suicide attempt; the correct event is death. The cause is the medication error, assault or suicide attempt. The cause would be captured in the comments field.

ROUTING THE SERIOUS OCCURRENCE REPORT (see below for fax numbers):

- PCA Only Recipient → Care Coordination Unit at the local Health Care Financing and Policy (DHCFP) District Office
- WIN Recipient → WIN Case Manager at the appropriate/local Health Care Financing and Policy (DHCFP) District Office
- CHIP Recipient → CHIP Case Manager at the appropriate/local Aging and Disability Services Division (ADSD) District Office
- MFP Recipient → MFP transition coordinator at the local Health Care Financing and Policy (DHCFP) District Office
- AL Recipient → AL Case Manager at the appropriate/local Aging and Disability Services Division (ADSD) District Office
- MR/RC Recipient → MR/RC Service Coordinator at the appropriate/local Mental Health and Developmental Services (MHDS) Regional Center
- ✓ Personal Assistance Services → Route to the local Aging and Disability Services Division (ADSD) District Office.
- ✓ State Funded Homemaker (HM) → Route to the local Aging and Disability Services Division (ADSD) District Office Note: this is only the state funded HM through ADSD, not a waiver service.
- ✓ Other, non waiver → Route as required by program.

FAX NUMBERS:

➤ **Health Care Financing and Policy Division**

- Carson City: (775) 684-3720
- Elko: (775) 753-1101
- Las Vegas: (702) 668-4280 or (702) 668-4279
- Reno: (775) 687-1901

➤ **Aging and Disability Services Division**

- Carson City: (775) 687-4264
- Elko: (775) 753-8543
- Las Vegas: (702) 486-3572
- Reno: (775) 688-2969

➤ **Division of Mental Health and Developmental Services**

- Rural Regional Center (RRC)
 - Carson City: (775) 684-1001
 - Elko: (775) 777-7884
 - Fallon: (775) 423-0357
 - Silver Springs: (775) 577-9571
 - Winnemucca: (775) 623-6594
- Sierra Regional Center (SRC) (775) 688-1947
- Desert Regional Center (DRC) (702) 486-5698

FORM COMPLETION:

1. Program Origin – Check the appropriate box indicating the recipient's Medicaid program: PCSA, WIN, CHIP, MR, AL, MFP or Other Non waiver.
2. Name – Enter the involved recipient's last and first name.
3. Involved Recipient's Nevada Medicaid ID # - Enter the correct 11 digit number
4. Address: Enter the address of the recipient.
5. Phone Number: Enter the phone number of the recipient.
6. Provider Agency and Provider ID number – Enter the name of the provider agency and provider ID number related to the recipient and the serious occurrence.
7. Recipient's Date of Birth – Enter the recipient's date of birth.
8. Person Reporting – Enter the name of the person reporting and the relationship of that person to the recipient.

9. Agency Supervisor – Enter the name of the supervisor or contact person of the person reporting. This should be the person who may be contacted to answer any further questions regarding the incident or follow-up.
10. Date of Discovery – Enter date of when the incident was discovered, if not witnessed.
11. Date/Place of Occurrence – Enter the date the occurrence occurred, and where.

FACTUAL DESCRIPTION OF INCIDENT: Check ONLY the box(es) that apply.

Unplanned Hospital/ER Visit

Facility – Enter the name of the hospital or facility the recipient was taken to.

1. Type of Unplanned Hospital or ER visit – Check the appropriate box:
 - ✓ Reason – Indicate either injury, illness or pain.

Injury or Fall Requiring Medical Intervention

1. Type of Injury- Check the appropriate box. It may be necessary to check more than one box. If checking “Other” enter the type of injury on the narrative line.
 - ✓ Bruise – A bruise is visible.
 - ✓ Abrasion/Cut – An abrasion/cut is visible.
 - ✓ Fracture/dislocation – Suspected - but may not be known until diagnosed at the hospital/doctor.
 - ✓ Sprain/strain – Suspected – but may not be known until diagnosed at the hospital/doctor.
 - ✓ Swelling/edema – swelling/edema is visible.
 - ✓ Fall.
 - ✓ Pain location – where is the pain.
 - ✓ Skin Tear – a skin tear is visible.
 - ✓ No visible signs of injury – This is common with falls and stumbles, some can trip, fall or stumble and not have any of the above injuries. Falls without injury need to be reported as they can be a sign of a safety risk.
 - ✓ Other – If something occurs that is not listed above, describe the injury.
2. Person(s) Involved in the Injury- Check the appropriate box. If checking “Other” enter the relationship of the individual to the recipient. Include the individual’s name if possible.
 - ✓ Self accident – recipient fell down or unintentionally injured themselves
 - ✓ Self inflicted – recipient intentionally injured themselves
 - ✓ Family member – family member intentionally injured recipient
 - ✓ Roommate – roommate intentionally injured recipient
 - ✓ Staff member – staff member intentionally injured
 - ✓ Other – someone not listed above
 - ✓ Indicate if the provider or staff was at the residence at the time of the incident
 - ✓ Indicate whether the fall may have been prevented

Alleged Physical, Verbal, Emotional, Sexual Abuse or Harassment

- Per NRS 200.471, 200.481 and 200.5092, the following definitions are provided to guide the categorization and description of Assault and Abuse.

- ✓ **Assault** means intentionally placing another person in reasonable apprehension of immediate bodily harm.
- ✓ **Battery** means any willful and unlawful use of force or violence upon the person of another.
- ✓ **Abuse** means any willful and unjustified infliction of pain, injury or mental anguish upon a client by a person other than another client. This includes, but is not limited to:

- The rape, sexual assault or sexual exploitation of a client- Examples include sexual molestation, attempts to engage a client in sexual conduct, sexual touching or fondling of a client, encouraging a client to sexually touch a staff member or other client, or himself, exposing one's sexual parts to a client and encouraging a client to expose his sexual parts to staff or other clients.
- Striking a client- Also included are any acts which cause physical pain or injury to the client. Examples include slapping, bruising, pinching, cutting, burning and unnecessary physical coercion of a client.
- Verbal intimidation or coercion of the client without a redeeming purpose- This includes actions or utterances that cause mental distress such as making obscene gestures to the client, name-calling, cursing and words that frighten, humiliate, intimidate, threaten or insult the client.

➤ Per NRS 200.5092 and 433.554 the following definitions are provided to guide the categorization and description of Neglect.

- ✓ **Neglect** means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for a person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person; or a person to provide for his own needs because of inability to do so.

- ✓ **Neglect** means any omission to act which causes injury to a client or which places the client at risk of injury, including, but not limited to failure to:

- Follow an appropriate plan of treatment to which the client has consented.
- Follow the policies of the facility for the care and treatment of clients.

1. Type of Alleged Incident – Indicate the type of incident based on the above definitions.
2. Alleged Victim – Indicate the alleged victim whether it is the recipient, provider or someone else.
3. Alleged Perpetrator – Indicate the alleged victim whether it is the recipient, provider or someone else.

Assault, Violence, Threat (by or towards a recipient): Check this box if appropriate and use the comments field to describe incident.

Suicide Threat with medical or police involvement: Check this box if appropriate and use the comments field to describe the incident.

Suicide Attempt: Check this box if appropriate and use the comments field to describe incident.

Criminal Activity: Defined as: An act committed or omitted in violation of a law forbidding or commanding it and for which punishment is imposed upon conviction; an unlawful activity; a serious offense, especially one in violation of morality; or an unjust, senseless, or disgraceful act or condition.

Legal Involvement: Personal involvement in some type of legal action or activity where the police are involved.

Alleged Theft or Exploitation

➤ Per NRS 200.5092, the following definitions are provided to guide the categorization and description of Exploitation or Isolation of Older Persons. The definition has been expanded to include persons of all ages by removing the term “older” in all instances where it appeared.

- ✓ **Exploitation** means any act taken by a person who has the trust and confidence of another person or any use of the power of attorney or guardianship of a person to:
 - Obtain control, through deception, intimidation or undue influence, over the other person’s money, assets or property with the intention of permanently depriving the other person of the ownership, use, benefit or possession of his money, assets or property; or
 - Convert money, assets or property of the other person with the intention of permanently depriving the other person of the ownership, use, benefit or possession of his money, assets or property.

- ✓ **Theft** means taking something, without permission, that does not belong to you
 1. Alleged Type - If the incident involved theft, check the box(es) indicating money and/or property and record the amount of money or specific property declared to be stolen.
 2. Other - Record a description of other assets or act of exploitation if the incident did not involve theft of money or property.
 3. Alleged Perpetrator- Indicate the alleged perpetrator whether it is the recipient, family member, provider or someone else.

Medication Error

1. Any incident involving medication.
 - ✓ Wrong Medication – the recipient took or was given the wrong medication
 - ✓ Wrong Dose – the recipient took or was given an incorrect amount of medication
 - ✓ Wrong person – the recipient took or was given medication not meantt for them
 - ✓ Wrong time of Administration – the recipient took or was given medication at the wrong time
 - ✓ Other - any other medication error not listed above. Please explain.

Loss of Contact

1. Loss of contact with the recipient for 3 consecutive days.

Elopement of any recipient residing in a 24 hour setting:

Elopement is defined as leaving a facility such as a nursing home, assisted living facility, group home or supported living arrangement without notice or prior arrangement.

Death

1. Death of Recipient or significant caregiver –. Indicate the death of a recipient or significant caregiver.

Other Serious Occurrence

1. Other – Record any other activities that are not addressed prior to this point. Types of incidents include:
 - a. HIPAA violation
 - b. Major property damage
 - c. Auto accident
 - d. Staff injury/illness/accident requiring medical attention
 - e. Other accident involving emergency response
 - f. Media inquiry

Action Taken to Protect and Reduce Future Risk

1. EPS/APS/CPS Notified? – Circle entity notified, mark “Yes” or “No” and enter the date notified.
2. Law Enforcement Notified? – Mark “Yes” or “No” and enter date notified.
3. Guardian/Responsible Person Notified? - Mark “Yes” or “No” and if marking “Yes”, enter the name and phone number of the person notified.
4. Medicaid or Waiver Personnel Notified? - Mark “Yes” or “No” and if marking “Yes”, enter the name and phone number of the professional.
5. Comments/details - Additional information if necessary.

Signatures

1. The reporting individual must print and sign their name and include the date the form was completed.

Internal Use Only

1. Internal use only for after form is sent to case manager/care coordinator.

DISTRIBUTION:

This form will be posted on the intranet and the internet for providers to access.

DHCFP Library
DHCFP District Office
ADSD
MHDS
HPES