STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

SELF REPORT FORM

According to NAC 449.74491 Any allegation of abuse, neglect, misappropriation of property, elopement, fall/injury, must be reported to the Division of Public and Behavioral Health within 24 hours. A final report must be received within 5 working days.

PLEASE TYPE IN ALL NECESSARY INFORMATION, THEN FAX TO: 702-486-6520; ATTENTION: SELF REPORT

HAND WRITTEN REPORTS ARE NOT RECOMMENDED

1. FACILITY NAME AND ADDRESS:

_____

2. CONTACT PERSON, PHONE NUMBER AND EMAIL ADDRESS:

_____

3. ALLEGED INCIDENT OCCURRED ON: _____ AT: _____ ☐ AM ☐ PM

A. RESIDENTS INVOLVED: (ATTACH RESIDENT FACE SHEET)

RESIDENT NAME: _____ **DATE OF BIRTH:** _____

DATE ADMITTED: _____ **ROOM #:** _____

RESIDENT NAME: _____ **DATE OF BIRTH:** _____

DATE ADMITTED: _____ **ROOM #:** _____

RESIDENT NAME: _____ **DATE OF BIRTH:** _____

DATE ADMITTED: _____ **ROOM #:** _____

RESIDENT NAME: _____ **DATE OF BIRTH:** _____

DATE ADMITTED: _____ **ROOM #:** _____

B. ALLEGED STAFF INVOLVED: (IF APPLICABLE)

ALLEGED STAFF: _____ LICENSE #: _____

ALLEGED STAFF: _____ LICENSE #: _____

ALLEGED STAFF: _____ LICENSE #: _____

4. TYPE OF REPORT:

☐ INITIAL	☐ FINAL	☐ INITIAL & FINAL	☐ ADDITIONAL INFO
(1st Report)	*(Completed Report)*	*(1st Report & Conclusion)*	*(MARS, Medical Records, Photos Etc.)*

5. TYPE OF ALLEGED INCIDENT:

ABUSE: ☐ RESIDENT TO RESIDENT ☐ EMPLOYEE TO RESIDENT ☐ FAMILY/VISITOR TO RESIDENT

☐ SEXUAL ☐ OTHER: _____

NEGLECT: ☐ PRESSURE SORES ☐ MEDICATIONS ☐ OTHER: _____

☐ MISAPPROPRIATION OF PROPERTY: ☐ MISUSE OF FUNDS BY FACILITY/STAFF ☐ OTHER: _____

☐ INJURY OF UNKNOWN ORIGIN

☐ QUALITY OF CARE/TREATMENT: ☐ RESIDENT FALL ☐ ELOPEMENT

☐ OTHER: _____

6. BRIEF DESCRIPTION OF EVENT: (ATTACH MEDICAL RECORD REVIEW, CNA RECORDS, INTERVIEWS, X-RAY RESULTS, ETC.)

7. **WAS RESIDENT TAKEN TO EMERGENCY ROOM? ☐ YES ☐ NO**
IF YES, WHAT HOSPITAL WAS THE RESIDENT TAKEN TO?

_____

8. **DATE RESIDENT RETURNED TO THE FACILITY: _____**
(ATTACH HOSPITAL RESULTS IF APPLICABLE)

9. **(A) IF THE PERPETRATOR WAS A STAFF MEMBER, WAS THE ALLEGATION SUBSTANTIATED? ☐ YES ☐ NO**

IF YES, WAS STAFF SUSPENDED? ☐ YES ☐ NO

IF YES, WAS STAFF TERMINATED? ☐ YES ☐ NO

(B) IF ALLEGATION WAS SUBSTANTIATED, PLEASE ATTACH A COPY OF THE LETTER SENT TO THE APPROPRIATE OCCUPATIONAL BOARD. (EX: NURSING, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SOCIAL WORKER, RESPIRATORY THERAPIST, ETC.)

(C) IF STAFF WAS REINSTATED, DESCRIBE ACTIONS TAKEN: (IF AN INSERVICE WAS HELD, ATTACH ALL SUPPORTING DOCUMENTATION INCLUDING DATE, ATTENDANCE ROSTER, OBJECTIVES, IF IT WAS MANDATORY, ETC.)

CONCLUSION:

10. BRIEF DESCRIPTION OF HOW YOU CAME TO YOUR CONCLUSION: (ATTACH FACILITY POLICIES IF APPLICABLE)

_____

11. DESCRIBE OR ATTACH A COPY OF RESIDENT CARE PLAN(S) PERTAINING TO THE INCIDENT:

_____

12. DESCRIBE ACTION STEPS TAKEN TO PREVENT FUTURE OCCURRENCE:

_____

13. WERE OTHER ENTITIES NOTIFIED, PLEASE MARK BOXES THAT APPLY:

- ☐ **AGING AND DISABILITY SERVICES**
- ☐ **LAW ENFORCEMENT: INCIDENT/REPORT ID# _____**
- ☐ **PUBLIC GUARDIAN**
- ☐ **FAMILY MEMBER**
- ☐ **PHYSICIAN**
- ☐ **OTHER: _____**

PRINT AND FAX TO: 702-486-6520; ATTENTION: SELF REPORT

MAKE SURE ALL REQUESTED DOCUMENTS ARE ATTACHED.

PLEASE RETAIN A COPY FOR YOUR RECORDS