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)

1. RESIDENT NAME: _____ DATE OF BIRTH: _____

DATE ADMITTED: _____ ROOM #: _____

2. RESIDENT NAME: _____ DATE OF BIRTH: _____

DATE ADMITTED: _____ ROOM #: _____

3. RESIDENT NAME: _____ DATE OF BIRTH: _____

DATE ADMITTED: _____ ROOM #: _____

(B) ALLEGED STAFF INVOLVED (IF APPLICABLE):

1. ALLEGED STAFF: _____ **LICENSE #:** _____

2. ALLEGED STAFF: _____ **LICENSE #:** _____

3. ALLEGED STAFF: _____ **LICENSE #:** _____

4. TYPE OF REPORT:

INITIAL ☐ FINAL ☐ INITIAL & FINAL ☐ ADDITIONAL INFORMATION

5. TYPE OF ALLEGED INCIDENT:

RESIDENT TO RESIDENT ALTERCATION ☐ EMPLOYEE TO RESIDENT ALTERCATION ☐

ELOPEMENT ☐ RESIDENT FALL ☐ INJURY OF UNKNOWN ORIGIN ☐

MISAPPROPRIATION OF PROPERTY ☐ OTHER: _____

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

BRIEF DESCRIPTION CONTINUED:

_____

7. (A) WAS RESIDENT TAKEN TO EMERGENCY ROOM? YES ☐ NO ☐

(B) 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. (FOR EXAMPLE: 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 COME TO YOUR CONCLUSION:
(ATTACH FACILITY POLICIES IF APPLICABLE)

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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. WHAT OTHER ENTITIES WERE NOTIFIED:

AGING AND DISABILITY SERVICES
LAW ENFORCEMENT: INCIDENT ID # _____
PUBLIC GUARDIAN
FAMILY MEMBER
PHYSICIAN
OTHER: _____

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

MAKE SURE ALL DOCUMENTS REQUESTED

ARE ATTACHED.

PLEASE RETAIN A COPY FOR YOUR RECORDS