SERIOUS REPORTABLE INCIDENT
INITIAL REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

RRDC Region: _____

Participant Name: _____ CIN: _____

Address: _____

_____ Phone: _____

Discovery Date and Time: ___/___/_____ am/pm Name of person discovering alleged incident: _____

Relationship to Participant: _____:

Date and Time alleged incident occurred: ___/___/_____ am/pm

Preliminary category of alleged incident:

☐ 1. Abuse/Neglect
☐ 2. Missing Person
☐ 3. Restraint
☐ 4. Death of Participant
☐ 5. Hospitalization
☐ 6. Possible Criminal Act
☐ 7. Sensitive Situation
☐ 8. Medication Error/Refusal
☐ 9. Medical Treatment Due to Accident or Injury

Describe the alleged incident (include the location where it occurred, any person(s) present at the time, and the circumstances). Include only known facts.

Describe waiver participant's current condition/status and current location:

List any person(s) alleged to be involved in incident:

Describe any actions taken to assist the waiver participant:

Name of Waiver Staff first notified, if not discoverer: _____ Title: _____

Report completed by: _____ Title: _____

Reporting Agency: _____ Telephone: _____

Date and Time reported to QMS: ___/___/_____ am/pm Name of QMS: _____
Date and Time Initial Provider Report faxed to QMS: ___/___/_____ am/pm
Date and Time copy of report sent to RRDS: ___/___/_____ am/pm Name of RRDS: _____
Date and Time copy of report sent to SC: ___/___/_____ am/pm Name of SC: _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

New York State Department of Health
Division of Home and Community Based Services

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name:_____ CIN: _____ RRDS Region: _____

Date alleged incident discovered: __/__/__ Time alleged incident discovered: _____ am / pm

Date alleged incident occurred: __/__/__ Time alleged incident occurred: _____ am / pm

Location and address of alleged incident: _____

_____

Did discovering person directly observe the alleged incident? _____ Yes _____ No

Individual(s)/witness(s) present at the time of the alleged incident:

Name	Agency/Relationship to Participant	Telephone Number	Waiver Service Provided (If Applicable)

Classification of the alleged incident: Check all that apply according to the definitions in the Serious Reportable Incident Policy.

a. Allegation of Abuse: (category)

____ Physical Abuse ____ Sexual Abuse ____ Psychological Abuse
____ Neglect ____ Seclusion ____ Violation of Civil Rights
____ Mistreatment ____ Exploitation (financial or material)
____ Unauthorized or Inappropriate Use of Restraint ____ Use of Aversive Conditioning

b. Other Serious Reportable Incidents:

_____Missing Person _____Possible Criminal Act _____Restraint
_____Sensitive Situation _____Death _____Medication Error/Refusal
_____Hospitalization _____Medical Treatment Due to Accident/Injury

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont.)

Participant Name:_____ CIN #: _____

c. Was the Alleged Incident:

___ Participant only
___ Participant to Staff?
___ Staff to Participant?
___ Participant to Participant?
___ Participant to Other?
___ Other to Participant?

d. If there was an injury, identify type of injury sustained, and any information regarding the possible cause:

_____
_____
_____
_____
_____

e. Describe the alleged incident including anyone who may have been involved, the follow-up steps taken, and person(s) conducting the follow-up?

f. Include a statement from the participant regarding this alleged incident (use “quotes” when applicable):

g. NOTIFICATIONS:

☐ APS notified By Whom: _____
☐ Police notified By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____
☐ Other notified: (specify) _____ By Whom: _____

SERIOUS REPORTABLE INCIDENT
24-HOUR PROVIDER REPORT (cont)

Participant Name:_____ CIN: _____

g. NOTIFICATIONS (continued):

Reporter's Notification to Waiver Entities:

	Person Notified, Title and Agency	Date Notified
Quality Management Specialist (QMS)		
Regional Resource Development Specialist (RRDS)		
Service Coordinator/ Supervisor		

_____
Person completing this report/Title Signature

_____
Provider Agency Telephone Date

_____
Supervisor of person completing this report/Title Signature

_____
Provider Agency Telephone Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
SERVICE COORDINATION
24-HOUR NOTIFICATION REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Date: _____

Participant Name: _____
RRDC Region: _____ CIN: _____
Incident Date: _____

Person(s) Notified by Service Coordinator or Service Coordination Supervisor:

	Name of Person Notified	Reason	Date Notified
Participant			
Legal Guardian			
Other			
Provider Agency Name:			
Provider Agency Name:			
Provider Agency Name:			

***Upon completion of form, send to Quality Management Specialist**

_____
Service Coordinator Name Signature Date

_____
Service Coordination Supervisor Name (if applicable) Signature Date

FOR QMS ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
INITIAL RESPONSE

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

An **allegation** of a Serious Reportable Incident involving

Participant Name: _____ CIN: _____

was reported on: _____ by: _____
Date Discoverer

The incident number for this Serious Reportable Incident is: _____ - _____ - _____ - _____

This incident has been originally classified as: _____
Category(s) of Incident

Select one (A, B or C):

A. ☐ QMS agrees with original classification of this incident.

B. ☐ QMS does not agree with original classification of the incident and has re-classified the incident to:

☐ 1. Abuse and Neglect (select type):

☐ Physical Abuse ☐ Sexual Abuse ☐ Psychological Abuse ☐ Seclusion
☐ Use of Aversive Conditioning ☐ Violation of Civil Rights ☐ Mistreatment
☐ Neglect ☐ Exploitation ☐ Missing Person ☐ Restraint

☐ 2. Missing Person ☐ 3. Restraint ☐ 4. Death ☐ 5. Hospitalization
☐ 6. Possible Criminal Act ☐ 7. Medication Error/Refusal ☐ 8. Medical Treatment Due to Accident/Injury
☐ 9. Sensitive Situation

C. ☐ QMS has re-categorized this Serious Reportable Incident to a Recordable Incident status.

NOTE: QMS must also complete the QMS "Status Report" form and 'Close' this investigation.

The investigation has been assigned on: ____/____/____ to: _____
Date Provider Agency

located at: _____
Address

QMS Comments: _____

A Follow-Up Report is due:
within seven (7) calendar days of the date of this report: (Date Due) _____ **and**
within thirty (30) calendar days of the date of this report: (Date Due) _____

QMS Comments: _____

QMS Name Signature Date

Copy sent to: Reporting Provider Agency (date) _____ Investigating Provider Agency (date) _____
Regional Resource Development Specialist (date) _____ Service Coordinator (date) _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: _____/_____/_____

SERIOUS REPORTABLE INCIDENT
PROVIDER FOLLOW-UP REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name: _____ Incident #_____-_____-_____-_____

Check One:

_____ Seven Day Report _____
Date Completed

_____ Thirty Day Report _____
Date Completed

_____ Additional Follow-Up Report(s) _____
Date Completed

1. What actions (initial or newly conducted) have been taken to investigate this incident (e.g person(s) interviewed, record review, consultations, etc)?
   NOTE: Attach all supporting documentation

2. What have been the results of these actions?

3. What follow-up actions have been taken in response to these results (e.g., changes to the Service Plan, staff changed, police called, etc.)?

4. What has been the results of these follow-up actions (e.g., NHTD waiver participant's behavior has changed, NHTD waiver participant is more satisfied with staff, safety of NHTD waiver participant has been secured, etc)?

SERIOUS REPORTABLE INCIDENT
PROVIDER FOLLOW-UP REPORT (cont.)

5. What, if any, long term activities has the provider initiated to decrease, either in frequency or intensity, the possibility of similar incidents occurring in the future?

6. What activities are necessary to complete the investigation?

7. At this time, do you expect that this incident should remain open or closed? Why?

Agency Investigator	Signature	Date
Responsible Provider Representative	Signature/Title	Date
Provider Agency		Telephone

For Investigating Agency:
Copy of this report was sent to: QMS _____ Date

For QMS:
Copy of this report was sent to: RRDS _____ Date

Service Coordinator _____ Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

New York State Department of Health
Division of Home and Community Based Services

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
STATUS REPORT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name: _____ CIN: _____

___ This incident has been re-categorized as a Recordable Incident as indicated on the QMS Initial Response form and is considered **CLOSED.**

QMS Comments: _____

_____

QMS received a Follow-Up Report on: _____ for incident #: _____-_____-_____-_____
Date

_____
Investigating Provider Agency

_____
Address

_____
Provider Representative Agency Investigator

___ The incident has been re-classified**.** (Please change your database to reflect this revised classification). The incident was re-classified as: _____

QMS Comments: _____

_____

Check One:

___ The incident is considered **OPEN**. Further follow-up/intervention/clarification is required. A Serious Reportable Incident Follow-Up Report must be submitted by: _____

QMS Comments: _____

_____

___ The incident is considered **CLOSED**. No further action is necessary.
Final Classification: _____

QMS comments: _____

_____

_____

_____
QMS Signature Date

_____

Copy sent to: RRDS Date: _____
Service Coordinator Date: _____
Investigating Provider Date: _____

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____

SERIOUS REPORTABLE INCIDENT
QUALITY MANAGEMENT SPECIALIST
POST-INVESTIGATION FOLLOW-UP CONTACT WITH PARTICIPANT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

Participant Name _____ Incident Number _____

Person(s) Contacted:

___ Participant Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

___ Other Person _____ Relationship to Participant: _____
Date Notified: _____ Time Notified: ____ am/pm

Participant/Legal Guardian Comments: _____

QMS Comments: _____

QMS Name Signature Date

Copy of this form was sent to: RRDS _____ Date

Service Coordinator _____ Date

Investigating Agency _____ Date

FOR QMS USE ONLY:
Form Sent to DOH WMS Date: ___/___/_____