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Authorized Signature

Number: APD-PT-16-034

Issue date: 9/26/2016

Topic: Other

Transmitting (check the box that best applies):

- New policy
 Policy change
 Policy clarification
 Executive letter
 Administrative Rule
 Manual update
 Other: _____

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input checked="" type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input checked="" type="checkbox"/> Aging and People with Disabilities | <input type="checkbox"/> Office of Developmental
Disabilities Services(ODDS) |
| <input type="checkbox"/> Self Sufficiency Programs | <input type="checkbox"/> ODDS Children's Intensive
In Home Services |
| <input type="checkbox"/> County DD Program Managers | <input type="checkbox"/> Stabilization and Crisis Unit (SACU) |
| <input type="checkbox"/> ODDS Children's
Residential Services | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Child Welfare Programs | |

Policy/rule title:	Report of Serious Event (ROSE) Guidelines and Procedures		
Policy/rule number(s):		Release no:	
Effective date:	Immediately	Expiration:	
References:			
Web address:			

Discussion/interpretation:

The purpose of this transmittal is to clarify guidelines and procedures for submitting the 09-2016 revised Report of Serious Event (ROSE) Form.

Implementation/transition instructions:

The ROSE Form is designed to alert Central Office staff of a serious event that could result in an immediate need for action to ensure safety of consumers in licensed care facilities or in-home settings. This notification also allows DHS Communications and Management to knowledgeably respond to media or other inquiries. Submission of the ROSE Form automatically ensures delivery to identified staff.

Completion of the ROSE Form must occur *immediately* following initial notification of the event. The ROSE Form should include only factual information. Please do not include assumptions, opinions, or judgments.

Possible reasons for submitting a ROSE Form include, but are NOT limited to:

- Physical assaults
- Sexual assaults
- Elopements
- Physical abuse or neglect that results in hospitalization, serious injury, or death
- Suicide
- Threat of violence or actual violence (including domestic violence)
- Media contact or potential for media contact related to an event

AAA/APD field staff and managers should collaboratively decide when to submit a ROSE Form. Effective immediately, please use the revised (9-2016) ROSE Form (APD 0307).

ROSE Forms should be resubmitted as new information becomes available. When submitting updates, please check the box at the top of the ROSE Form indicating a resubmission.

Once information from the ROSE Form has been reviewed by Central Office staff, follow-up communication with field office staff and/or other agency partners may occur to discuss a course of action.

The Law Enforcement Agency Notification (APD 0307a) is no longer combined with the ROSE Form (APD 0307). A check box has been added to the ROSE Form (APD 0307) to indicate whether law enforcement has been notified. Please continue to use the Law Enforcement Agency Notification (APD 0307a), to notify law enforcement as appropriate.

Training/communication plan:

Technical assistance will be provided to field offices as needed.

Local/branch action required:

Please distribute this transmittal to all staff, especially case managers, licensors, surveyors, and APS specialists.

Central office action required: Provide technical assistance as necessary.

Field/stakeholder review: Yes No

If yes, reviewed by: APD Policy Group

Filing instructions:

If you have any questions about this policy, contact:

Contact(s):	Marsha Ellis or Becky Callicrate		
Phone:	Marsha: 503-945-6415; Becky: 503-945-6601	Fax:	
Email:	MARSHA.M.ELLIS@dhsoha.state.or.us Becky.CALLICRATE@dhsoha.state.or.us		

Report of Serious Event (ROSE)



Check here if this is an update to a previously submitted ROSE.

Local office information

Today's date:	Date of incident:	Branch name and number: Choose one A-L Choose one M-Z	
AAA/APD manager name:		Manager phone:	Manager email:
Name of person completing form:		Phone:	Email:
Has law enforcement been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of notification: _____ Law enforcement agency contacted: _____ Law enforcement agency contact: _____ Phone: _____ <input type="checkbox"/> Law enforcement has requested that no further action be taken until they notify us			
Has a death occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of death, if known: _____	
Allegation of abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Abuse type, if known: _____	
Provide a brief summary of incident. Include key facts about the incident and any involvement with the media, elected officials, other agencies, or community partners. Please include any actions taken to respond and to ensure individuals' safety thus far (<i>this box will expand as needed</i>):			

Reported victim information

Reported victim:	Medicaid consumer <input type="checkbox"/> Yes <input type="checkbox"/> No	Prime number (<i>if applicable</i>):
Address:	Phone number:	Setting: Choose one
City/state/ZIP code:		
Please note any previous contact with this individual:		
Are there additional victims? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) below:		

Reported perpetrator(s):

Is the reported perpetrator an individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the reported perpetrator a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please note — it can be both.)</i>	
Reported perpetrator name	Perpetrator title: Choose one
Street address:	Phone number:
City/State/ZIP code:	
Are there additional reported perpetrators? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s):	

Provider Information — Please list the full name and contact information for the provider involved.

Provider name:	
Facility type <i>(if applicable)</i> : Choose one	Endorsed Memory Care Community (MCC) <input type="checkbox"/> Yes <input type="checkbox"/> No
Street address:	Provider phone number:
City/State/ZIP code:	
Provider license or Medicaid provider number	Number of residents currently living in facility:

After clicking the **“Submit Request”** button below, a new email message will appear. Please:

1. Fill in the **“To”** section of the email message with OLRO.ROSE@dhsosha.state.or.us.
2. Add the provider’s name in the subject line.
3. Send email.

Note: Your completed ROSE Form will automatically attach to the email when you click the **“Submit Request”** button below.

Submit Request