

**REPORTING FACILITY**

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
(Street/PO Box) (City/State) (Zip code)

**REPORTING PARTY**

Name: \_\_\_\_\_  
(Last) (First) (Title/Position)  
 Address: \_\_\_\_\_  
(Street/PO Box) (City/State) (Zip code)  
 Work Telephone: \_\_\_\_\_ Work E-mail: \_\_\_\_\_

**INCIDENT INFORMATION**

Date of Incident (on or about): \_\_\_\_\_

Name of resident(s) involved	Cognitive status of resident(s)	Description of injury, if any

Information upon which this report is being made is as follows: (Please include a specific description of the incident, who was involved, what happened, when it happened, where it happened and how it happened)

**Corrective Actions taken in response to this incident:**

**For licensed nurse(s),** was report made to the Ks State Board of Nursing? \_\_\_\_Yes\_\_\_\_No

**Plan for monitoring the on-going effectiveness of the corrective action plan through QAA program or other:**

Quality Assurance & Assessment guidance resource: S & C Letter 06-11 at <http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp>

**For reporting suspected crime in a LTC facility in accordance with the Affordable Care Act (Certified facilities only):**

Date and time report made to Law Enforcement \_\_\_\_\_ LE case number: \_\_\_\_\_

List of covered individuals who were present or had knowledge of the incident:

**Attachments:**

- ✓ Facility Investigative Report & supportive documentation. Please include MDS, care plan, nursing notes pertinent to the incident. For state licensed only ACH such as ALF, RHCF, Home Plus, etc. submit copies of the FCS, NSA and Health Care Plans as appropriate.
- ✓ Nurse Aide Registry verification if the alleged perpetrator is a CNA and/or CMA and copy of certificate
- ✓ Copy of license if the alleged perpetrator is a licensed nurse
- ✓ List of witnesses and original **Notarized witness statements** from those individuals regarding abuse, neglect or exploitation alleged to have been committed by a facility staff member.
- ✓ Completed Alleged Perpetrator Information form (if applicable)

**Attestation Statement:** I certify that all the information given is true and correct.

Signature of person completing the investigation

Printed name

Title

Date

Please send completed investigation and attachments within 5 working days to:

**Regional Manager review/comments/recommendations:**

RM Signature

Date

**ALLEGED PERPETRATOR INFORMATION FORM**

Facility: \_\_\_\_\_  
City: \_\_\_\_\_

**ALLEGED PERPETRATOR INFORMATION:**

Name: \_\_\_\_\_  
(Last) (First) (MI) (Alias)

Address: \_\_\_\_\_  
(Street/PO Box) (City/State) (Zip code)

Telephone: \_\_\_\_\_

Please ensure the following information is attached or provided with this form.

- EVIDENCE OF PRE-EMPLOYMENT SCREENING & TRAINING ON ANE FOR THIS EMPLOYEE**
- COPY OF CERTIFICATE OR LICENSE**
- ALLEGED PERPETRATOR'S NOTARIZED STATEMENT**

Date of Hire: \_\_\_\_\_

Was the AP Suspended? \_\_\_\_\_ If suspended, date(s) of suspension \_\_\_\_\_

Was the AP Terminated? \_\_\_\_\_ If terminated, date of termination: \_\_\_\_\_

**CREDENTIALING/LICENSURE INFORMATION:**

Certificate or License No. \_\_\_\_\_

Type if Certification (check all that apply)

NAT  CNA  CMA  HHA  AD  SSD  Other

NAT = Nurse Aide Trainee I or II      CNA = Certified Nurse Aide      CMA = Certified Medication Aide  
HHA = Home Health Aide      AD = Activity Director      SSD = Social Service Designee

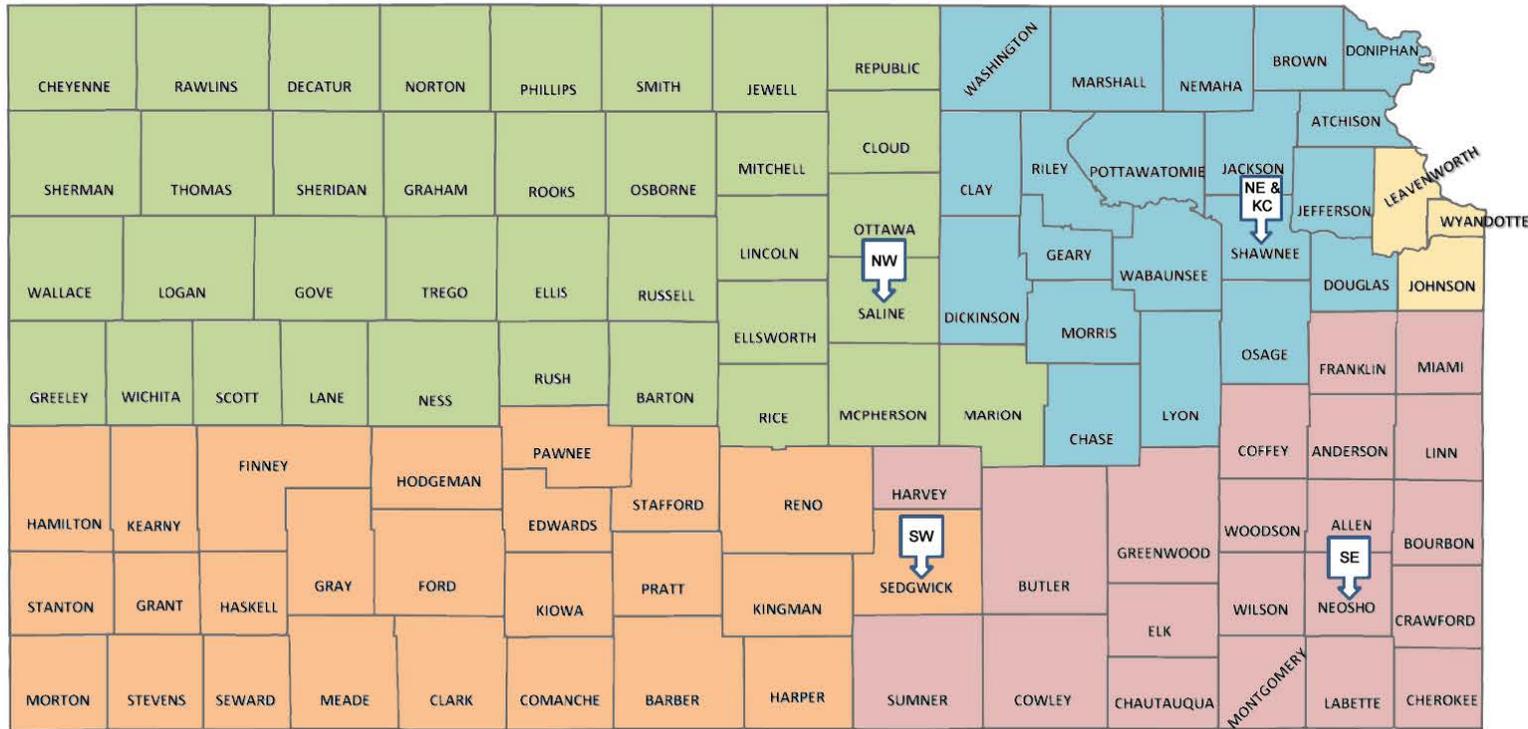
Type of License (check all that apply)

ACHA  RN  LPN  RPT  OT  LMHT  Licensed SW

ACHA = Adult Care Home Administrator      RN = Registered Nurse      LPN = Licensed Practical Nurse  
RPT = Registered Physical Therapist      OT = Occupational Therapist      LMHT = Licensed Mental Health Tech  
Licensed SW = Licensed Social Worker



## Survey, Certification and Credentialing Commission District Offices



### Kansas City District Office

Denise German, Regional Manager  
612 S. Kansas Ave.  
Topeka, Kansas 66603  
(785) 368-6552  
Fax: (785) 296-0256  
denise.german@kdads.ks.gov

### Northeast District Office

Kim Barnes, Regional Manager  
612 S. Kansas Ave.  
Topeka, KS 66603  
(785) 296-1256  
Fax: (785) 296-0256  
kim.barnes@kdads.ks.gov

### Northwest District Office

Sue Hine, Regional Manager  
2501 Market Place, Suite D  
Salina, KS 67401  
(785) 827-9639  
Fax: (785) 827-4201  
sue.hine@kdads.ks.gov

### Southwest District Office

Teresa Fortney, Regional Manager  
266 N. Main, Suite 230  
Wichita, KS 67202  
(316) 337-6063  
Fax: (316) 337-6731  
teresa.fortney@kdads.ks.gov

### Southeast District Office

Janice Van Gotten, Regional Manager  
1500 W. 7th  
Chanute, KS 66720  
(620) 432-5115  
Fax: (620) 431-0972  
janice.vangotten@kdads.ks.gov

### State Licensed-Only

Patty Brown, Regional Manager  
612 S. Kansas Ave.  
Topeka, KS 66603  
(785) 296-1269  
Fax: (785) 296-0256  
patty.brown@kdads.ks.gov