**KANSAS DEPT FOR AGING & DISABILITY SERVICES CP Number:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **REPORTING FACILITY** | | | | | |
| Name: Phone No.:  Address: E-mail Address:  (Street/PO Box) (City/State) (Zip code) | | | | |  |
|  |
|  |
| **REPORTING PARTY** | | | | | |
| Name:  Address: Work Tele |  | | | | |
| (Last) (First) (Title/Position) | | | | |
| (Street/PO Box) (City/State)  phone: Work E-mail: | | (Zip code) | | |
|  | | |
| **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 |

# Case Number:

**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 HHA = Home Health Aide

CNA = Certified Nurse Aide AD = Activity Director

CMA = Certified Medication Aide SSD = Social Service Designee

Type of License (check all that apply)

ACHA RN LPN RPT OT LMHT Licensed SW

ACHA = Adult Care Home Administrator RPT = Registered Physical Therapist Licensed SW = Licensed Social Worker

RN = Registered Nurse

OT = Occupational Therapist

LPN = Licensed Practical Nurse

LMHT = Licensed Mental Health Tech