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: _____

(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

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
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