Kansas Department of Health & Environment
Bureau of Community Health Systems / Health Facilities Program
1000 SW Jackson, Suite 330 Topeka, Kansas 66612

CP Number: _____

REPORTING FACILITY

Name: _____ Phone No.: _____

Address: _____ E-mail Address: _____

(Street/PO Box) (City/State) (Zip code)

Facility ID: Administrator / CEO:

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 patient/client involved	Contact Information/DOB	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)

Witness(es) to the incident were: (Include name/contact information)

Corrective Actions taken in response to this incident:(Include specific measures and/or systemic changes made to ensure the safety & welfare of the patient/client and the person(s) responsible)

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 QA program: (How will solutions be sustained and integrated into the facility's QA program)

Law Enforcement Notification:

Date report made to Law Enforcement _____ LE case number: _____

Include name and contact information of law enforcement:

Attachments:

- ✓ Facility Investigative Report and all supportive documentation.
- ✓ All original **notarized witness statements** from those individuals regarding abuse, neglect or exploitation alleged to have been committed by a facility staff member.
- ✓ Copy of license if the alleged perpetrator is a licensed and or certified health professional.
- ✓ 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 the completed investigation and attachments by certified mail or FAX within 5 working days to:

Health Facilities Program Director
Kansas Department of Health & Environment
Bureau of Community Health Systems
1000 SW Jackson, Suite 330
Topeka, Kansas 66612 **FAX**: (785) 559-4250

ALLEGED PERPETRATOR INFORMATION FORM

Facility: _____

Address: _____

Contact: _____

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: _____

CERTIFICATION/LICENSURE INFORMATION: Include all certifications/licensure if in other state(s)

Certificate or License No. State Issued:

Certificate or License No. State Issued:

Certificate or License No. _____ State Issued:

Type if Certification (check all that apply)

☐ CNA ☐ CMA ☐ HHA ☐ AD ☐ SSD ☐ Other ☐

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)

ARNP ☐ RN ☐ LPN ☐ RPT ☐ OT ☐ LMHT ☐ Licensed SW ☐

MD ☐ PA ☐ OTHER ☐

ARNP = Advanced Reg. Nurse Practitioner
RN = Registered Nurse
LPN = Licensed Practical Nurse
RPT = Registered Physical Therapist
OT = Occupational Therapist
LMHT = Licensed Mental Health Tech
MD = Physician
PA = Physician Assistant
SW = Social Worker

Additional Information: