KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL – DIVISION OF HEALTH CARE
LONG TERM CARE FACILITY – SELF-REPORTED INCIDENT FORM
FINAL REPORT/5 DAY FOLLOW-UP

FORM MUST BE COMPLETED AND RETURNED TO THE APPROPRIATE BRANCH OFFICE WITHIN FIVE (5) BUSINESS DAYS OF THE INCIDENT

PART A

Facility Name: _____ CCN: _____

Address: _____
Street City State Zip Code

Phone: _____ Email Address: _____

Incident Date/Time: _____ Incident Location: _____

Administrator Notification Date/Time: _____

Resident(s)/Clients(s) Involved:
_____
_____
_____

Witness(es) [Name, position *(if staff)*, relationship, and contact information *(if known)*]:
_____
_____
_____

PART B – **Additional/Updated Information Related to the Initial Reported Incident**

Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm:

Describe whether the allegation was reported to the resident representative, and if so, date/time:

Describe whether the allegation was reported to another agency, and if so, which agency, date/time, and outcome if they conducted an investigation:

Steps Taken to Investigate the allegation – Provide a detailed summary of ALL steps taken to investigate the allegation.

Summary of interview(s) with the alleged victim and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress:

Summary of interview(s) with witness(es), what the individual observed or knowledge of the alleged incident or injury:

Summary of interview(s) with the alleged perpetrator(s) (staff, resident, visitor, contractor, etc.):

Summary of interview(s) with other residents who may have had contact with the alleged perpetrator:

Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides:

Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident:

Provide summary information from the investigation related to the incident from the resident's clinical record, such as relevant portions of the Resident Assessment Instrument (RAI), the resident's care plan, nurses' notes, social services note, lab reports, x-ray reports, physician or other practitioner reports or reports from other disciplines that are related to the incident. If a resident-to-resident altercation occurred, provide any relevant details that may have caused the alleged perpetrator's behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or BIMS score:

If available within the five-business day timeframe, provide summary information of other documents obtained, such as hospital/medical progress notes/orders & discharge summaries, law enforcement reports, and death reports as applicable:

PART C – **Conclusion**

Provide a brief description of the conclusion of the investigation and if the findings were verified, not verified, or inconclusive:

Provide in detail a summary of all corrective action(s) taken. If the allegation is verified, describe the plan for oversight of implementation of corrective action:

Provide the name of the facility individual who had the primary responsibility for conducting the investigation:

Form to be returned to the appropriate branch:

- Western Branch Phone: 270-889-6052 Fax: 270-889-6089 E-Mail: WEB.Complaints-Reports@ky.gov
- Northern Branch Phone: 502-595-4958 Fax: 502-595-4540 E-Mail: NEBComplaints-Reports@ky.gov
- Southern Branch Phone: 606-330-2030 Fax: 606-330-2054 E-Mail: SEBComplaints-Reports@ky.gov
- Eastern Branch Phone: 859-246-2301 Fax: 859-246-2307 E-Mail: EEB.Complaints-Reports@ky.gov

Reporting Party

Date/Time Report Submitted

Reporting Party's Contact Number

Reporting Party's Email Address