IOWA DEPARTMENT OF

INSPECTIONS & APPEALS

Thomas J. Vilsack, Governor **Sally J. Pederson, Lt. Governor**
Steven K. Young, Director

FACILITY COMPLAINT INVESTIGATION REPORT FORM

(Please attach additional sheets as needed.)

Today's Date_____ **Intake Number:_____**

REPORTING FACILITY

Name: _____Phone No.: (____)_____

Address: _____

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

E mail address: _____

Licensure of facility where incident occurred: ❑RCF ❑NF ❑SNF ❑ALP ❑ICF/MR ❑Hospital

REPORTING PARTY

Name:_____

(Last) (First) (Middle initial) (Title/position)

Address: _____

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

Telephone: (____)_____ (____)_____

(Work) (Home)

INCIDENT INFORMATION

Date of Incident or date possession was reported missing (on or about): _____.
Date facility became aware of the incident _____.

Information upon which this report is being made is as follows: (Please include a specific description of the incident, including the date, time, and location of the alleged incident. If the incident is a resident to resident incident/altercation, include any prior history of either/both residents regarding this type of behavior. If the report is in regard to a missing possession, please include a specific description of the possession, including where the item was kept, the time and date it was last seen, and if you have an alleged perpetrator. If you have identified an alleged perpetrator, complete page 3.

Do you suspect theft? Yes ☐ No ☐

Does the resident have a history of false allegations? Yes ☐ No ☐

Include the Name and Cognitive Status of Resident(s) involved:

_____

_____

If injured, please describe the injury and any medical treatment required:_____

_____

_____

Corrective Actions Taken by the Facility:

_____

_____

_____

_____**If this report is in regard to a missing item and the item is found after this form is submitted, please contact the Department.**

Report made to law enforcement? ☐ Yes ☐ No

Police Case # _____

Name, telephone number, e-mail address and mailing address of law enforcement contact.

_____

_____

_____

_____

Facility must submit the following attachments:

- ❑ A one page summary of the Facility's Investigation. Please include the name of the resident/s involved, any staff involved and their position (CNA, LPN, RN etc.), the names of any witnesses and a summary of any statements, and details of the allegation which you are reporting.
- ❑ Completed Alleged Perpetrator Information Form (if applicable).

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

_____

Name of Person Completing Form Title Date

Please return completed form within 5 working days via fax, e-mail or regular mail to:

Program Coordinator for the Complaint Unit, Department of Inspections and Appeals, Health Facilities Division,
Lucas State Office Building,
Des Moines, Iowa 50319-0083
Complaint Unit Fax (515) 281-7106

THE REPORTING ENTITY SHOULD RETAIN A COPY OF THE REPORT FORM

Program Coordinator Use Only: Review of information has been completed. **Onsite investigation: Yes ❑ No ❑**

Comments:

_____

Signature **Date**

ALLEGED PERPETRATOR (AP) INFORMATION FORM

TO BE COMPLETED BY THE FACILITY

Facility:

City:

ALLEGED PERPETRATOR INFORMATION:

Name:_____

Last First MI Alias

Address:_____

Street/Box City State Zip Code

Telephone Number: ( ) _____ Soc. Security #: _____

Date of Hire:_____

AP Suspended? YES ❑ NO ❑ Date: _____ AP Terminated? YES ❑ NO ❑ Date: _____

CREDENTIALING/LICENSURE INFORMATION

Certificate or License No. _____

(Attach copy of certificate/license)

Type of **Certification** (check all that apply) CNA ❑ CMA ❑ HHA ❑ AD ❑ SSD ❑ QMRP ❑

Other ❑ Specify_____

CNA = Certified Nurse Aide CMA = Certified Medication Aide

HHA = Home Health Aide AD = Activities Director

QMRP = Qualified Mental Retardation Professional SSD = Social Service Designee

OR

Type of **License** (Check all that apply):

ACHA ❑ RN ❑ LPN ❑ RPT ❑ OT ❑ LMHT ❑ LSW ❑ Other: ❑ specify_____

ACHA = Adult Care Home Administrator RN = Registered Nurse LPN = Licensed Practical Nurse

RPT = Registered Physical Therapist OT = Occupational Therapist

LMHT = Licensed Mental Health Technician LSW = Licensed Social Worker

THIS SECTION TO BE COMPLETED BY THE PROGRAM COORDINATOR:

DIA No:_____

Comments:_____

_____

_____

_____

Onsite investigation: Yes ☐ No ☐

Complaint Unit Program Coordinator's Signature:_____ Date: _____