



KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT  
Risk Management Program  
Confidential Quarterly Report Pursuant to KSA 65-4923(d)  
Please type or use a black pen when completing this form.

Reports are due to KDHE within 30 days of each completed quarter.

Confidential Cover Page

Quarterly Report (QR) Pursuant to KSA 65-4923(d)

(d) Each review and executive committee referred to in subsection (a) shall submit to the Secretary of Health and Environment, on a form promulgated by such agency, at least once every three months, a report summarizing the reports received pursuant to subsections (a)(2) and (a)(3) of this section. The report shall include the number of reportable incidents reported, whether an investigation was conducted and any action taken.

Reporting Year \_\_\_\_\_ Reporting Quarter \_\_\_\_\_

Check this box if this is an amendment to a previous QR report submitted. What Quarter? \_\_\_\_

Name of Facility \_\_\_\_\_ \*CCN# (Format: Year – Number) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Name and Title of Risk Manager: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Sent to KDHE: \_\_\_\_\_

\*CCN is CMS Certification Number: If your facility is not CMS Certified, please list State ID#

With this submission, as the above listed Risk Manager I hereby attest that the report submitted to Kansas Department of Health and Environment is true, complete and accurate to the best of my knowledge without known errors or omissions.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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Facility Name: \_\_\_\_\_ CCN#: \_\_\_\_\_

City: \_\_\_\_\_

1. Facility Type:  Hospital  Psychiatric Hospital  Ambulatory Surgical Center  Other

2. Year: \_\_\_\_\_

Reporting Quarter: Jan. – March  April – June  July – Sept.  Oct. – Dec.

3. Total number of final SOC determinations by the facility’s risk management program this quarter:

a. \_\_\_\_\_ Total number of final SOC III (standard of care not met with injury occurring or reasonably probable) determinations.

b. \_\_\_\_\_ Total number of final SOC IV (possible grounds for disciplinary action by the appropriate licensing agency) determinations.

4. Specify the individual number of reports submitted to each of the following licensing agencies:

(Please note: Including the facility’s Incident Report Number (IRN) ID number(s) for each incident, or SOC assignment creates a common numbering system that can be used by both KDHE and the appropriate licensing agency. KDHE can then track the report, if needed, to confirm that it was submitted to the licensing agency.)

# \_\_\_\_\_ Board of Healing Arts – facility Incident Report Number(s) (IRN): \_\_\_\_\_

# \_\_\_\_\_ Board of Nursing – facility Incident Report Number(s) (IRN) : \_\_\_\_\_

# \_\_\_\_\_ Board of Pharmacy – facility Incident Report Number(s) (IRN): \_\_\_\_\_

# \_\_\_\_\_ Dental Board – facility Incident Report Number(s) (IRN): \_\_\_\_\_

# \_\_\_\_\_ KDHE – facility Incident Report Number(s) (IRN): \_\_\_\_\_

# \_\_\_\_\_ Other: \_\_\_\_\_

(Specify other agency name) – Facility Incident Report Number(s) (IRN): \_\_\_\_\_

5. Indicate the category type of each individual incident/occurrence such as:

- |  |   |
|--|---|
| <input type="checkbox"/> Fall  | <input type="checkbox"/> Documentation of Narcotics |
| <input type="checkbox"/> Abuse, neglect or Exploitation                    | <input type="checkbox"/> Medication Error           |
| <input type="checkbox"/> Assessment / treatment                            | <input type="checkbox"/> Improper Procedure         |
| <input type="checkbox"/> Professional licensure event                      | <input type="checkbox"/> EMTALA-Related             |
| <input type="checkbox"/> Delay   | <input type="checkbox"/> IV line mix-up             |
| <input type="checkbox"/> Facility process or system-related                | <input type="checkbox"/> Drug Diversion             |
| <input type="checkbox"/> Scope of Practice                                 | <input type="checkbox"/> Unprofessional conduct     |
| <input type="checkbox"/> Falsification                                     | <input type="checkbox"/> IV infiltration            |
| <input type="checkbox"/> Impairment due to drug / alcohol                  | <input type="checkbox"/> Other: (explain)           |
| <input type="checkbox"/> Impairment physical, mental, emotional, cognition |   |



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Nelleda L. Faria, RN, BSN, MBA, PMP, CPHRM

Risk Manager/OASIS Education Coordinator

KDHE / BCHS / Health Facilities Program

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Fax: 785-559-4250

[KDHE.Riskmanagement@ks.gov](mailto:KDHE.Riskmanagement@ks.gov)

**Return this report to:**

LaDonna Lee

Sr. Administrative Assistant/RM Coordinator

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Topeka, KS. 66612-1365

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Fax: 785-559-4250

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Data Collection Purpose: The purpose of the data collection activity is solely for usage as business analytics for the KDHE Risk Management Program. This includes but is not limited to overall Risk Management Program business intelligence, enterprise information management, enterprise performance management, analytic applications, and governance, risk, and compliance.

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