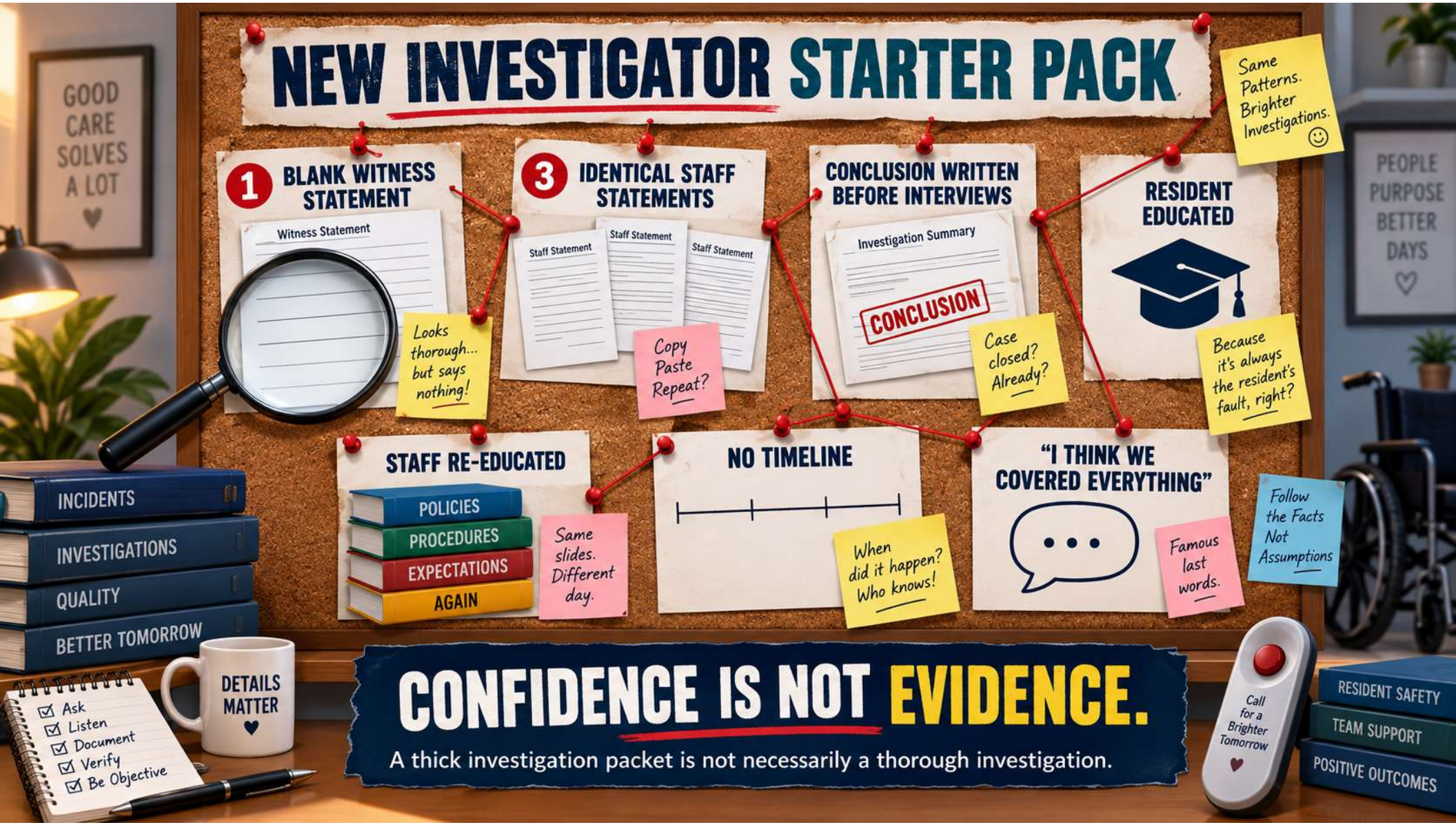

NEW INVESTIGATOR STARTER PACK
Same Patterns. Brighter Investigations.
1 BLANK WITNESS STATEMENT
Witness Statement
Looks thorough... but says nothing!
3 IDENTICAL STAFF STATEMENTS
Staff Statement
Staff Statement
Staff Statement
Copy Paste Repeat?
CONCLUSION WRITTEN BEFORE INTERVIEWS
Investigation Summary
CONCLUSION
Case closed? Already?
RESIDENT EDUCATED
Because it's always the resident's fault, right?
STAFF RE-EDUCATED
POLICIES
PROCEDURES
EXPECTATIONS
AGAIN
Same slides. Different day.
NO TIMELINE
When did it happen? Who knows!
"I THINK WE COVERED EVERYTHING"
Famous last words.
Follow the Facts Not Assumptions
GOOD CARE SOLVES A LOT
PEOPLE PURPOSE BETTER DAYS
INCIDENTS
INVESTIGATIONS
QUALITY
BETTER TOMORROW
DETAILS MATTER
Ask
Listen
Document
Verify
Be Objective
CONFIDENCE IS NOT EVIDENCE.
A thick investigation packet is not necessarily a thorough investigation.
Call for a Brighter Tomorrow
RESIDENT SAFETY
TEAM SUPPORT
POSITIVE OUTCOMES

THREE SITUATIONS YOU NEVER FORGET

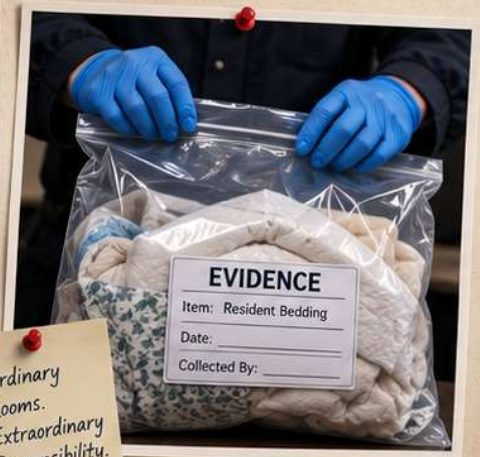
Same People. Safer Care. That's the Work.

Different Cases. Same Lesson. Be Prepared.

Details Matter. Residents Count. So Does Integrity.

THE EVIDENCE BAG

A detective begins bagging resident bedding.



Ordinary Rooms. Extraordinary Responsibility.

THE DETENTION CENTER CALL

An employee sent resident photos and videos to an inmate's tablet.

One Call Can Uncover a Lot.

Digital Choices Have Real Consequences.

THE DRUG DIVERSION INVESTIGATOR

An investigator from the Kansas Attorney General's Office enters your office.

MISSING MEDICATION. PERFECT COUNT. NOW WE HAVE TWO MYSTERIES.

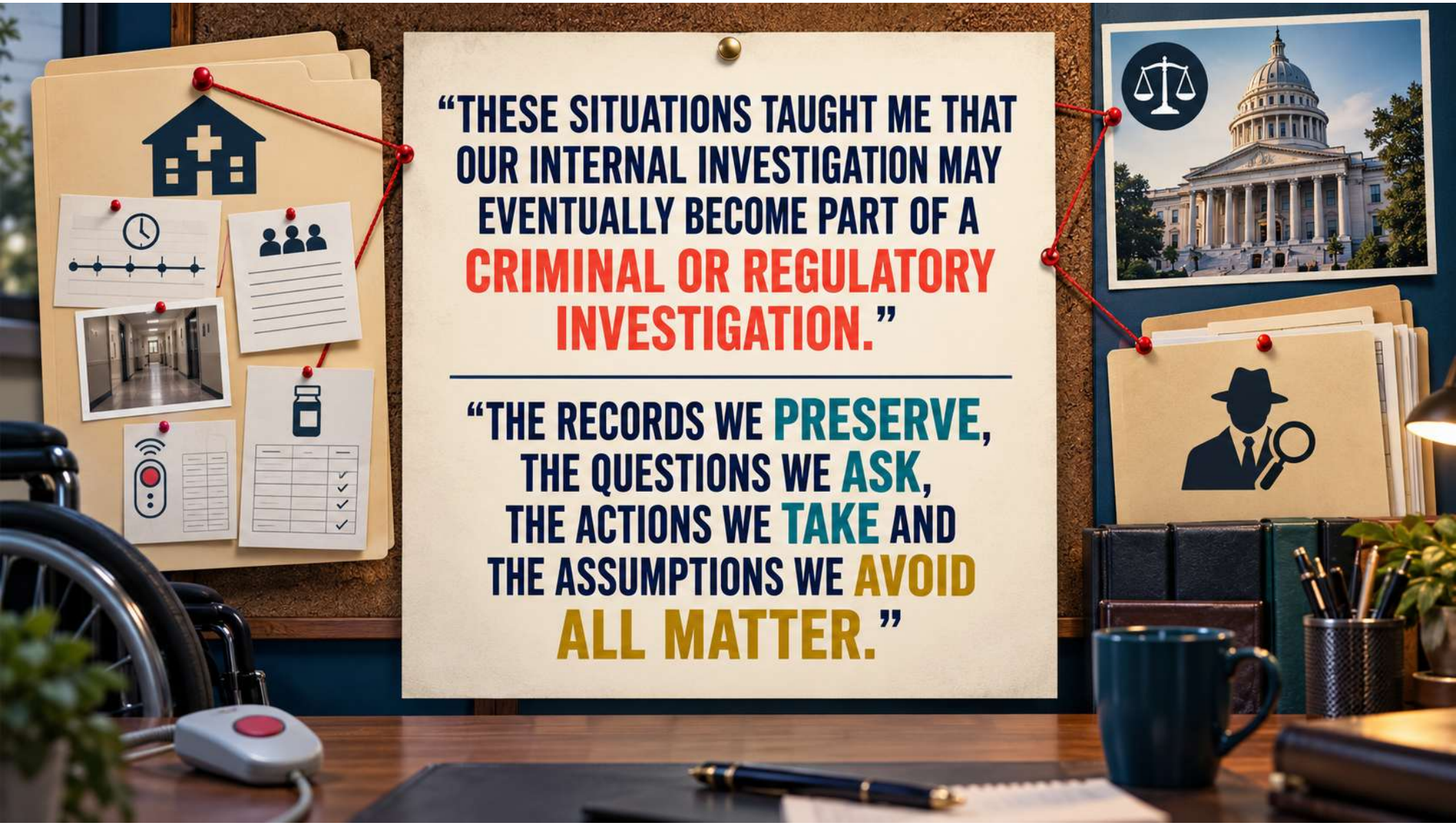
Investigate
Understand
Improve
Protect
Residents

OBSERVE
ASK
VERIFY
DOCUMENT
MAKE A DIFFERENCE

GOOD QUESTIONS LEAD TO SAFER CARE

YOUR INVESTIGATION MAY BECOME SOMEONE ELSE'S EVIDENCE.

Integrity today. Better tomorrow.


"THESE SITUATIONS TAUGHT ME THAT OUR INTERNAL INVESTIGATION MAY EVENTUALLY BECOME PART OF A CRIMINAL OR REGULATORY INVESTIGATION."
"THE RECORDS WE PRESERVE, THE QUESTIONS WE ASK, THE ACTIONS WE TAKE AND THE ASSUMPTIONS WE AVOID ALL MATTER."


THESE SITUATIONS WERE VERY DIFFERENT,
BUT THEY ALL REQUIRED THE SAME BASIC RESPONSE:
PROTECT THE RESIDENT.
PRESERVE THE EVIDENCE.
ESTABLISH THE FACTS.
FOLLOW EVERY REASONABLE LEAD.
DOCUMENT HOW THE FINAL DECISION WAS MADE.
THE DETAILS WILL ALWAYS CHANGE.
THE INVESTIGATIVE FOUNDATION SHOULD NOT.

MY BARE-BONES ANE INVESTIGATION GUIDE

This is not the investigation. It is the structure that keeps it from falling apart.

1	**DEFINE**	What was alleged? When, where and who?
2	**ASSESS**	Injury • pain • cognition • resident's words
3	**PROTECT**	Separate • treat • safeguard others • preserve
4	**REPORT**	Leadership • physician • representative • authorities
5	**COLLECT**	Interviews • records • environment • electronic evidence
6	**ANALYZE**	Timeline • conflicts • findings • root causes
7	**CORRECT**	Intervene • monitor • follow up • QAPI

THE TEMPLATE GIVES ME THE BONES. THE FACTS DETERMINE WHERE THE INVESTIGATION GOES.


WHAT MY GUIDE PREVENTS ME FROM FORGETTING
Every critical action needs an owner—and every unfinished task needs to remain visible.
✓ Resident protection
✓ Clinical assessment
✓ Evidence preservation
✓ Care-plan changes
✓ Measurable monitoring
✓ Resident and representative follow-up
✓ Required reporting
✓ Independent interviews
✓ Other residents at risk
✓ Root-cause analysis
✓ Leadership and legal review
✓ A conclusion supported by facts
“I THOUGHT SOMEONE ELSE HANDLED IT” IS NOT AN INVESTIGATIVE STRATEGY.

THE GUIDE IS NOT THE INVESTIGATION

A checklist provides structure. Skilled investigators still have to think.

WHAT THE GUIDE DOES

- Establishes the bases to cover
- Creates consistency under pressure
- Assigns responsibility
- Tracks incomplete tasks
- Prompts notifications
- Organizes evidence
- Connects findings to action

WHAT THE INVESTIGATOR MUST DO

- Think critically
- Ask follow-up questions
- Resolve inconsistencies
- Expand the scope when needed
- Evaluate credibility objectively
- Recognize patterns
- Tailor actions to the facts

A CHECKLIST CAN TELL YOU WHERE TO LOOK. IT CANNOT TELL YOU WHAT THE EVIDENCE MEANS.

THE INVESTIGATION ROADMAP

A strong investigation follows a repeatable path.

1. **Receive the concern**
2. **Protect residents immediately**
3. **Report and preserve evidence**
4. **Interview, build and test the timeline**
5. **Conclude, correct and monitor**

The details change. The investigative foundation should not.

THE FIRST 15 MINUTES

Protection begins before the paperwork.

1. Separate the alleged perpetrator when appropriate
2. Assess and protect the resident
3. Identify other residents who may be at risk
4. Preserve the scene, records and electronic evidence
5. Assign one lead investigator and begin the decision log

Before you open Word, make sure you have protected the resident.

DEFINE THE ALLEGATION

You cannot thoroughly investigate what you have not clearly defined.

VAGUE: “The aide was rough.”

INVESTIGATION-READY: What occurred? Who was involved? When and where? Who may have witnessed it?

Separate every allegation—and let new evidence expand the scope.

WHAT EVIDENCE COULD DISAPPEAR?

Preserve it before normal operations erase it.

PEOPLE

Residents • staff • roommates • visitors • contractors

PAPER

MAR/TAR • assignments • count sheets • care plans

ELECTRONIC

Audit trails • call lights • video • door access

PHYSICAL

Room layout • bedding • clothing • equipment

If it can be moved, washed, overwritten or forgotten—secure it now.

WHO KNOWS SOMETHING?

The best witness is not always wearing scrubs.

OBVIOUS

Resident • accused employee • assigned nurse • direct witness

OFTEN MISSED

Roommate • housekeeper • dietary • therapy • previous shift • agency staff • family

Ask who had access, opportunity, proximity—or noticed a change.

INTERVIEW LIKE AN INVESTIGATOR

Use Tell → Clarify → Verify.

LEADING: “You were trying to keep her from falling, correct?”

NEUTRAL: “Describe what happened from the moment you entered the room.”

Listen first. Narrow the questions second. Test the account against evidence third.

BUILD THE TIMELINE

Put every fact in order—and the gaps become visible.

- **9:42 Last observed in bed**
- **9:51 Call light activated**
- **9:54 Second announcement**
- **9:58 Aide charts in another room**
- **10:03 Resident found on floor**

What does the timeline prove—and what does it only suggest?

PUT THE EVIDENCE ON TRIAL

Do not force the evidence to agree. Explain what it means.

1. **What facts were established?**
2. **What supports or contradicts the allegation?**
3. **Are the accounts physically possible?**
4. **Which inconsistencies remain unresolved?**
5. **What additional evidence is reasonably available?**

Confidence is not evidence. Neither is repetition.

INVESTIGATION ≠ ROOT-CAUSE ANALYSIS

Three different questions. Three different jobs.

INVESTIGATION	ROOT CAUSE	ACTION PLAN
What happened?	Why did it happen—and why did safeguards fail?	What will prevent recurrence and prove improvement?

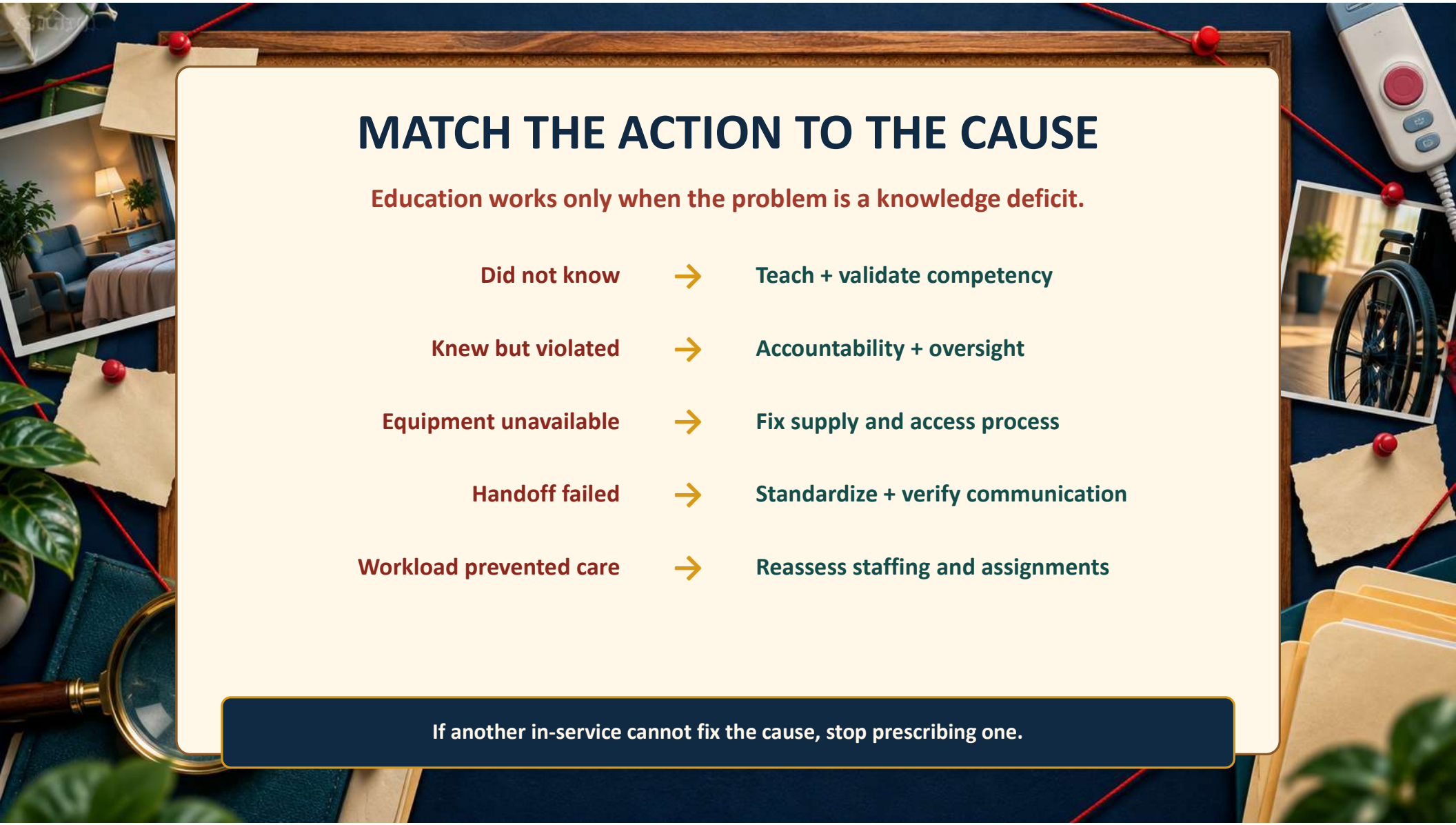
Do not jump from “resident fell” directly to “resident educated.”

FROM FINDING TO MEANINGFUL ACTION

Your template provides the bones. The facts determine the path.

1. **Organize the evidence**
2. **Identify the finding**
3. **Separate immediate cause from contributing factors**
4. **Identify the true root cause**
5. **Choose actions that directly address it**

A completed checklist is not the same as critical thinking.



MATCH THE ACTION TO THE CAUSE

Education works only when the problem is a knowledge deficit.

Did not know	→	**Teach + validate competency**
Knew but violated	→	**Accountability + oversight**
Equipment unavailable	→	**Fix supply and access process**
Handoff failed	→	**Standardize + verify communication**
Workload prevented care	→	**Reassess staffing and assignments**

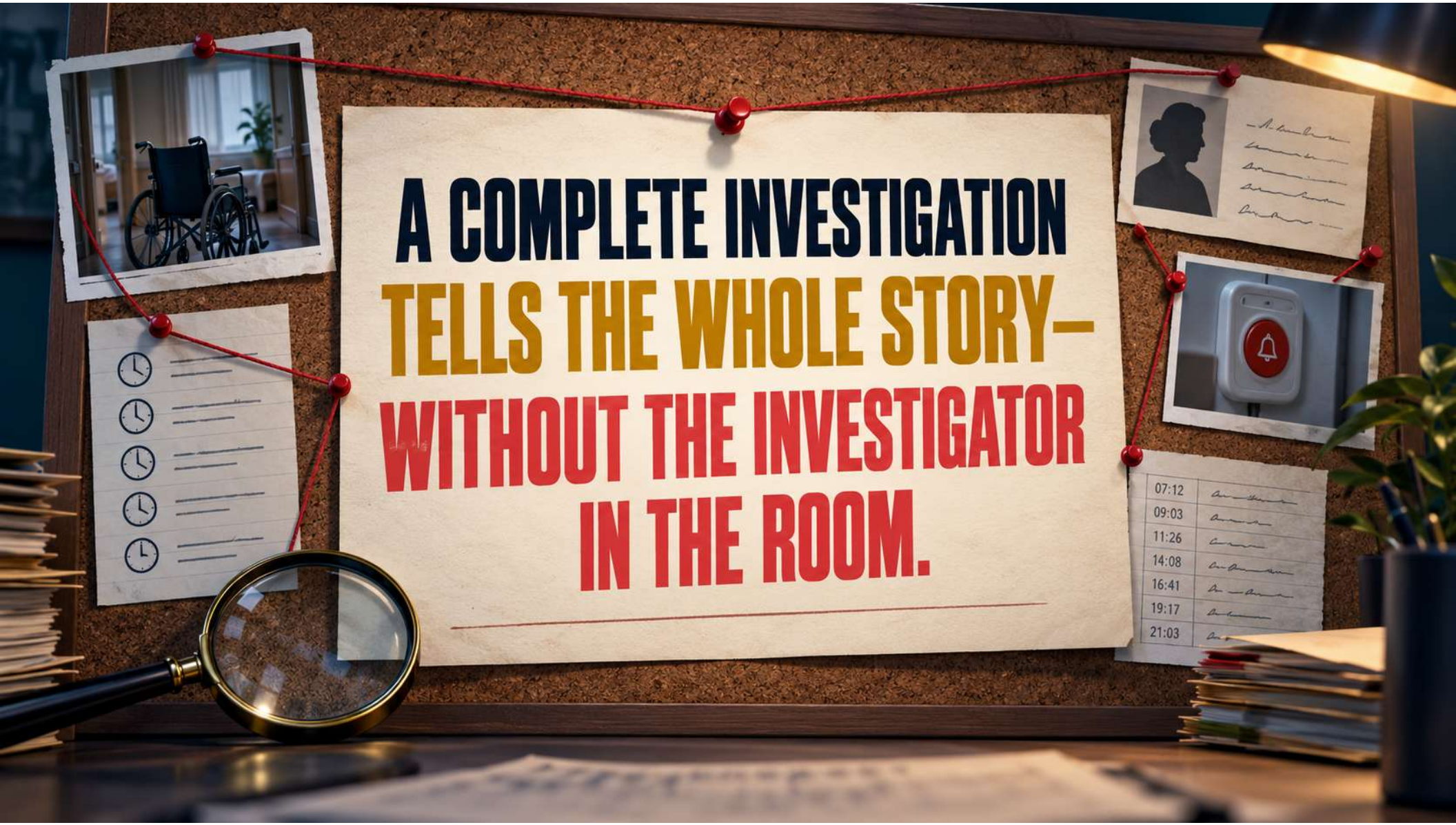
If another in-service cannot fix the cause, stop prescribing one.

MAKE THE ACTION PLAN SURVEY-READY

A strong plan answers eight questions.

1. **WHAT will be done?**
2. **WHO is responsible?**
3. **WHEN does it begin?**
4. **WHO or WHAT will be audited?**
5. **HOW OFTEN and HOW LONG?**
6. **WHAT is the compliance goal?**
7. **WHAT happens when problems are found?**
8. **WHERE will results be reviewed?**

Specific. Measurable. Owned. Monitored. Sustained.


A COMPLETE INVESTIGATION
TELLS THE WHOLE STORY–
WITHOUT THE INVESTIGATOR
IN THE ROOM.
07:12
09:03
11:26
14:08
16:41
19:17
21:03

Attendance Verification & Course Evaluation

Verify your attendance to earn CE's by using this code

Creating an effective action plan through the investigation process