



North Carolina Department of Health & Human Services
Division of Health Service Regulation
Adult Care Licensure Section

Final Report of Investigation of a Resident Death

Investigation conducted by (check all that apply): County DSS DHSR ACLS

Intake Number:

License Number: _____ County: _____

Facility Name: _____

Address: _____

Date(s) and time(s) of visit(s):

Investigation Closed Date:

Participants:

Conclusion/Determinations: (choose one)

- Non-compliance with rules/regulations was identified: (choose one)
- Refer to attached Corrective Action Report issued to facility on ** ** (date) (attach CAR)
 - Refer to attached Statement of Deficiencies dated ** ** (date)
- Non-compliance with rules/regulations was not identified, see investigation details below.

If CAR or SOD was written, do not go any further on this form. The details of the investigation will be provided in the CAR/SOD. If CAR or SOD was not written, provide details of the investigation in the section below.

Details of Investigation:

Comments:

*Signature of Investigator
Date: _____

*Signature of Administrator/Designee
Date: _____

INSTRUCTIONS FOR COMPLETING FORM
Final Report of Investigation of a Resident Death

Investigation conducted by (check all that apply): County DSS DHSR ACLS

Intake Number: # on the Intake Information form

License Number: _____ County: _____

Facility Name: _____

Address: _____

Date(s) and time(s) of visit(s):

Enter the dates and times of each visit made as part of the death investigation.

Investigation Closed Date:

Enter the date the investigation was closed, usually the date of the last visit to the facility.

Participants:

List individuals who participated in the investigation.

Conclusion/Determinations: (choose one)

- Non-compliance with rules/regulations was identified: (choose one)
 - Refer to attached Corrective Action Report issued to facility on ** ** (date) (attach CAR)
 - Refer to attached Statement of Deficiencies dated ** ** (date)

- Non-compliance with rules/regulations was not identified, see investigation details below.

If CAR or SOD was written, do not go any further on this form. The details of the investigation will be provided in the CAR/SOD. If CAR or SOD was not written, provide details of the investigation in the section below.

Details of Investigation:

Enter details of how the resident death was investigated and facility compliance with rules/regulations was determined, including observations, interviews, and record reviews.

Comments:

*Signature of Investigator
Date: _____

*Signature of Administrator/Designee
Date: _____

REPORT OF DEATH TO DHHS

All requested information must be provided. This form is for reporting resident deaths for all facilities operating under G.S. 131D-2. A resident's death occurring within seven days of physical restraint or physical hold of the resident, including death occurring within 24 hours of transfer to a hospital, must be reported immediately. All resident deaths resulting from accident, homicide, suicide or violence must be reported within three days of the death. If any requested information is unavailable, provide an explanation. The information must be provided immediately upon its availability. ■ *If additional space is needed,* attach separate sheets, referencing the part of the form to which the information pertains. ■ You may include additional information that you consider helpful, such as resident assessments and discharge summaries. ■

(Please Note: Facilities are encouraged to keep a copy of the report for their records)

Submit form to: Complaint Intake Unit, 2711 Mail Service Center., Raleigh, NC 27699. Fax: (919) 715-7724; Phone: (919) 733-8499.

Section I: Reporting Facility

| | | | |
|-----------------------------|---|--|---|
| Name of reporting facility: | Medicare/Medicaid Provider # (if applicable): | Facility director: | Telephone: |
| Address: | License # : | First person to discover decedent: | Staff first receiving report of decedent's death: |
| | County: | Person (including title) preparing report: | Date/Time report prepared: |

Section 2: Resident Information

| | | | |
|---|---|--|-------|
| Name of decedent: | Resident Record # (if applicable): | Unit/Ward (if applicable): | |
| | Medicare/Medicaid No (if applicable): | Date of Birth: | Age: |
| Admitting diagnoses: | Adjudicated incompetent: <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight (if known): | Race: |
| | Date(s) of last two (2) medical exams (if known): | Height (if known): | Sex: |
| Date of most recent admission to a State operated psychiatric, developmental disability or substance abuse facility (if known): | | Date of most recent admission to an acute care hospital for physical illness (if known): | |
| Primary/secondary mental illness, developmental disability, or substance abuse diagnosis (if applicable): | | Primary/secondary physical illness/conditions diagnosed prior to death: | |

Section 3: Circumstances of Death

| | | |
|---|---------------------------------------|--|
| Place where decedent died: | Date and time death was discovered: | |
| Address: | Physical location decedent was found: | |
| | Cause of death (if known): | |
| Was decedent "restrained" at the time of death or within 7 days of death including a death that occurred within 24 hours of transfer or discharge to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," describe type and usage: | | |
| Describe events surrounding the death: | | |

Section 4: Other Information

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| Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death: |
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