N.C. Department of
Health & Human Services
Division of Health Service
Regulation

Health Care Personnel Registry

5-WORKING DAY REPORT

Investigation Report from Facility/Provider

FAX: (919) 733-3207
Phone: (919) 855-3968
2719 Mail Service Center
Raleigh, NC 27699-2719

24-Hour Initial report sent to HCPR? ☐ Yes ☐ No Date submitted: ________ Via: ☐ FAX ☐ Mail ☐ IRIS ☐Other

The results of all investigations must be reported within 5-working days of the initial notification. [see NC Gen. Stat. §131E-256(g)]	*Certain Nursing Facilities (NF), Skilled Nursing Facilities (SNF), Hospices provided in LTC facilities, & Intermediate Care Facilities for the Mentally Retarded (ICF-MR) are required to report a reasonable suspicion of a crime. [see Sec. 1150B.(42 U.S.C. 1320b-25)]*

Provider Information

County: ________ Facility/ Provider Type: ________

Facility/Provider Name: ________

Facility/Provider License #: ________ National Provider #: ________ Other ID #: ________

Main Office Phone #: ( ) ________ Main Office **(Secure)** Fax #: ( ) ________ Administrator/ Director Email Address: ________

Contact Person: ☐ Mr. ☐ Ms. ________ Title: ________

Administrator: ☐ Mr. ☐ Ms. ________ Title: ________

MAIN OFFICE Mailing Address: ________ City: ________ State: ________ Zip: ________

ACTUAL INCIDENT Location Address: ________ City: ________ State: ________ Zip: ________

Allegation/Incident Type

(check all that apply)

☐ REASONABLE SUSPICION OF A CRIME *(Explain under "Allegation/Incident Details" below)*

Is reasonable suspicion of a crime related to any allegation checked below? ☐ Yes ☐ No

☐ ① RESIDENT ABUSE	☐ ④ DIVERSION OF FACILITY DRUGS (*Estimated Value*:________)	☐ ⑦ MISAPPROPRIATION OF FACILITY PROPERTY (*Estimated Value*:________)
☐ ② RESIDENT NEGLECT	☐ ⑤ FRAUD AGAINST RESIDENT	☐ ⑧ MISAPPROPRIATION OF RESIDENT PROPERTY (*Estimated Value*:________)
☐ ③ DIVERSION OF RESIDENT DRUGS (*Estimated Value*:________)	☐ ⑥ FRAUD AGAINST FACILITY	☐ ⑨ INJURY OF UNKNOWN SOURCE (*Explain under "Allegation/Incident Details" below*)

Allegation/Incident Details

Incident Date: ________ Time: ________ ☐ a.m. ☐ p.m.

Incident location description: ________

Description of Incident:

Incident result in physical injury/ harm? ☐ Yes ☐ No
Describe resident's injury/ harm below (attach pictures):

Mental anguish lasting 5 days or more? ☐ Yes ☐ No
Describe resident's emotional response & behaviors below:

Accused Individual Information

Full Name: ☐ Mr. ☐ Ms. ________

Job Title: ________ Date of Hire: ________ Date of Birth: ________

Social Security # *(required)*: ________ Taxpayer ID # or other ID #: ________

Last Known Address: ________ City: ________ State: ________ Zip: ________

Home Phone #: ( ) ________ Other Phone # *(Cell phone, work, etc.)*: ( ) ________

E-mail address: ________ Other information: ________

Resident Information

Resident Full Name: ☐ Mr. ☐ Ms. ____________ Date of Birth: ____________

Resident Address if different from Facility: ____________ City: ____________ State: ______ Zip: ______

Is Resident Interviewable? ☐ Yes ☐ No Memory & Orientation of Resident: ____________

Resident's Type of Care/ Service & Setting: ____________

(Examples - Home Care, Nursing Home, Hospital/Acute Care, Day Program, CAP, CBS, Substance Abuse, Respite, etc.)

Additional resident information:

Actions

Allegation Substantiated? ☐ Yes ☐ No Investigation End Date: ____________

Facility/ Provider

Facility/ Provider Investigator: ☐ Mr. ☐ Ms. ____________ Title: ____________

Accused individual's employment terminated? ☐ Yes ☐ No Termination related to allegation? ☐ Yes ☐ No

Date of Termination: ____________ Other employment actions: ____________

Other information:

Social Services

Incident reported to County Dept. of Social Services (DSS)? ☐ Yes ☐ No Date reported to DSS: ____________

Name of County Dept of Social Services: ____________

On-site visit by DSS? ☐ Yes ☐ No Date of on-site visit: ____________

Name of DSS Investigator: ____________ Phone # (   ) ____________

Other information:

Law Enforcement

Is there a Reasonable Suspicion of a Crime? ☐ Yes ☐ No Is there Serious Bodily Injury? ☐ Yes ☐ No

Incident reported to law enforcement? ☐ Yes ☐ No Date reported: ____________ Time Reported: ____________

Name of law enforcement agency: ____________

Investigating Officer: ____________ Phone #: (   ) ____________

Accused charged? ☐ Yes ☐ No Charges related to allegation? ☐ Yes ☐ No

Specific Charges: ____________

Other information:

Witness(es)

Witnesses to Incident? ☐ Yes ☐ No Number of Witnesses: ______ *[Include any resident witnesses]*

① Name: ☐ Mr. ☐ Ms. ____________ Title: ____________ Relationship to Victim/Accused: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone #: (   ) ____________ Other Phone *(Cellular, Work, etc.)*: (   ) ____________

② Name: ☐ Mr. ☐ Ms. ____________ Title: ____________ Relationship to Victim/Accused: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone #: (   ) ____________ Other Phone *(Cellular, Work, etc.)*: (   ) ____________

(LIST ADDITIONAL WITNESS NAMES & INFORMATION ON AN ATTACHED SHEET)

Check the following supporting documents/information attached & submitted with this report

☐ Complete details of facility investigation
☐ Documentation of injury/harm to victim
☐ Reports from other agencies investigating incident
☐ Witness, accused, & other statements
☐ Other pertinent documents:

(Print Name and Title of Person Preparing Report)	*(Signature of Person Preparing Report)* *(Date Signed)*