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

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