

REPORT OF DEATH TO DHHS

Use this form to report resident deaths for all facilities operating under G.S. 131D (*adult care homes and family care homes*).

- The facility must **immediately** report 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.
- All resident deaths resulting from accident, homicide, suicide or violence must be reported **within three days** of the death.
- **All requested information must be provided.** 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.
- Once completed and signed, make a copy of this report for your records.

Submit form to: DHSR Complaint Intake Unit, 2711 Mail Service Center, Raleigh, NC 27699 Fax: (919) 715-7724 Phone: (919) 855-4500

Section 1: Reporting Facility

Name of reporting facility:		Address:		Facility Administrator:	
License#:		County:		Medicare/Medicaid Provider #:	
				Telephone:	

Section 2: Resident Information

Name of Resident:		Date of Birth:		Age:	Sex:	Race:	Room #/Apt. #:	
Admitting diagnoses:		Medicare/Medicaid #:		Date of most recent admission to an acute care hospital:			Adjudicated incompetent: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Primary/secondary physical illness/conditions diagnosed prior to death:			Diagnoses of mental illness, developmental disability, or substance abuse:			

Section 3: Circumstances of Death

Place where resident died:		Date and time death was discovered:	
Address:		Physical location resident was found:	
First person to discover resident:		Staff first receiving report of resident's death:	

Was the resident "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? Yes No *If "yes," describe type of restraint and how it was used:

Event related to or resulting in the resident's death (*check one--required*):

- Accident** ("Accident" means an unexpected, unnatural or irregular event contributing to a resident's death and includes, but is not limited to, medication errors, falls, fractures, choking, elopement, exposure, poisoning, drowning, fire, burns or thermal injury, electrocution, misuse of equipment, motor vehicle accidents, and natural disasters.)
- Violence** ("Violence" means physical force exerted for the purpose of violating, damaging, abusing or injuring, or abusing another person.)
- Suicide**
- Homicide**
- Unknown** (*If checked, facility must submit an amended death report within 3 days once circumstances of the resident's death are known to the facility and it was determined that the death resulted from any events listed above. When submitting an amended death report, make changes to the original report and initial those changes, check the "Amended Death Report" box at the bottom of this form, and provide your signature and date.)

Describe all events preceding and/or surrounding the resident's death, including cause of death if known (*if more space is needed, attach separate sheets*):

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:

I attest that the information provided in this report is true and accurate to the best of my knowledge.

Name of person preparing report: _____ Title: _____

Signature: _____ Date/time report was prepared: _____