

Division of Health Service Regulation
Complaint Intake and Health Care Personnel Investigations Section
Initial Allegation Report Instructions

Section A: Provider Information Date

Facility/Provider Name - Enter the complete name of the facility/agency (Limit abbreviations).

Facility/Provider Type - Select type of facility with the drop down arrow.

Adult Care Home - as defined by G. S. 131D-2.1.

Community Based Services - Providers of services for the mentally ill, developmental disabled and substance abusers not required to be licensed under Article 2, Chapter 122C.

Family Care Homes - defined by G. S. 131D-2.1.

Home Care Agency - defined by G.S. 131E-136.

Home Health Agency - as defined by G.S. 131E-136.

Hospice - defined by G. S. 131E-201.

Hospital - defined by G. S. 131E-76.

ICF/IID - Intermediate Care Facility/Individuals w/Intellectual Disabilities - Residential facilities, 24 hour Facilities and Licensable Facilities - as defined by G. S. 122C-3 (14) and/or certified as an ICF/IDD per CFR §440.150 (includes state operated Developmental Facilities and Neuro Medical Treatment Facilities).

In Home Aide - Agencies providing in-home aide services funded through the Home & Community Care Block Grant Program.

Mental Health Licensure - Residential facilities, 24 hour Facilities and Licensable Facilities - as defined by G. S. 122C-3 (14).

Multi Unit Housing With Services - defined by G. S. 131D-2.1.

Nursing Home - defined by G. S. 131E-101 (includes state operated neuro-medical treatment facilities).

Nursing Pool Agency - defined by G. S. 131E-154.2.

Psychiatric Hospital - defined by G. S. 122C-3(14) (includes state operated psychiatric hospitals & ADATCs).

Psychiatric Residential Treatment Program - defined by G. S. 122C-3(14) (Includes state operated PRTFs).

Facility/Provider License # - Enter the entire state license number for the facility/provider (i.e., NH0000, HC0000, MHL-000-000, H0000).

National Provider # - Enter the facility/provider National Provider number, if applicable. This number is a unique identification 10-digit number for Health Insurance Portability and Accountability Act (HIPAA) covered health care providers to use in the administrative and financial transactions.

Main Office Phone # - Enter the phone number of the facility/provider including area code without any dashes (i.e., 1234567890).

Main Office (Secure) Fax # - Enter the facility/provider secure fax number where confidential requests and information can be faxed, including area code without any dashes (i.e., 1234567890).

Facility/Provider Physical Address

Street - Enter the street address of the facility's/provider's physical location.

City - Enter the city of the facility's/provider's physical location.

State - Enter the state of the facility's/provider's physical location.

Zip - Enter the zip code of the facility's/provider's physical location.

County - Select the county with the drop down arrow for the facility's/provider's physical location.

Facility/Provider Main Office Mailing Address

Check the box if facility/provider mailing address is the same as the facility/provider physical address and skip to Administrator/Director.
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Street - Enter the mailing street address or PO Box for the facility/provider.

City - Enter the city for the facility's/provider's mailing address.

State - Enter the state for the facility's/provider's mailing address.

Zip - Enter the zip code for the facility's/provider's mailing address.

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Section A: Provider Information continued

Administrator/Director

Name - Select the title (Mr. or Ms.) with the drop down arrow for the facility/provider Administrator/Director's title. Enter the name of the facility Administrator/Director.

Phone - Enter the direct telephone number for the facility/provider Administrator/Director, including area code without any dashes (i.e., 1234567890).

Ext - Enter the telephone extension for the facility/provider Administrator/Director, if applicable.

Email - Enter the email address for the facility/provider Administrator/Director (i.e., name@example.com).

Contact Person

Check the box if the facility/provider contact person is the same as the facility/provider Administrator/Director and skip to Section B Accused Employee Information

Name - Select the title (Mr. or Ms.) with the drop down arrow of the facility contact person's title. Enter the name of the facility/provider person, who should be contacted by the DHSR staff for information regarding this incident.

Phone - Enter the direct telephone number for the facility/provider contact person, including area code without any dashes (i.e., 1234567890).

Ext - Enter the telephone extension for the facility/provider contact person, if applicable.

Email - Enter the email address for the facility/provider contact person (i.e., name@example.com).

Job Title - Enter the job title of the facility/provider contact person (No abbreviations).

Section B: Accused Employee Information (please complete a separate Initial Allegation Report if multiple Accused Employees are involved in the incident)

Check the box if there are multiple accused employees involved in the same incident and use the Accused tab to list additional accused names for Section B in the area at the top of the tab. Complete a separate Initial Allegation Report for each accused employee listed.

Check the box if there are no named accused employees and skip to Section C Allegation/Incident Type.

Employee's Full Name - Select the title (Mr. or Ms.) with the drop down arrow for the accused employee's title. Enter the full name (no initials) of the accused employee. (Obtain from employee's driver's license and/or Social Security card.)

Full Social Security # - Enter the full social security number without any dashes (i.e., 123456789) for the accused employee. Please verify the Social Security number from the employee's Social Security card.

Date of Birth - Enter the employee's date of birth i.e. 3/14/1980.

Job Title - Enter the job title of the accused employee at the time of the incident (no abbreviations).

Date of Hire - Enter the employee's date of hire i.e. 3/14/2010.

Last Known Mailing Address - Please check the employee's personnel file to obtain the most recent address on record.

Street - Enter the mailing street address or PO Box for the accused employee. Include house/apartment # if applicable.

City - Enter the city for the accused employee's mailing address.

State - Enter the state of the accused employee's mailing address.

Zip - Enter the zip code of the accused employee's mailing address.

Home Phone # - Enter the home telephone number for the accused employee, including area code without any dashes (i.e., 1234567890). Please check the employee's personnel file to obtain the most recent phone contact number on record.

Other Phone # - Enter any other known telephone number for the accused employee, if different from their home number, including area code without any dashes (i.e., 1234567890). For example, mobile, other job, emergency contacts.

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Section B: Accused Employee Information continued

Email - Enter the email address for the accused employee, if known (i.e., name@example.com).

Section C: Allegation/Incident Type - Check beside the box according to the definitions below:

1. **Resident Abuse*** - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
2. **Resident Neglect*** - the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.
3. **Diversion of Resident Drugs** - unauthorized taking or use of a resident's drug.
4. **Diversion of Facility Drugs** - unauthorized taking or use of facility drugs.
5. **Fraud Against Resident** - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
6. **Fraud Against Facility** - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
7. **Misappropriation of Facility Property** - the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a health care facility's property without the facility's consent.
8. **Misappropriation of Resident Property*** - the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
9. **Injury of Unknown Source** - source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time.

***Skilled nursing facilities/nursing facilities should select abuse, neglect or misappropriation of resident property for allegations of mistreatment or exploitation of residents.**

Section D: Allegation Information

Incident Date – Enter when incident occurred, if date known. If date not known, explain in Allegation Details below i.e. 3/14/2010.

Date Facility Became Aware of Incident – Enter date of when any staff at facility/provider first became aware of incident i.e. 3/14/2010.

Time Facility Became Aware of Incident - Enter the hour and minutes (i.e. 1:40, 10:35) including and AM or PM.

Allegation Details (703 characters, including spaces) - Provide a brief description of the specific allegation such as who made the allegation, what was said or done, when it was reported or discovered versus when it happened, where the incident occurred. Use the exact terminology given by the person making the allegation.

Details of Physical or Mental Injury/Harm (352 characters, including spaces) - Describe any type of injury such as a bruise, scratch, laceration, puncture wound, fracture, bleeding, redness on the skin and/or any changes in the resident's behavior that indicated something different from the resident's normal baseline such as crying, express or displays of fear, cowering, anger, withdrawal, difficulty sleeping. Be as descriptive as possible.

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Section E: Resident Information

Check the box if there are multiple residents affected by the incident and use the Residents tab to document additional residents' information.

Check the box if there are no residents affected and skip to Section F Accused Other Individual Information.

Resident's Full Name - Select the title (Mr. or Ms.) with the drop down arrow for the resident's title. Enter the full name of the resident.

Date of Birth – Enter the resident’s date of birth e.g. 3/14/2010.

Was this resident residing in a nursing home bed at the time of the incident? Select yes or not using the drop down arrow to indicate whether or not the resident was residing in a nursing home at the time of the incident.

Section F: Accused Other Individual Information (Non-employee - Skilled Nursing/Nursing Facility & ICF/IIDs only) - This section is for documenting anyone accused of an allegation in/at your facility/provider that is NOT employed by your facility, for example, visitors, family members, another agency employee, etc.

Check the box if there are multiple accused other individuals (non-employees). Use the Accused tab to document additional accused other individuals' (non-employees) information in Section F at the bottom of the tab.

Check the box if there are no named accused other individuals and skip to Section G Notifications to Other Agencies.

Other Individual's Full Name - Select the title (Mr. or Ms.) with the drop down arrow for the accused other individual's title. Enter the full name (no initials) of the accused other individual.

Relationship - Enter the relationship of the accused other individual to the resident (Example: brother, daughter, friend, visitor, other agency staff, etc).

Section G: Notifications to Other Agencies

Check the box if there is a reasonable suspicion of a crime. (Skilled nursing facilities/nursing facilities, ICF/IID and Hospices providing services in a long term care (LTC) facility only). A “crime” is defined by law of the applicable local enforcement district, where a LTC facility is located.

Check the box if there is serious bodily injury (Skilled nursing facilities/nursing facilities, ICF/IID and Hospices providing services in a long term care (LTC) facility only). “Serious bodily injury” is defined as an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery.

Incident Reported To Law Enforcement? - Select Yes or No using the drop down arrow to document whether or not the incident was reported to any law enforcement agency (local police department, county sheriff’s office, Medicaid Investigations Unit, State Bureau of Investigation, or Federal Bureau of Investigation).

Date Reported - If the incident was initially reported to law enforcement, enter the date i.e. 3/14/2010.

Time - If the incident was initially reported to law enforcement, enter the hour and minutes (i.e. 1:40, 10:35 and include AM or PM for the time.

Law Enforcement Agency - Enter the full name of the law enforcement agency notified (name of local police department, county sheriff’s office, Medicaid Investigations Unit, State Bureau of Investigation, or Federal Bureau of Investigation).

Investigating Officer*** - Enter the full name of responding Law Enforcement Officer or if the case was later assigned to an investigating officer, please list that Officer's name.

***If the case has been later assigned to an investigating officer, please list that Officer’s name instead.

Phone # - Enter the telephone number for the law enforcement officer listed above, including area code without any dashes (i.e., 1234567890).

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Section H: Signature

Name of Person Preparing Report - Enter the full name of the person preparing this report.

Title of Person Preparing Report - Enter the job title (No abbreviations) of the person preparing this report.

Signature of Person Preparing Report - Person preparing this report must sign the report.

Date Signed - Enter full date for when this report was signed by the person preparing the report.

Nursing Homes - §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, **within 5 working days of the incident.**

ICF/IID - §483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law **within five working days of the incident.**

Other Providers - N.C. General Statute 131E-256(g) The results of all investigations must be reported **within five working days of the initial notification to the department.**

Failure to comply may result in a report to the agency having jurisdiction for compliance enforcement.