



**STATE OF TENNESSEE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
DIVISION OF MENTAL RETARDATION SERVICES  
ANDREW JACKSON BUILDING, 15TH FLOOR  
500 DEADERICK STREET  
NASHVILLE, TN 37243**

**TITLE:** Death Reporting and Review Policy

**POLICY #:** P - 015

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**A. PURPOSE:** This policy outlines the process for reporting deaths and conducting a systematic review and investigation of the death of an individual receiving services through a Home and Community-Based Services (HCBS) waiver program or other community program administered by the Division of Mental Retardation Services (DMRS), through a developmental center operated by DMRS, or through a private Intermediate Care Facility for the Mentally Retarded (ICF/MR).

**B. APPLICABILITY:** This policy, which is applicable to any death occurring on and after December 1, 2008, applies to all DMRS staff, service providers and individuals who are responsible for reporting deaths or participating in the systematic review and investigation of the death.

**C. DEFINITIONS**

1. "Class Member" means:

- a. Any person who was a resident of the Arlington Developmental Center, as ordered by the Court on September 27, 1995;
- b. Any person who was a resident of the Clover Bottom Developmental Center or the Nat T. Winston Developmental Center any time since December 22, 1992, as specified in the *People First v. Clover Bottom, et al.* Settlement Agreement;
- c. Any person who was a resident of the Greene Valley Developmental Center during any time after December 22, 1992, and before March 12, 2006, when the Court dismissed Greene Valley Developmental Center from the lawsuit; or
- d. Any person who was a resident of the Harold W. Jordan Habilitation Center during any time after December 22, 1992, and before September 29, 2008, when the Court dismissed Harold W. Jordan Habilitation Center from the lawsuit;
- e. Any person who has been formally determined by DMRS to be a Class Member due to being "at risk of being placed at Arlington Developmental Center" based on the class definition specified in *People First v. Arlington Developmental Center*.

2. "Developmental Center" means an Intermediate Care Facility for the Mentally Retarded operated by the Division of Mental Retardation Services.

3. "DMRS" means the Division of Mental Retardation Services in the Department of Finance and Administration.

4. **“Home and Community-Based Services waiver” or “HCBS waiver”** means a Medicaid Home and Community-Based Services program that provides services in the home and community as an alternative to services provided in an ICF/MR and that is administered by the Division of Mental Retardation Services.
5. **“Intermediate Care Facility for the Mentally Retarded” or “ICF/MR”**, as defined in Section 1905(d) of the Social Security Act, means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if:
  - a. The primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;
  - b. The mentally retarded individual with respect to whom a request for payment is made under a plan approved under this title is receiving active treatment under such a program; and
  - c. In the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this title, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this title.
6. **“Private ICF/MR”** means a private for-profit or private not-for-profit Intermediate Care Facility for the Mentally Retarded (ICF/MR).
7. **“Suspicious, Unexpected, or Unexplained Death”** means any death that did not result from the normal progression of a known medical condition or disease, including but not limited to medical care or emergency intervention that is inappropriate, untimely, or inconsistent with relevant physicians’ orders, advance directives, or applicable policies or standards governing withholding of medical treatment.

**D. DESCRIPTION OF POLICY**

**1. Reporting a Death**

a. Responsibility for reporting the death:

(1) Deaths shall be reported in accordance with the following:

(a) Deaths in HCBS waiver programs or other DMRS community programs: The executive director or designee of the provider agency primarily responsible for serving the individual shall report the death to the DMRS Regional Director who shall report the death to the DMRS Deputy Commissioner.

Where the deceased individual had more than one provider, the provider agency primarily responsible would be the provider of the residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, Family Model Residential Support), if applicable. If the individual did not receive a residential service, the priority order for determining the responsible provider agency, from highest to lowest, would be:

i. The provider of Day Services, if applicable;

- ii. The provider of Personal Assistance services if applicable.
    - iii. The Independent Support Coordinator, if applicable; or
    - iv. The DMRS Regional Office.
  - (b) Deaths in DMRS developmental centers: The Chief Officer of the developmental center or designee shall report the death to the DMRS Assistant Commissioner for Facility Services who shall report the death to the DMRS Deputy Commissioner.
  - (c) Deaths in private ICFs/MR: The administrator of the private ICF/MR or designee shall report the death to the DMRS Regional Director who shall report the death to the DMRS Assistant Commissioner for Facility Services and to the DMRS Deputy Commissioner.
- b. Timelines for reporting deaths:
- (1) The entity responsible for reporting the death shall report any death that is or may be a Suspicious, Unexpected, or Unexplained Death within four hours of discovery to the DMRS Investigator.
  - (2) Deaths in HCBS waiver programs or other DMRS community programs or deaths in private ICFs/MR: Within four hours of becoming aware that a death has occurred, the entity responsible for reporting the death shall report the death by telephone to the DMRS Regional Director or designee who shall report the death to the DMRS Deputy Commissioner and, if applicable, to the DMRS Assistant Commissioner for Facility Services.
  - (3) Deaths in DMRS developmental centers: Within four hours of becoming aware that a death has occurred, the entity responsible for reporting the death shall report the death by telephone to the DMRS Assistant Commissioner for Facility Services or designee.
  - (4) The entity responsible for reporting the death shall:
    - (a) Immediately report the death to the parents, guardian or conservator, or next of kin; and
    - (b) Report the death as soon as possible and in all cases within twenty-four (24) hours to the individual's Independent Support Coordinator, case manager, or equivalent.
- c. Notification of law enforcement or the medical examiner: Any person who has reason to believe that criminal action may have contributed to an individual's death shall immediately notify law enforcement officials of the relevant facts and circumstances. The medical examiner shall also be notified immediately by the appropriate staff at the DMRS Regional Office, by staff of the developmental center, or staff of the private ICF/MR, as applicable, if the death occurred suddenly when the person was in apparent good health or if the death occurred in a suspicious, unexpected, or unexplained manner.
- d. Notice of Death form: A Notice of Death form shall be completed in accordance with the following:

- (1) Deaths in HCBS waiver programs or other DMRS community programs: Within one business day of the date of the death, a Notice of Death form (Attachment 1) shall be completed by the provider agency and submitted by facsimile or similar means to the DMRS Regional Director. The DMRS Regional Director or designee shall review the form for completeness and shall transmit it immediately to the DMRS Deputy Commissioner.
  - (2) Deaths in DMRS developmental centers: Within one business day of the date of the death, a Notice of Death form shall be completed and reviewed by the Chief Officer of the developmental center or designee and transmitted by facsimile or similar means to the DMRS Assistant Commissioner for Facility Services and to the DMRS Deputy Commissioner.
  - (3) Deaths in private ICFs/MR: Within one business day of the date of the death, a Notice of Death form shall be completed and reviewed by the administrator of the private ICF/MR or designee and transmitted by facsimile or similar means to the DMRS Regional Director who shall transmit the Notice of Death Form to the DMRS Assistant Commissioner for Facility Services and to the DMRS Deputy Commissioner
- e. Reportable Incident Form: If the death involves an individual receiving services through an HCBS waiver program or other DMRS community program, the provider agency shall complete and transmit a Reportable Incident Form (Attachment 2) regarding the death as soon as possible and in all cases within one business day. The completed form shall be transmitted by facsimile or similar means to the DMRS Central Office as indicated on the Reportable Incident Form the DMRS Regional Director, and the ISC agency.
- f. Preliminary Death Review for Suspicious, Unexpected, or Unexplained deaths:
- (1) Upon receipt of a Notice of Death form, the DMRS Regional Director or designee or, as applicable, the Chief Officer of the developmental center or designee, shall schedule a Preliminary Death Review Committee meeting. Within five (5) business days of receipt of the Notice of Death, the Preliminary Death Review Committee shall perform a preliminary death review to determine if the death was Suspicious, Unexpected, or Unexplained.
  - (2) The Preliminary Death Review Committee shall be performed in accordance with the following:
    - (a) Death of an individual in an HCBS waiver program or other DMRS community program: The Preliminary Death Review Committee shall be composed of the DMRS Regional Director or designee, the DMRS Regional Compliance Director or designee, and the DMRS Regional Nursing Director or designee.
    - (b) Death of an individual in a DMRS developmental center: The Preliminary Death Review Committee shall be composed of the Chief Officer of the developmental center or designee, the developmental center's TQI Coordinator or designee, and the developmental center's Nursing Director or designee.
    - (c) Death of an individual in a private ICFs/MR: The Preliminary Death Review Committee shall be composed of the DMRS Regional Director or designee, the DMRS Regional Compliance Director or designee, and the DMRS Regional Nursing Director

or designee. The administrator of the private ICF/MR shall also be invited to participate in the Preliminary Death Review,

- (3) The Preliminary Death Review Committee shall make a determination whether the death meets the criteria for a Suspicious, Unexpected, or Unexplained death. In some cases, the committee may delay making a determination beyond the 5-day timeframe in order to gather additional information. If information is received after a determination has been made and such information could reasonably change the determination, the committee can reconvene and review the information.
- (4) Any death determined to be Suspicious, Unexpected, or Unexplained shall trigger a DMRS Investigation, the preparation of a Clinical Death Summary, and a DMRS Death Review. If additional review does not support that the death was Suspicious, Unexpected, or Unexplained, the Preliminary Death Review Committee may determine the DMRS Investigation, Clinical Death Summary and DMRS Death Review are no longer necessary and may stop further review.

3. **Provider's Death Review:** The purpose of the Provider's Death Review is to identify any conditions or practices that require immediate intervention in order to protect other individuals from similar untoward events. Examples of such conditions or practices might include environmental hazards, a delay in emergency response or in seeking medical intervention, or abusive or neglectful conduct on the part of staff or others. The Provider's Death Review is not expected to resolve all outstanding issues or result in conclusions as to the cause of death but may be used to identify questions or concerns to be addressed in subsequent investigations and proceedings. The review may be conducted in accordance with the provider's own policies and procedures or, as applicable, the policies and procedures of the developmental center or private ICF/MR. The review may be formal or informal; however, the review must include a review of events surrounding the death, identification of known or likely contributing factors, and review of any other required information.

- a. The Provider's Death Review shall be performed for the death of any person who is:
  - (1) Receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, Family Model Residential Support) through a Home and Community-Based Services (HCBS) waiver program or other community program administered by DMRS;
  - (2) A resident of a DMRS developmental center; or
  - (3) A resident of a private ICF/MR when such residence is funded by the State of Tennessee or by the Title XIX Medicaid Program.
- b. When the death involves an individual receiving a residential service through an HCBS waiver program or other community program administered by DMRS, the provider agency that was the provider of the residential service for the individual shall immediately initiate a Provider's Death Review.
- c. When the death involves a resident of a DMRS developmental center, a medical review or physician peer review of the death may be conducted in accordance with Tennessee Code Annotated 63-6-219, either as part of the Provider's Death Review or at any time thereafter.
- d. A Provider's Death Review shall be completed within five (5) business days of the individual's death and the Provider's Death Review Form (Attachment 3) shall be submitted in accordance with the following:

- (1) Deaths in HCBS waiver programs or other DMRS community programs: The Provider's Death Review Form shall be completed by the provider agency and submitted by facsimile or similar means to the appropriate DMRS Regional Director. The DMRS Regional Director or designee shall review the form and transmit it to the DMRS Deputy Commissioner.
- (2) Deaths in DMRS developmental centers: The completed Provider's Death Review Form shall be reviewed by the Chief Officer of the developmental center or designee and transmitted by facsimile or similar means to the DMRS Assistant Commissioner for Facility Services and to the DMRS Deputy Commissioner.
- (3) Deaths in private ICFs/MR: The completed Provider's Death Review Form shall be reviewed by the administrator of the private ICF/MR or designee and transmitted by facsimile or similar means to the DMRS Regional Director who shall transmit the Provider's Death Review Form to the DMRS Assistant Commissioner for Facility Services and to the DMRS Deputy Commissioner.

e. The Deputy Commissioner or designee shall review the Notice of Death Forms, the Reportable Incident Forms, and the Provider's Death Review Forms upon receipt and shall determine whether immediate intervention is necessary to protect other individuals who are receiving services.

4. **DMRS Death Reviews:** The purpose of a DMRS Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the medical care provided, to identify practices or conditions which may have contributed to the death and to make recommendations, where necessary, to prevent similar occurrences.

a. Deaths requiring a DMRS Death Review: Death Reviews shall be performed in accordance with the following:

- (1) Death of Class Member in a DMRS Developmental Center: A committee chaired by the developmental center's TQI Coordinator shall conduct a Death Review of any death of a Class Member residing in a DMRS developmental center.
- (2) Suspicious, Unexpected, or Unexplained Deaths
  - (a) The Regional Death Review Committee shall conduct a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained which involves an individual receiving services through a Home and Community-Based Services (HCBS) waiver program or other community program administered by DMRS.
  - (b) The developmental center's Death Review Committee shall conduct a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained which involves an individual who resided in a developmental center and who was not a Class Member.
  - (c) The Regional Death Review Committee shall conduct a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained which involves an individual residing in a private ICF/MR.

b. Timeline for Conducting a Death Review: Death Reviews shall be conducted within 45 business days of the individual's death; however, this time period may be extended by the DMRS Deputy Commissioner for good cause.

c. Arranging a Death Review Committee meeting:

- (1) The responsibility for making the arrangements for a Death Review Committee meeting shall be as follows:
  - (a) The Regional Compliance Director, if the death involves an individual who was receiving services through a Home and Community-Based Services (HCBS) waiver program or other community program administered by DMRS;
  - (b) The developmental center's TQI Coordinator, if the death involves an individual who was residing in a developmental center; or
  - (c) The Regional Compliance Director, if the death involves a resident of a private ICF/MR when such residence was funded by the State of Tennessee or by the Title XIX Medicaid Program.
- (2) The responsible party specified above shall:
  - (a) Send official notice of the Death Review Committee meeting to the participants and to the DMRS Central Office Nursing Director;
  - (b) At least five (5) calendar days prior to the Death Review Committee meeting, provide a death review packet to each member of the Committee and to the DMRS Central Office Nursing Director;
  - (c) Ensure that the complete clinical record of the individual is available at the time of the Death Review Committee meeting;
  - (d) Coordinate the efforts of nursing staff, the DMRS Investigator, and others to develop the death review packet which shall include the following:
    - i. Notice of Death form;
    - ii. Reportable Incident Report, if applicable;
    - iii. Provider's Death Review Form;
    - iv. Clinical Death Summary;
    - v. Current and recent medication history;
    - vi. DMRS Investigation Report;
    - vii. Autopsy Report (or preliminary report if available);
    - viii. Death Certificate, if available; and
    - ix. Individual Support Plan or equivalent in a private ICF/MR; and
  - (e) Ensure that the death review packets for the DMRS Central Office Nursing Director and Physician also include hospital and other discharge summaries, medication histories, and other relevant medical information; any emergency services or 911

records; and any relevant psychosocial or other information relating to the deceased individual.

d. Death Review Committee:

- (1) The chair of Death Review Committee shall be determined in accordance with the following:
  - (a) Deaths in HCBS waiver programs or other DMRS community programs: The DMRS Regional Compliance Director or designee shall chair the Regional Death Review Committee meeting.
  - (b) Deaths in DMRS developmental centers: The developmental center's TQI Coordinator shall chair the Death Review Committee meeting.
  - (c) Deaths in private ICFs/MR: The DMRS Regional Compliance Director or designee shall chair the Death Review Committee meeting.
- (2). The Death Review Committee shall include the following:
  - (a) A physician who was not involved in the care of the individual and who was not associated with the provider agency, DMRS developmental center, or private ICF/MR, as applicable, at the time of the individual's death (A DMRS physician shall, upon request, serve as the physician on the Death Review Committee.)
  - (b) The registered nurse who completed the Clinical Death Summary;
  - (c) The executive director or designee of the provider agency primarily responsible for serving the individual through an HCBS waiver program or other DMRS community program, the Chief Officer of the developmental center or designee, or the administrator of the private ICF/MR or designee, as applicable;
  - (d) At least one program staff person from the provider agency, the DMRS developmental center, or the private ICF/MR (as applicable) who is familiar with the individual's health status and history and the course of events prior to death; and
  - (e) The Independent Support Coordinator or equivalent, assigned to the individual.
- (3) The Death Review Committee may also include the following people:
  - (a) The DMRS Investigator, who shall be accessible to the Committee by telephone (or in person upon special request) to answer questions, if any, about the investigation;
  - (b) The primary care physician, nurse practitioner, or physician assistant who coordinated or provided medical care to the individual;
  - (c) The Director of Nursing or the nurse who provided care to the individual while receiving services through an HCBS waiver

program or other DMRS community program, in a DMRS developmental center, or in a private ICF/MR, as applicable; and

- (d) One or more physician specialists (e.g., psychiatrist, neurologist) if determined by the DMRS Regional Director, Chief Officer of the developmental center, or administrator of the private ICF/MR, as applicable, or by the DMRS Deputy Commissioner to be necessary for an adequate Death Review.
- (4) In instances when an autopsy is conducted but the final report is not available at the time of the Death Review Committee meeting, the nurse who wrote the Clinical Death Summary shall be responsible for attempting to obtain a preliminary oral or written autopsy report for discussion at the Death Review Committee meeting.
- (5) A follow-up meeting of the Death Review Committee may be scheduled for additional review either upon the request of the DMRS Deputy Commissioner or any two members of the Death Review Committee.

e. Records of Death Review Committee Meetings

- (1) Confidentiality:
  - (a) A Death Review Attendance Form (Attachment 4) containing a statement of confidentiality must be signed by all participants at the beginning of each meeting.
  - (b) With the exception of reports required by this policy, the proceedings of the Death Review Committee, including discussions among the members and any documents reviewed, shall be treated as confidential.
- (2) Minutes: Formal minutes shall be maintained for each Death Review Committee meeting.
  - (a) Preparation of minutes:
    - i. Draft minutes shall be prepared by the chair and made available to all Committee members for comment within eight (8) business days after the meeting.
    - ii. Committee members shall have four (4) business days to review the draft minutes and submit corrections and comments.
    - iii. Following the comment period deadline, the chair of the Committee shall finalize the minutes within three (3) business days.
    - iv. These timeframes may be extended by the DMRS Deputy Commissioner for good cause.
  - (b) The minutes shall include:
    - i. Name of the deceased;
    - ii. Age of the deceased at the time of death;
    - iii. Place of residence of the deceased at the time of death;

- iv. Date, time, and place of death;
- v. Cause of death;
- vi. Brief summary of the circumstances surrounding the death;
- vii. Full summary of issues discussed by the committee;
- viii. The Committee's specific findings with regard to the care and treatment provided to the individual;
- ix. Identification of any factors which may have contributed to the death in question; and
- x. Any recommendations for improvement agreed to by the committee. (The minutes must clearly indicate the basis for all such recommendations.)

(3) Distribution and maintenance of Death Review Committee minutes:

(a) Copies of the final minutes shall be distributed to the following:

- i. DMRS Deputy Commissioner or designee;
- ii. DMRS Central Office Nursing Director;
- iii. DMRS Regional Director, if the death involved an individual in an HCBS waiver program or other DMRS community program or if the death involved an individual in a private ICF/MR;
- iv. Assistant Commissioner of Facility Services, if the death involved an individual in a DMRS developmental center or private ICF/MR;
- v. Chief Officer of the DMRS developmental center, if the death involved an individual in a DMRS developmental center;
- vi. The administrator of the private ICF/MR, if the death involved an individual residing in the private ICF/MR; and
- vii. The executive director of the provider agency primarily responsible for serving the individual (or DMRS Regional Director if there is no primary provider agency), if the death involved an individual receiving services in an HCBS waiver program or other DMRS community program.

(b) Individuals authorized to receive the minutes shall maintain their copies in a secure location.

(c) The developmental center's TQI Coordinator or DMRS Regional Compliance Director, as applicable, shall be responsible for maintaining a complete file of all relevant documents (including those reviewed by or made available to the Death Review Committee) in a secure location for at least ten years, in accordance with Tennessee Code Annotated 33-3-101. Records

of Class Members shall be maintained until the lawsuit is dismissed, which, for some, may extend beyond the ten year requirement.

- (4) Referrals to licensing, regulatory, or law enforcement agencies: The Death Review Committee, in consultation with the DMRS Central Office Nursing Director, shall determine from a review of the minutes whether any aspect of the death should be referred to any licensing or regulatory agency or to law enforcement officials, if referrals have not already been made.
- (5) Other dissemination of information: The DMRS Deputy Commissioner, in consultation with the DMRS Central Office Nursing Director, shall determine whether the death review findings should be disseminated more widely or made the subject of a statewide information bulletin or other such general issuance.

f. Follow-up of Death Review Committee recommendations:

- (1) Response to Death Review Committee recommendations:
  - (a) Deaths in HCBS waiver programs or other DMRS community programs: The executive director of the provider agency or designee shall provide a written response to any Death Review Committee recommendations within thirty (30) calendar days of the receipt of the recommendations. The response shall include a complete plan for implementing each recommendation with time frames for complete implementation or an explanation of proposed alternative actions that will be taken to address the problem identified. The response shall be submitted to the DMRS Regional Compliance Director who shall submit the response to the DMRS Regional Director and to the DMRS Central Office Nursing Director for review.
  - (b) Deaths in DMRS developmental centers: The Chief Officer of the developmental center or designee shall provide a written response to any Death Review Committee recommendations within thirty (30) calendar days of the receipt of the recommendations. The response shall include a complete plan for implementing each recommendation with time frames for complete implementation or an explanation of proposed alternative actions that will be taken to address the problem identified. The response shall be submitted to the DMRS Assistant Commissioner of Facility Services and to the DMRS Central Office Nursing Director for review.
  - (c) Deaths in private ICFs/MR: The administrator of the private ICF/MR or designee shall provide a written response to any Death Review Committee recommendations within thirty (30) calendar days of the receipt of the recommendations. The response shall include a complete plan for implementing each recommendation with time frames for complete implementation or an explanation of proposed alternative actions that will be taken to address the problem identified. The response shall be submitted to the DMRS Regional Compliance Director who shall submit the response to the DMRS Regional Director, to the DMRS Assistant Commissioner of Facility Services, and to the DMRS Central Office Nursing Director for review.

- (2) The DMRS Regional Director or designee or the Chief Officer of the developmental center or designee, as applicable, shall be responsible for having a reliable tracking system and for monitoring the effectiveness of the implementation of recommendations issued by the Death Review Committee. This monitoring of implementation may include on-site review of records and practices of provider agencies or private ICFs/MR.
- (3) The DMRS Regional Compliance Director or the developmental center TQI Coordinator, as applicable, shall submit implementation status reports to the DMRS Central Office Nursing Director on a monthly basis.

## 5. Clinical Death Summaries and Investigations

- a. Clinical Death Summary: The Clinical Death Summary is a written report by a qualified registered nurse regarding the circumstances surrounding an individual's death that includes information such as services received or omitted, significant events, medical and medication histories, cause of death and autopsy findings (if available), and other information relevant to the death.
  - (1) A Clinical Death Summary shall be done for the following deaths:
    - (a) Any death of a Class Member who:
      - i. Receives community service through an HCBS waiver program or other DMRS community program; or
      - ii. Resides in a DMRS developmental center; or
      - iii. Resides in a private ICF/MR; or
    - (b) Any Suspicious, Unexpected, or Unexplained death.
  - (2) The Clinical Death Summary shall be completed in accordance with the following:
    - (a) Death of a Class Member in an HCBS waiver program or other DMRS community program: The DMRS Regional Nurse shall complete a Clinical Death Summary within thirty (30) calendar days of the death.
    - (b) Death of a Class Member in a DMRS developmental center: A developmental center nurse shall complete a Clinical Death Summary within thirty (30) calendar days of the death.
    - (c) Death of a Class Member in a private ICF/MR: The DMRS Regional Nurse shall complete a Clinical Death Summary within thirty (30) calendar days of the death.
    - (d) Suspicious, Unexpected, or Unexplained death of an individual in an HCBS waiver program or other DMRS community program: The DMRS Regional Nurse shall complete a Clinical Death Summary within thirty (30) calendar days of the death.
    - (e) Suspicious, Unexpected, or Unexplained death of an individual in a DMRS developmental center: A developmental center nurse shall complete a Clinical Death Summary within thirty (30) calendar days of the death.
    - (f) Suspicious, Unexpected, or Unexplained death of an individual in a private ICF/MR: The DMRS Regional Nurse shall complete a

Clinical Death Summary within thirty (30) calendar days of the death.

- (g) Upon determining that a Clinical Death Summary should be completed, the DMRS Regional Director or Chief Officer of the developmental center, as applicable, shall notify the DMRS Central Office Nursing Director.
- (h) DMRS may contract with or make other arrangements for a qualified, independent registered nurse to complete the Clinical Death Summary.

b. DMRS Investigation:

- (1) A DMRS investigation shall be done for any Suspicious, Unexpected, or Unexplained death of an individual who:
  - (a) Receives community service through an HCBS waiver program or other DMRS community program; or
  - (b) Resides in a DMRS developmental center; or
  - (c) Resides in a private ICF/MR and is a Class Member.
- (2) The DMRS Investigation shall be completed in accordance with the following:
  - (a) Suspicious, Unexpected, or Unexplained death of an individual in an HCBS waiver program or other DMRS community program: Within thirty (30) calendar days of a Suspicious, Unexpected, or Unexplained death, the DMRS Office of Investigations shall complete an Investigation Report focusing on any possible or alleged abuse, neglect, or mistreatment. The DMRS Regional Nurse and the DMRS Investigator will confer with each other and share information prior to completion of their reports.
  - (b) Suspicious, Unexpected, or Unexplained death of an individual in a DMRS developmental center: Within five (5) calendar days of a Suspicious, Unexpected, or Unexplained death, the DMRS Office of Investigations shall complete an Investigation Report focusing on any possible or alleged abuse, neglect, or mistreatment. The DMRS developmental center registered nurse and the DMRS Investigator will confer with each other and share information prior to completion of their reports.
  - (c) Suspicious, Unexpected, or Unexplained death of an individual in a private ICF/MR: Within five (5) calendar days of a Suspicious, Unexpected, or Unexplained death, the DMRS Office of Investigations shall complete an Investigation Report focusing on any possible or alleged abuse, neglect, or mistreatment.

c. Distribution of Clinical Death Summaries and Investigation Reports: Clinical Death Summaries and Investigation Reports shall be transmitted immediately upon completion to:

- (1) The DMRS Central Office Nursing Director;
- (2) The DMRS Regional Director if the death involved an individual receiving services in an HCBS waiver program or other DMRS community program or if the death involved an individual residing in a private ICF/MR;

- (3) The executive director of the provider agency primarily responsible for serving the individual, if the death involved an individual receiving services in an HCBS waiver program or other DMRS community program;
- (4) The Chief Officer of the developmental center, if the death involved an individual residing in a DMRS developmental center.
- (5) The administrator of the private ICF/MR, if the death involved an individual residing in the private ICF/MR.

**6. Additional quality improvement activities**

1. Annual review of mortality data:
  - a. At least annually, the Central Office Nursing Director or designee shall review and analyze mortality data to determine possible patterns or risk factors in such areas as:
    - (1) The demographic, medical, mental health, and service provision profile of the deceased individuals;
    - (2) The immediate and root causes of death;
    - (3) The issues, problems, and deficient practices or procedures identified in death reviews; and
    - (4) The implementation of recommendations issued as a result of the death reviews.
  - b. The data analysis shall be done in such a way as to show differences, if any, by type of provider (i.e., DMRS developmental center, private ICF/MR, HCBS waiver program, or other DMRS program).
2. Peer review process
  - a. At least annually, a random sample of 10% of the clinical death summaries and DMRS Death Reviews from each DMRS region and each DMRS developmental center shall be selected for peer review.
  - b. The peer review process shall be coordinated by the DMRS Central Office Nursing Director and the TQI Director or DMRS Regional Compliance Director, as applicable.
  - c. The peer review group shall include the regional and developmental center nurses who write the clinical death summaries and the DMRS Regional Compliance Directors and developmental center TQI Coordinators who chair the death review meetings.
  - d. The peer review group shall review the sample of clinical death summaries, DMRS Death Reviews, and Death Review Committee minutes and shall make recommendations, where applicable, for improving consistency and quality. Such recommendations shall be considered for incorporation into clinical death summary and/or death review training.

**E. ATTACHMENTS:**

1. Notice of Death Form
2. Reportable Incident Form
3. Provider's Death Review Form
4. Death Review Attendance Form

**F. PREVIOUS POLICY:** Death Reporting and Review Policy # 2000-76 effective June 1, 2000.

**G. DATE APPROVED BY TENNCARE:** November 25, 2008

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**H. POLICY APPROVAL**

Joanna Damone by W Moore  
Signature of Assistant Commissioner  
Office of Policy, Planning, and Consumer Services

12-2-2008  
Date

Stephen D. Davis  
Signature of Deputy Commissioner  
Division of Mental Retardation Services

12/2/2008  
Date