

Assisted Living Facility Full Adverse Incident Report - 15 Day

Confidential



Refer to sections 429.23(2) and (4), Florida Statutes. The facility must submit a full report on all adverse incidents to the agency within 15 days by electronic mail, online reporting, or United States mail.

SEND REPORT TO:

Agency for Health Care Administration
Risk Management and Patient Safety Program
2727 Mahan Drive, MS 16
Tallahassee, FL 32308-5403
Phone: (850) 412-3731; Fax (850) 922-2217

AHCA USE ONLY:

Report #: _____
Incident #: _____
Review Date: _____

I. ASSISTED LIVING FACILITY INFORMATION

A. Facility Name _____

License Number: _____

Street Address: _____

City: _____ County: _____

Phone: (____) _____ FAX: (____) _____

Person reporting: _____

Title: _____

B. Assisted Living Facility Risk Manager (If Applicable)

Name: _____

Credentials (optional): _____

Phone: (____) _____ FAX: (____) _____

III. INCIDENT INFORMATION

A. Date of Incident: _____

(Attach Copy of 1-Day Report)

II. RESIDENT INFORMATION

A. Resident Name

Last Name: _____

First Name: _____

Medicaid ID #: (If Applicable) _____

Current Age: _____ Sex: _____

B. Resident Representative Information

Name: _____

Relationship to Resident: _____

Address: _____

Telephone Number: _____

B. Outcome of the Adverse Incident *(please check all that apply):*

- Death*
- Brain or spinal damage
- Permanent disfigurement
- Fracture or dislocation of bones or joints
- Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives
- Any condition that required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Location to which resident was transferred (*i.e. Name of Hospital, Emergency Room, etc.*) _____
- Abuse, neglect or exploitation as defined in Section 415.102, Florida Statutes
- Events reported to law enforcement; or
- Elopement

*NOTE: If the Incident involved a death, was the Medical Examiner notified? Yes No

Name and contact number of the Medical Examiner _____

IV. ANALYSIS AND CORRECTIVE ACTION

A. Analysis (apparent cause) of this incident *(use additional sheets as necessary for complete response):*

B. Describe corrective or proactive action(s) taken *(Use additional sheets as necessary for complete response):*
Note: This section is not required if incident is not adverse.

V. NOT AN ADVERSE INCIDENT

If after a complete investigation, the risk manager or authorized ALF representative determined that the incident **was not an adverse incident**, check this item, complete Items I, II, IIIA, IIIB, IIIC, IVA, the signature block (below) and send to AHCA.

Signature of Person Preparing Report

E-mail Address

Date Prepared

Printed Name of Person Preparing Report

Title