Assisted Living Facility
Full Adverse Incident
Report - 15 Day

Refer to sections 400.423(2) and (4), Florida Statutes. The facility must submit a full report to the agency within 15 days by electronic mail, facsimile, or United States mail on all adverse incidents.

SEND REPORT TO:

Agency for Health Care Administration
Facility Data Analysis Unit
2727 Mahan Drive, MS 47
Tallahassee, FL 32308
Phone: (850) 414-6936; Fax (850) 922-2217

AHCA USE ONLY:
Date: _____ Incident ID:_____

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: _(_____)_____

II. RESIDENT INFORMATION

Name: _____

Social Security Number: _____

Medicaid ID #:(if applicable)_____

Age: _____ Sex: _____

Resident Representative Information:

Name: _____

Relationship to Resident: _____

Address: _____

Telephone Number: _____

III. INCIDENT INFORMATION

A. Date of Incident: _____

B. Was an Initial Adverse Incident Report (1 Day report) submitted for this incident? ☐ **Yes** ☐ **No**

C. Date Submitted_____ **(Attach Copy)**

D. Check one:

❑ 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, IVA, the signature block and send to AHCA.**

❑ After a complete investigation, the risk manager or authorized ALF representative determined that **the incident did qualify as an adverse incident** check this item and complete requested information all 3 pages of this form, then send this form to AHCA.

E. Outcome of the Adverse Incident (please check):

- ❑ Death*
- ❑ Brain or spinal damage
- ❑ Permanent disfigurement
- ❑ Facture 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 _____.
- ❑ Abuse, neglect or exploitation as defined in Section 415.102, Florida Statutes
- ❑ Events reported to law enforcement; or
- ❑ Elopement

Do you have a risk management and quality assurance program? ___Yes ___ No

*Note: If the incident involved a death, was the Medical Examiner notified? ❑ Yes ❑ No
Name and contact number of the Medical Examiner_____

F. Describe circumstances of the incident (narrative):
(Use additional sheets as necessary for a complete response)

_____

_____

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G. List license numbers of personnel and the capacity in which they were directly involved with this incident, i.e., registered nurse, certified nursing assistance, etc. (List social security numbers and capacity of unlicensed personnel):

_____

_____

_____

_____

H. List license numbers of witnesses (List social security numbers and capacity of unlicensed personnel):

_____

_____

_____

_____

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):

Signature of Person Preparing Report | E-mail Address | Date

Printed Name | Title