

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
- 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](#) _____.
- 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)

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):
