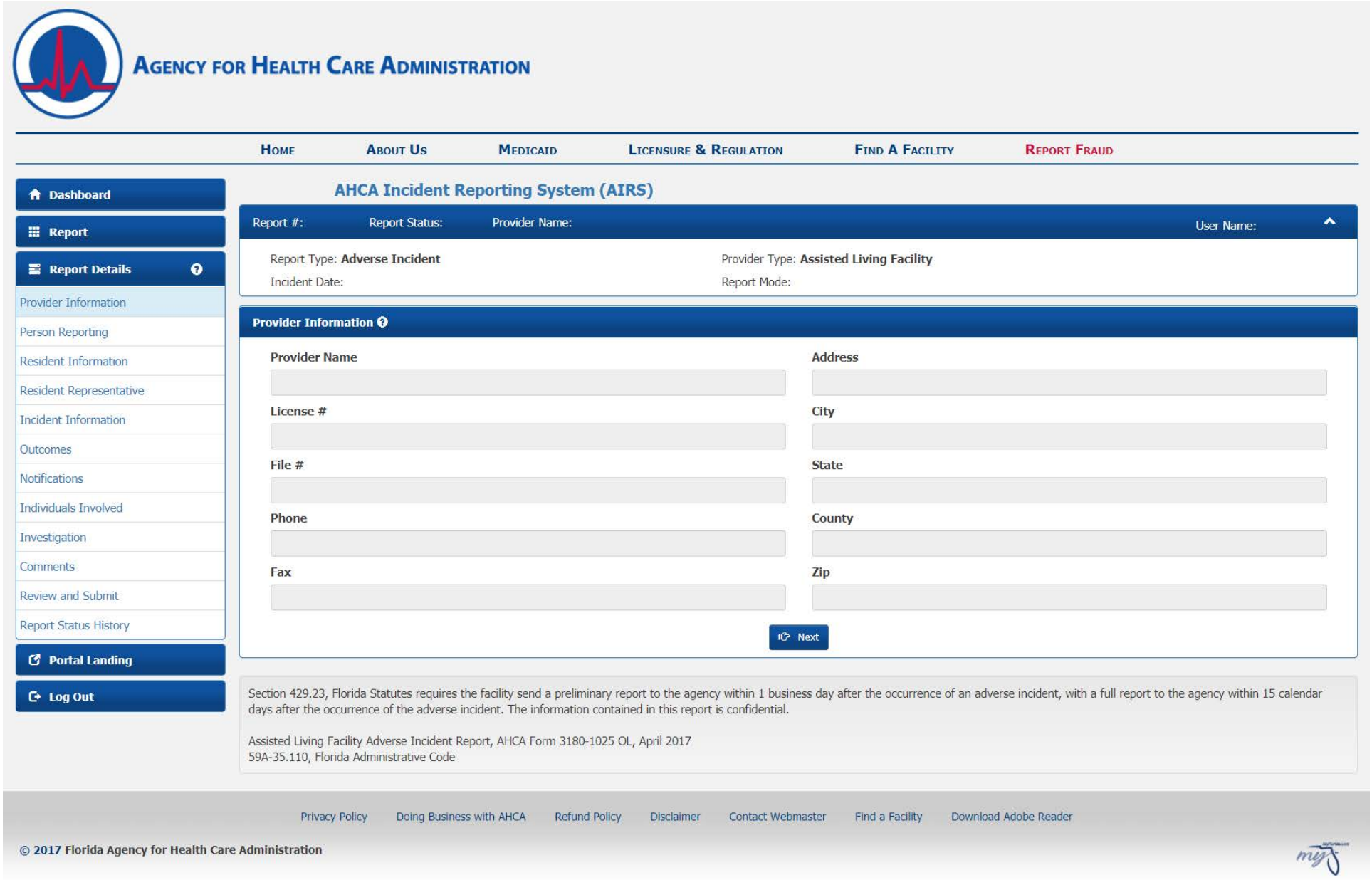
AIRS External Screens – Assisted Living Facilities



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AHCA Incident Reporting System (AIRS)

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Report Type: **Adverse Incident**
Provider Type: **Assisted Living Facility**
Incident Date:
Report Mode:

Person Reporting Information

First Name

Last Name

Email

Phone

Title

License #

Other Title

Do you have a risk management and quality assurance program?

Yes No

Save Save/Next

Section Comments

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AHCA Incident Reporting System (AIRS)

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Incident Date: Report Mode:

Resident Information

First Name **Last Name**

Resident # **SSN #**

Age **Gender**

-- Select -- Male Female

Medicaid Recipient? **Medicare Recipient?**

Yes No Yes No

Medicaid # **Medicare #**

Save Save/Next

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Resident Representative

☐ Check if the resident does not have a resident representative and the resident represents themselves.

First Name

Last Name

Address

City

State

-- Select --

Zip

Phone

Relationship

Save Save/Next

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Incident Information

Incident Date

Incident Time - Slide to select time of incident.

Equipment Involved?

Yes No

Incident Location

Other

Other Incident Location

List Equipment Involved

Save Save/Next

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Outcomes

- [ ] 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 consent, including failure to honor advanced directives.
- [ ] Any condition that requires 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

- [ ] An event that is reported to law enforcement or its personnel for investigation.
- [ ] Resident elopement, if the elopement places the resident at risk of harm or injury.

Save Save/Next

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Notifications

Medical Examiner Notified?
Yes No

First Name

Last Name

Phone

Family Notified?
Yes No

List Family Notified

External Agencies Notified?
Yes No

List Agencies Notified
- DOH
- Elder Affairs
- DCF
- Others

List Other Agencies Notified

Physician Notified?
Yes No

List Physician Recommendations

Save | Save/Next

Section Comments

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Individuals Involved

Add Individual

First Name	Last Name	Role	Capacity	License #	SSN #	Action

Next

Section Comments

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Circumstances of the Incident (Narrative of Facts)

Text	User Name	DateTime	Action

Analysis of the Incident (Apparent Cause(s))

Text	User Name	DateTime	Action

Corrective Action Summary (Corrective or Proactive Actions Taken)

Text	User Name	DateTime	Action

Action

Next

Section Comments

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Comments

Comments from all sections are shown below.

Comment	Section Name	Created By	Created Date

Next

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Report Submission History

Please correct the errors listed below. Once all of the errors have been corrected, please submit the report.

Section Name	Error Description

Cancel Report

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Report Submission History

Submit Report
Withdraw

Document Name	Submitted Date

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Report Status History

Status Code	Status Description	Report Mode	Created By	Status Date

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