Alpha HealthPlus –Quality Improvement Form.

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Section A: Submitter Information (Optional)

Full Name: _____

Role/Relationship to Alpha Health Plus:

☐ Resident ☐ Family Member ☐ Staff ☐ Vendor ☐ Community Partner ☐ Other: _____

Phone Number: _____ Email Address: _____

Section B: Area of Concern or Opportunity for Improvement

☐ Resident Care & Support ☐ Staff Professionalism ☐ Medication Administration

☐ Communication & Responsiveness ☐ Safety & Cleanliness

☐ Community Integration ☐ Compliance with Standards (RSA, COMAR, HIPAA, etc.)

☐ Other: _____

Section C: Describe Your Concern or Suggestion

_____

_____

_____

Section D: Impact or Outcome Observed (If Any)

_____

_____

_____.

Section E: Your Recommendation

_____

_____

_____

Section F: Would You Like to Be Contacted About This?

☐ Yes – Please contact me for follow-up ☐ No – I prefer to remain anonymous

Best time to reach you: _____

Section G: For Internal Use Only (To be completed by QA Team)

Date Received: _____

Initial Reviewer Name: _____

Action Taken:

☐ Logged in Quality Improvement Database ☐ Investigation Initiated

☐ Resolution Implemented ☐ Other

☐ Referred to Department Manager ☐ No Action Needed

_____

Final Resolution Date: _____

Follow-Up Completed By: _____

Outcome Summary:

_____

_____

■ ***Thank you for helping us improve! Your feedback supports our mission of delivering the highest quality care in a compassionate, person-centered environment.***