STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965781	**08/10/2017**
NAME OF PROVIDER OR SUPPLIER **AZALEA OPCO LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1701 MAYO STREET** **HOLLYWOOD, FL 33020**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A monitoring inspection was conducted on . The Azalea Opco LLC (license #10106) assisted living facility was not found to be in compliance during this visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the facility failed to provide 1 out of 1 resident (resident #1) at least a 45-day written notice of relocation of residency to indicate the reason for the relocation.

The findings are:

In an interview with the administrator on at 1:20pm, she stated that based on the facility's inability to adequately supervise resident #1, the facility was in process of relocating the resident to another facility which could adequately meet the resident's needs. She stated that the facility made this decision when the resident eloped and returned to the facility on . She stated that she verbally notified the resident's representative of there facility's intent to relocate the resident and that the facility did not provide the resident's representative a 45-day written notice of relocation of residency to indicate the reason for the relocation.

Review of resident #1's record indicated that the facility did not provide the resident and/or her representative a 45-day written notice of relocation of residency to indicate the reason for the relocation.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and interview, the facility failed to develop detailed resident elopement policies and procedures to prevent the elopement for 1 out of 1 resident (resident #1).

The findings are:

In an interview with the administrator on at 1:15pm, she stated that resident #1 eloped from the facility on at around 8:00am and no facility staff was directly supervising the resident at this time. She stated that when she reviewed the security video recording which showed resident #1 eloping from the facility's main gate on , she saw that the resident was walking independently without any staff supervision. She stated that the she was not aware of the resident's required previous or present level of daily supervision, but she was aware that the resident was an elopement risk. She stated that the facility did not implement any special interventions to prevent the resident from eloping, besides relying

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on the facility's security coded main gate located in the courtyard, on the east side of the facility.

Review of resident #1 health assessment dated on indicated that she was diagnosed with , adjustment , , , glucose tolerance, tobacco and . Further review of this health assessment indicated that the resident was an elopement risk and required supervision with ambulation and transferring, due to instability.

Review of the security video recording on at 1:30pm, it showed that resident #1 eloped from the facility's main gate on at around 8:00am and the resident was walking independently without any staff supervision. In an interview with the administrator on at 1:35pm, she stated that she was not sure if resident #1 entered the correct code the main gate's security key , to unlock the gate or if the gate was not previously latched properly by the housekeeper who entered the facility a few minutes before the resident departed the facility. She stated that the facility had not yet changed the main gate's security code and did not yet replace the gate's closure spring to ensure that the gate latched annd locked properly after it was opened.

In an interview with resident #1 on at 1:45pm, she stated that she had lived in the facility for a few weeks and that she did not like it living there because she wanted to go back home. She stated that on at around 8:00am, she was walking independently in the facility's courtyard and she entered the code at the facility's main gate security key , to leave the facility. She stated that when she eloped on , there were no staff members in the courtyard area and she returned to the facility later that same morning. She stated that she was aware that she eloped from the facility and she just wanted to leave.

In an observation on at 2:05pm, the facility's main gate did not have a closure spring installed and the gate did not properly close and lock if left partially opened.

In an interview with the facility's housekeeper on at 2:15pm, she stated that she was sure that the facility's main gate was latched and locked after she entered the facility on at or around 8:00am.

In an interview with the facility's maintenance coordinato on at 2:20pm, he stated that he was aware that resident #1 eloped from the facility on and that the facility's main gate did not yet have a closure spring installed. He stated that he was aware that the gate did not properly close and lock if left partially opened and that he did not change the main gate's security code because he did not know how to perform this function.

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In an interview with the administrator on at 2:30pm, she stated that the facility's main gate with security coded entry was installed without a local permit, she did not know if this was required and the facility did not have a maintenance plan or log to ensure the main gate was in good working condition. She stated that the facility resident elopement policies and procedures did not include details relating to the maintenance of the facility's main gate and the supervision of at-risk residents while they were in the courtyard, so as to prevent elopements.

Review of the facility resident "elopement management" policies and procedures indicated that it had no details relating to the maintenance of the facility's main gate and the supervision of at-risk residents while they were in the courtyard, so as to prevent elopements.

Class III