STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968661	**11/22/2017**
NAME OF PROVIDER OR SUPPLIER **LIVING WITH FRIENDS ALF II**	STREET ADDRESS, CITY, STATE, ZIP CODE **3405 N 12TH ST** **BROADWAY, FL 33605**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2017, a complaint survey, (CCR# 2017013727) was conducted at Living With Friends Assisted Living Facility II. Deficiencies were identified at the time of the visit.

(License # 12542)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interview the facility failed to provide personal supervision for 1 of 6 (#1) residents who were identified as being at risk for elopement. Additionally they failed to maintain a general awareness of the whereabouts for 1 of 6 (#1) residents.

Findings included:

On , 2017 a record review was conducted for Resident #1. Resident #1's record included a health assessment form (1823) signed by a licensed physician dated stating they were an elopement risk.

A review of the facility daily observation notes was conducted on 11/ . Dated , the notes documented by Staff D stated Resident #1 left the facility at 10:15 AM without telling staff he was leaving or signing out.

On at 10:33 AM an interview was conducted with the Administrator. The Administrator stated Resident #1 left the facility on at 10:15 AM and did not return for his evening medications. The staff alerted her at approximately 8PM and she starting looking for him. She called family/friends and the police. She stated Resident #1 was not located until at approximately 12 PM when his daughter brought him back to the facility.
The Administrator stated they were aware that Resident #1's 1823 stated they were an elopement risk but did not think he actually was. The Administrator stated they did not have anything in the facility to alert anyone that Resident #1 is an elopement risk. He did not have anything on him to identify him, the facility name/address or phone number. He did not have his medications when he left. He did not take

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them that night or the next morning. The Administrator confirmed that Resident #1 routinely left the facility to go walking without notifying staff or signing out. The Administrator confirmed the facility had not taken any steps to address this although Resident #1 was identified as an elopement risk.

On , 2017 at 9:05 AM an interview was conducted with Staff A. Staff A stated, " I did not know Resident #1 was an elopement risk."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to initiate an adverse incident report for 1 resident (#1) who eloped from the facility putting the resident at risk of harm due to missing their daily medications and the Administrator's awareness they were an elopement risk and failing to ensure Resident #1 had proper identification on his person.

Findings included:

On a review of the facility records was conducted. The records did not include documentation of an adverse incident report for Resident #1 following an elopement on .

On at 10:33 AM an interview was conducted withe the Administrator. The Administrator stated they were aware Resident #1 was an elopement risk but did not make staff aware or ensure they had proper identification on their person. Resident #1 did not take their medications with them when they left therefore they missed two doses of all physician ordered medications.

Class III