STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965179	**02/05/2018**
NAME OF PROVIDER OR SUPPLIER **SAFE HARBOR ASSISTED LIVING RESORT**	STREET ADDRESS, CITY, STATE, ZIP CODE **1320 SW 26TH STREET** **FORT LAUDERDALE, FL 33315**	

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

0000 - Initial Comments

A unannounced complaint inspection, CCR #2017012530, was conducted on and at Safe Harbor Assisted Living Resort, License #9568. The facility was not found to be in compliance during this visit.

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

Based on record review and interview, the facility failed to implement their resident elopement response policies and procedures for 1 out of 10 sampled residents (Resident #1) after the resident eloped and was discharged from the facility.

The findings include:

Review of the facility records indicated that Resident #1 was admitted to the facility on and discharged on .

Review of Resident #1's health assessment dated indicated that the resident was diagnosed with , , , , Nuclear and , , . Further review of the resident's health assessment indicated that he needed assistance with self-administration of his daily medications.

In an interview with the Administrator on at 3:00pm, she stated that Resident #1 left the facility on and the facility was not aware of the resident's whereabouts from to . She stated that she did not review and/or implement the facility's resident elopement management policies and procedures to attempt to locate this missing resident after . She stated that she contacted the resident's representative by telephone on or about to determine the resident's whereabouts, and she left a voicemail message. She stated that the facility did not attempt to search for the resident or notify the police when the resident went missing on and did not make further efforts to determine the resident's whereabouts until the resident contacted the facility by telephone on to express that he no longer wanted to live there and to arrange for the pick up of his personal items. She stated that the facility discharged the resident from the facility on .

Review of the facility's elopement management policy and procedure indicated that the facility staff members are responsible to know of each resident's whereabouts and it will make every effort to locate a missing resident as quickly as possible. The elopement management policies and procedures indicated that the facility must perform an immediate search of the missing resident and must notify the

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police and Agencies, shall the resident remain missing. Further review of the elopement management policies and procedures indicated that the resident's representative must be notified by the facility no later than 2 hours after the resident's disappearance.

In an interview with Resident #1's representative on at 3:20pm, she stated that she did not know that the resident departed the facility on until and that the resident went to the hospital because he was displeased with the facility's meals. She stated that the facility did not immediately notify her that the resident was missing and did not make efforts to locate the resident when he was missing for several days. She stated that she attempted to reach the facility by telephone on or after , but she was not able to reach the Administrator, and communication with the facility was useless after this because the resident chose not to go back to the facility on .

Class III

Z827 - Unlicensed Activity - 408.812 FS

Based on interview and record review, the facility failed to report an unlicensed provider to the Agency when it became aware that 5 out of 5 sampled residents (Resident # 3, 4, 5, 6 and 7) were discharged from the facility to reside in a facility operated by an unlicensed provider.

The findings include:

Review of the facility admission/discharge log indicated that Resident #4 was admitted to the facility on and discharged on ; and Resident #5 was admitted to the facility on and discharged on .

In an interview with the facility manager on at 1:35pm, she stated that Resident #3, 4, 5, 6 and 7 lived in the facility for several months until the residents chose to depart the facility in , 2017. She stated that none of these residents provided the facility with a notice to represent that they were going to discharge themselves from the facility. She stated that in , 2017 she learned from staff member A, who previously worked in the facility, that Resident #3, 4, 5, 6 and 7 moved with an unlicensed provider after being discharged from the facility in , 2017 and that the unlicensed provider was operated by a previous facility employee, staff member B. She stated that staff member B used to work in the facility until , 2017. She stated that she did not notify the Agency after becoming aware that the residents possibly lived in an unlicensed facility.

In an interview with the facility administrator on at 1:45pm, she stated that at the moment when

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Resident #3, 4, 5, 6 and 7 were discharged in , 2017, she was not aware of where the residents moved to, and that she found out within one or two weeks thereafter that staff member B "took the facility's residents" to live in an unlicensed facility. She stated that she did not notify the Agency after becoming aware that the residents possibly lived in an unlicensed facility.

In an interview with the facility's previous staff member A on at 3:55pm, he stated that he use to work at the facility for about a year until he left in , 2017. He stated that staff member B also used to work in the facility as a supervisor and that he notified the facility manager sometime in , 2017 that Resident #3, 4, 5, 6 and 7 were discharged from the facility to reside in a facility operated by staff member B, who was an unlicensed provider.

Unclassified