STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963784	**03/13/2018**
NAME OF PROVIDER OR SUPPLIER **WILD FLOWER INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **639 MICHIGAN BLVD. #1500** **DUNEDIN, FL 34698**	

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

0000 - Initial Comments

Assisted Living Facility

A complaint investigation (CCR 2018000536) was conducted at Wild Flower Inn on . . . . . Wild Flower Inn had a deficiency at the time of the investigation.

(License #8223)

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

Based on record review and interview, the facility failed to contact a resident's health care surrogate (HCS) after the resident exhibited a significant change and hospitalizations for one (Resident #1) of three resident records sampled.

Findings included:

A review of resident records conducted on showed that Resident #1 had on and . . and was sent to the hospital. Incident reports reviewed stated that Resident #1's power of attorney (POA) was notified. The records also showed documentation dated that the facility received a text message from the POA indicating that the resident underwent surgical procedures (photographic evidence obtained).

A review of Resident #1's record showed no documentation concerning individuals named as POA. The review of the file showed a document for a HCS that was signed by Resident #1 and witnessed by two individuals (photographic evidence obtained). There was no indication in the record that the HCS was notified about the resident's . . and hospital visits.

An interview was conducted with the Administrator at 12:52 PM on . . . . and the Administrator was asked who Resident #1's POA was. The Administrator stated that they didn't know and stated that the individual referred to as POA in facility records was the resident's "trustee". They identified this person as the Former Owner (of the facility). When asked why Resident 1's HCS (a different person, not connected with the facility) wasn't indicated as being notified after hospital visits on . . . . and , the Administrator stated that they had never met the HCS and they called this person but they never picked up the phone. The Administrator stated they had no proof/documentation that they attempted to reach the HCS.

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A phone interview was conducted with the HCS on at 11:10 AM. The HCS stated that they did not receive phone calls from the facility concerning Resident #1's hospital visits on or . An additional phone interview was conducted at 11:48 AM on with the Case Manager at the hospital where Resident #1 was admitted as a patient (after being transferred from another hospital). The Case Manager stated that Resident #1 was admitted without appropriate paperwork being provided by the facility showing any HCS or POA documentation. They stated that the Administrator brought in the HCS document a few days after the resident was admitted on . They stated that there was documentation on file that the Former Owner had approved the surgical procedures for Resident #1 at the hospital where Resident #1 was previously admitted.

Class III