STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968771	**03/20/2018**
NAME OF PROVIDER OR SUPPLIER **SKAGWAY LIVING FACILITY, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2210 W SKAGWAY AVE** **TAMPA, FL 33604**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018 a Complaint CCR#2018002788 survey in conjunction with a Revisit to 1/17/18 Complaint CCR#2017013550 survey was conducted at Skagway Living Facility. Deficiencies were identified during the visit.

(License #12613)

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 honor the rights of 1 (#1) prior resident who was not treated with consideration and respect upon discharge and failed to ensure the residents belongings were safely maintained (including the resident's ,). Specifically, the facility dropped Resident #1 off at a local hospital emergency to not being able to find alternate placement. Additionally, they allowed Resident #1's dog to leave the facility.

Findings Included:

A review of Resident #1's record revealed a 45-day notice of discharge given on due to non payment. A progress report dated stated the notice would be enforced if the facility did not receive payment by .

During a review of the facility admission/discharge log it revealed Resident #1 was discharged to a local hospital emergency due to non-payment and aggressive behavior.

During an interview with the Owner on at 10:12 AM, the Owners stated they could not find placement for Resident #1 and was told by another agency representative to take them to the local hospital emergency leave him. They stated they took Resident #1 to the local hospital emergency the Owner told the lady at the desk he was leaving Resident #1.

During an interview with Resident #1's case manager on at 1:01 PM, they stated they visited Resident #1 at the facility on . They stated they gave the Owner their business card and the Owner never told her that Resident #1 had been given a 45-day notice or that alternate placement was

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needed for Resident #1.

During a review of Resident #1's record it revealed a shot record for their dog that moved in and lived at the facility with them.

During an interview with the Owner on at 10:12 AM, they stated Resident #1's dog did in fact live in the facility . They stated the dog did not go with the resident at discharge. Shortly after he discharged the resident on the dog got out of the facility "looking for the resident" and they could not locate the dog.

During an interview with Resident #1's case manager on at 1:01 PM, they stated Resident #1 had the dog for a number of years and he was his reason for living. They stated Resident #1 was heartbroken without the dog and they watched Resident #1 deteriorate following the loss of his dog.

Class III