STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969010	**07/03/2018**
NAME OF PROVIDER OR SUPPLIER **ELDERLY PRIDE ASSISTED LIVING LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **322 REGAL PARK DR** **VALRICO, FL 33594**	

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

0000 - Initial Comments

ASSISTED LIVING FACILITY

A complaint investigation (CCR#2018006044) was conducted at Elderly Pride Assisted Living on in conjunction with a biennial re-licensure survey with limited nursing services (LNS) and limited mental health (LMH) services. Elderly Pride Assisted Living had a deficiency at the time of the investigation.

(License# 12869)

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

Based on record review and interviews, the facility failed to offer personal supervision to 3 (Resident #2, Resident #5 and Resident #6) of 3 sampled residents who were left alone in a hospital lobby.

Findings included:

The administrator stated on at 1:10 pm his other staff did not come to work so since he did not want Resident #4 to miss her appointment at the hospital, he took the three residents, Resident #2, Resident #5 and Resident #6 with him. When the administrator got to the hospital, he sat the three residents down in the busy main lobby of the hospital and told the residents to sit still and don't move until he came back from Resident #4's appointment.

Resident #5 stated on at 1:15 pm that as soon as the administrator left with Resident #4, Resident #2 said he wanted to go to the . She stated she told him to sit still but he went anyway. When the administrator came back, she told him Resident #2 had gone to the had not come back.

The administrator stated on at 1:25 pm he went to the Resident #2 was not there. He got in touch with security and they told him he was in the emergency . He stated he found Resident #2 lying on a bed and he did not know why he was there and he had not been to the

Record review on of Resident #2 and Resident #6s' health assessments revealed both had . Resident #2 had short term memory loss which enabled him to forget where or who he was in

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a short amount of time.

Resident #2's case manager was interview by phone on . . . . at 12:45 pm and she stated because of Resident#2's short term memory loss, he should not be left unsupervised in a large unfamiliar place. He would just walk off and not be able to say who he was or why he was there.

Class III