STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969091	07/10/2018
NAME OF PROVIDER OR SUPPLIER **TUSCAN GARDENS OF VENETIA BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **841 VENETIA BAY BLVD** **VENICE, FL 34285**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR#2018005729 was conducted on through at Tuscan Gardens at Venetia Way, an assisted living facility (license #12918) located in Venice, Florida.

The following is description of the deficiency.

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

Based on 1 of 2 resident records reviewed, and interview with administrative staff, the facility failed to ensure there was documentation about the elopement and the interventions for 1 (Resident #6) of 12 residents reviewed.

The findings include:

1. Resident #6 was admitted to the memory care locked unit on . A review of the adverse incident reports dated revealed the resident eloped from the facility. A review of the resident's record revealed there was no documentation about the elopement in the resident's record.

On at 12:12 p.m., the executive director and the wellness director, both indicated the previous director had given a electronic key (fob) to the landscaping staff who needed to get into the patio area of the memory care unit. One of the landscaping staff had unlocked the door for the resident to allow the resident to leave.

Further review of the resident's record revealed a home health nurse note dated which documented the resident had . There was no documentation in the resident's record about the or the circumstances about the . The review of the resident's record for the home health notes revealed the resident was being seen for a to the hand, physical , , and occupational , , . There was no documentation demonstrating an awareness of the status, nor was there communication between the , and the assisted living staff to demonstrate continuity of care.

On at 12:12 p.m., the wellness director said they had just changed their computer systems and were having difficulty with documentation. Both the executive director and the wellness director said they have a program, but they had not been putting interventions in the record.

Class III