STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966757	09/18/2018
NAME OF PROVIDER OR SUPPLIER **LIFESTYLE LIVING #2**	STREET ADDRESS, CITY, STATE, ZIP CODE **833 NORTH RAINBOW DRIVE** **HOLLYWOOD, FL 33021**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on . . . . . and . . . . . at Lifestyle Living #2, a 6 bed Assisted Living Facility, License #10901. The facility had deficiencies at the time of the visit.

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to ensure that an Adverse Incident Report was completed for an event in which law enforcement was involved/called, for 1 out of 7 residents (Resident #7).

The findings include:

During an interview with the Administrator on at 2:18 PM, it was revealed that Resident #7 attempted to commit . . . . . by slashing her wrist. The Administrator stated the event happended on , "It was right after lunch, said she wanted to go lay down in her ." According to administrator, the resident did not ask to go (to hospital).

During an interview with Employee B on . . . . . between 2:36 PM and 2:45 PM regarding the incident for Resident #7 the following was noted. Employee B stated that "We were fixing lunch. She came out and said she was going to her . . . I said when I finish lunch, I will come get you." When I went into her 's when I saw the red mark on her hand. Employee B, stated "She said nothing and gave no indication that she was going to do such. She wasn't upset or anything."

During a phone interview on . . . . . at 11:01 AM with the local police department it was revealed that the matter was sent to them because Resident #7 slashed her wrist. Not in an attempt to harm herself, but to get attention. It was revealed upon arrival of local police, I met with (resident), who was in bed, holding her wrist that was already bandaged. She was breathing heavily, and not very responsive to any of my questions, so I walked her outside to be checked out by Fire Rescue. During a further interview, it was revealed that the resident while at the hospital stated she cut her wrist not in an attempt to harm herself, but rather because she wanted her nurses to take her to the hospital because she wasn't feeling well."

During a confidential interview on at 12:08 PM, the following was revealed. Resident #7 had brought a razor from another ALF that she was living at. She was having a difficult moment at the time.

During the interview with the Administrator on . . . . . , between 2:18 and 2:35 PM, this surveyor

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asked the Administrator if the Adverse Incident Report had been filed with the Agency. Administrator stated they had completed one, but was not able to provide it at the time of the investigation. However, a review of the facility did not yield such.

Lastly, this surveyor received an email from the Administrator on at 9:01 PM in which it states "I went through my files for the discharge resident and couldn't find proof I did the adverse but only the internal incident report." As such, the facility failed to complete/submit the required Adverse Action Report.

Class III