STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968818	R 11/13/2018
NAME OF PROVIDER OR SUPPLIER **LIVING CARE FACILITY INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **10355 SW 38 TERR** **MIAMI, FL 33165**	

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

0000 - Initial Comments

A complaint (CR #2018009624) revisit survey was conducted on . Living Care Facility, Inc. with a standard license number 12671, had the following deficiency identified at the time of survey:

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

Based on record review and interview, the facility failed to submit an initial adverse incident report to the agency within 1 business day after the incident and failed to submit a full adverse incident report to the agency within 15 days of the incident in two different occasions for one of eight sampled residents (Resident 2).

Findings included:

Record review of Resident 2 showed admission date of . Record review showed no elopement assessment on file. Last health assessment dated showed diagnoses of , , or behavioral status - Memory . No elopement risk. Supervision with ambulation, and toileting. Assistance with bathing, grooming and transferring.

Record review of Resident 2's progress notes showed:

- "Resident remains the same, no change at the only sometimes the resident is very agitated and screaming to other residents too".

- "Resident doing good at the moment, no change at this time. The resident is very aggressive with the staff and wants to go out to the street. I already told the son and he is aware".

- "Resident continues at the same condition during this month. The resident continues aggressive sometimes with the staff".

- "Resident continues at stable condition at the moment but the resident is screaming and wants to go out".

- "At 2:36 PM, I received a phone call from the employee telling me that could not find Resident 2 at the facility or around the facility. On my way to the facility, I called the son to let him know but he did not answer, at 2:40 PM he returned my call and I explained what happened and his answer

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was that the police had found the resident and was at his house; something that left me on doubt due to the resident being totally ; the resident is the type of resident who always wanted to leave and likes a lot to go to the main exit door".

On , at 11:20 am, the Owner stated, "No, she used to go to the door and tell us that she was leaving but we would watch her outside and she always would come to the facility". "No, I did not report. The primary doctor would come to the facility, and he said that the meds were Ok and the behavior was due to the condition, the resident had 's".

On , at 10:00 AM, when Owner was asked "Do you have any problems with any residents eloping from the facility? the Owner stated, "Well, sometimes they go outside to walk but no, no issues with elopement".

On , at 12:17 PM, Resident #2's son stated in a phone interview, "Resident 2 left the facility and by a miracle, someone on the streets told the police and Resident 2 remembered by name and the police looked for it and brought the resident to my house. My wife was there and called me few minutes after the facility had called me to let me know. I live about 10 minutes away from the facility. Now, the resident did this also about a year or a year and a half ago; the facility called me to let me know that they found the resident near the facility so because of the last time and this was the second time, I decided to remove the resident from that facility. The resident is now in another facility and doing great".

On , at 9:00 AM, the Owner stated, "We did not report it."

Class III