STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911145	**03/25/2019**
NAME OF PROVIDER OR SUPPLIER **ELDERLY LIVING CENTER OF HOLLY**	STREET ADDRESS, CITY, STATE, ZIP CODE **810 OLEANDER** **HOLLY HILL, FL 32117**	

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

0000 - Initial Comments

A complaint survey (#2019004183) was conducted at Elderly Living Center of Holly Hill on . Deficient practice was identified at the time of the survey.

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

Based on record review and interview, the facility failed to maintain documentation of a significant change for 1 of 3 sampled residents (Resident #1).

The findings include:

On a record review was conducted on Resident #1. The file contained information that on , the resident was sent to the hospital. There were no details about the events leading up to this event, or details about who was contacted. The notation included the following details: on Resident #1 "went out this morning talking about her running and out of nowhere she was not responding". Further documentation showed on to , she was in the hospital, and returned on . There was no documentation in any the file showing any family or clinicians were contacted for this hospitalization.

The Administrator confirmed on at 11:56 AM that Resident #1 was sent to the hospital on after experiencing a at the facility. The Administrator confirmed Employees C and A were working at that time.

Employee C was interviewed on at 12:00 PM and confirmed she deferred to Employee A during Resident #1's , and was not responsible for entering those details in Resident #1's record.

The Administrator was asked for more documentation and explained at 1:00 PM on that there are some files kept offsite, maintained by the facility owner. An incident report was produced but did not include information about the family or physician being contacted. A screenshot was produced showing family contact, observed on the Administrator's phone, but there was no documentation in Resident #1's record to summarize this contact.

Employee A also confirmed on at 2:03 PM that she is not tasked with maintaining documentation in the resident files. She confirmed she was on duty during Resident #1's , with Employee C. The Administrator arrived as Resident #1 was being taken to the hospital.

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The Administrator was interviewed again on . . . . . at 2:50 PM. She confirmed the entry in Resident #1's file was done by the facility's owner. She confirmed it lacked the details necessary to document everything that happened to Resident #1 on , including the contact with the physician and Resident #1's family.

Photographic Evidence Obtained

Class III