STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965628	**02/14/2019**
NAME OF PROVIDER OR SUPPLIER **ALL STARS ASSISTED LIVING, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1131 W LAKE BRANTLEY ROAD** **ALTAMONTE SPRINGS, FL 32714**	

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

0000 - Initial Comments

A Complaint Investigation #2019000789 was conducted on . . . . . All Stars Assisted Living, Inc. (License #9972) had deficiencies at the time of the visit.

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

Based on resident record review, facility's reports and interview, the facility failed to provide appropriate and adequate supervision to 1 of 4 sampled resident (#4) who recently had a life changing event.

Findings:

Resident #4's record review revealed date of admission . . . . . into the facility with . . . . . documented on the 1823 Health Assessment dated . The record revealed resident #4's children, primarily her son was listed as emergency contact and next of kin.

On at 11:16 AM, resident #4 eloped from the facility after receiving news from her in-laws during a visit that her husband of approximately 40 years . This information was told to the resident against her children wishes. The resident's children had expressed that they to tell their mother at a later time. The facility staff were aware of the resident being told about the of her husband. The staff knew that the resident was upset and agitated. During this same time, the facility failed to monitor resident #4 and provide continuous supervision during her grieving process to make sure that resident #4 was comforted during this difficult time.

On . . . at 11:30 AM, the submitted adverse incident report reflected that caregiver B went to get resident #4 from her room for lunch and discovered that she was not in her room. Caregiver B further searched inside the facility in the bathrooms, other resident rooms, the outside front patio, backyard, and activity room resident #4 was not found. Caregiver B called the Administrator and local police. The police found resident #4 at a bank, 3 to 4 miles from the facility.

On . . . . . at 1:30 PM, resident #4 was interviewed and it reflected that resident #4 told the police that after she received the news of her husband's , she went outside to the backyard and saw the gate was opened so she left to go to the bank.

On . . . . . at 10:30 AM, in a telephone interview with the Administrator, stated she spoke with the resident's in-laws and they said the resident was very upset. The Administrator asked them why they told resident #4 about her husband's . . . against the children's decision not to. The in-laws responded

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to the Administrator that resident #4 had a right to know. The Administrator further stated there were issues between the in-laws and children. She also said that when resident #4 lived at home with her husband she would go to the bank and shopping to stores. The resident also would go to the bank and shopping alone at times.

On . . . . . at 1 PM, in an exit telephone interview with the Administrator, she confirmed the findings.

Class III