STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910533	**05/09/2017**
NAME OF PROVIDER OR SUPPLIER **BROOKDALE PHILLIPPI CREEK**	STREET ADDRESS, CITY, STATE, ZIP CODE **5501 SWIFT ROAD** **SARASOTA, FL 34231**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR# 2017004213 was conducted on at Brookdale Phillippi Creek, an assisted living facility (license #7102) located in Sarasota, Florida.

The complaint contained 2 allegations, none of which were substantiated.

Unrelated deficiencies were identified during the visit.

The following is a description of the deficiencies.

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

Based on record review and resident, responsible party, and facility staff interview, the facility failed to notify the physician of a change in condition for 1 (Resident #8) of 8 sampled residents. The facility failed to maintain a written record of Resident #8's change in condition and failed to maintain an awarness of the resident's general whereabouts.

The findings included:

An interview was conducted with the administrator on at 11:00 a.m. She said she was told Resident #8 had to be escorted back to the facility by police. She did not write up an adverse incident on this event. She found out about this two days ago. She said she reviewed Resident #8's record and there is no documentation of this event.

An interview was conducted with Resident #8 on at 11:05 a.m., concerning a possible elopement. He said he does not remember leaving the facility.

An interview was conducted with Resident #8's responsible party on at 11:13 a.m. She said she was told by a facility nurse that Resident #8 left the facility and had law enforcement bring him back. This was the first time he has left the facility unescorted. He has and would not know how to get back to the facility.

A review of Resident #8's facility record was conducted. There was no documentation showing this incident. A review of his health assessment showed he has a diagnosis of and is not an elopement risk. There was no documentation his physician was notified. A review of the sign-in and sign-out book was conducted. There was no documentation showing Resident #8 signed himself out of the facility in the past month.

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Resident #8 showed signs of a change in condition by leaving the facility, requiring the police to bring him back and him not remembering this incident. There was no documentation by facility staff showing this change in condition, the resident's physician was not notified of this change, and the facility staff was not aware of him leaving the facility.

Class III

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 submit an adverse incident when 1 (Resident #8) of 8 residents left the facility and required law enforcement to bring him back.

The findings include:

An interview was conducted with the administrator on at 11:00 a.m. She said she was told Resident #8 had to be escorted back to the facility by police. She did not write up an adverse incident on this event. She found out about this two days ago. She said she reviewed Resident #8's record and there is no documentation of this event.

An interview was conducted with Resident #8's responsible party on at 11:13 a.m. She said she was told by a facility nurse Resident #8 left the facility and had law enforcement bring him back. This happened about two weeks ago. This was the first time he had left the facility unescorted. He has and would not know how to get back to the facility.

A review of Resident #8's record showed there was no documentation of this adverse incident. The facility failed to submit an adverse incident on Resident #8 concerning this elopement requiring law enforcement to return him back to the facility.

Class III