STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965634	**04/30/2018**
NAME OF PROVIDER OR SUPPLIER **ELMCROFT OF CARROLLWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **2626 WEST BEARSS AVENUE** **CARROLLWOOD, FL 33618**	

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

0000 - Initial Comments

Assisted Living Facility

An unannounced Change of Ownership survey (CHOW Provisional License issued for the period to) was conducted on , in conjunction with a Complaint investigation (CCR#2018003328 & 2018002523 & 2018005010).

The Elmcroft of Carrollwood, Assisted Living Facility (License #9981), had deficiencies at the time of this visit.

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0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the Facility failed to obtain an interdisciplinary care plan specifying care and service provided by Hospice and those provided by the Facility and agreed upon by Hospice, the Facility, and the residents for two hospice Residents (#2 and #18) of two sampled hospice resident.

Findings Included:

During a record review for Resident #2 conducted on revealed that resident #2 on hospice services for a decline in condition. Resident #2's record did not contain an interdisciplinary care plan between Hospice and the Facility specifying care and service provided by Hospice, those care, and services provided by the Facility and agreed upon by Hospice, the Facility, and Resident #2 (or Responsible Party.

During a medication, observation for Resident #2 conducted on at 12:15pm revealed that Staff F administered Resident #2's medication. Staff F is a Certified Medication Technician and did not have a license to administer medication to Resident #2.

During a review of Resident #2's Medication Observation Record conducted on , revealed that Resident #2 had not received prescribed medication for the months of 208 and , 2018. Resident #2's Medication Observation Record indicated (by lack of documentation) that the medications Iprat- , Cream, and not given as prescribed (See Photographic Evidence4). No reason documented on the back of the Medication Observation Records explaining why these medications not given.

During a record review for Resident #18 conducted on revealed that resident #18 on hospice services for a decline in condition. Resident #18's record did not contain an interdisciplinary care plan between Hospice and the Facility specifying care and service provided by Hospice, those care, and services provided by the Facility and agreed upon by Hospice, the Facility, and Resident #18 (or Responsible Party.

During a review of Resident #18's Medication Observation Record conducted on , revealed that Resident #18 Medication Observation Record indicated (by lack of documentation) that the medications , and not given as prescribed (See Photographic Evidence5). No reason documented on the back of the Medication Observation Records explaining why these medications not given.

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During a Staff interview with the Health and Wellness Director conducted on at 04:30pm, revealed that the Facility did have a Hospice Care Plan for Resident #2. This Hospice Care Plan was not an Interdisciplinary Care Plan specifying care and services provided by Hospice, those care, and services provided by the Facility and agreed upon by Hospice, the Facility, and Resident. No Interdisciplinary Care Plan provided for either Resident #2 or Resident #18. The Health and Wellness Director acknowledged and confirmed that both Residents #2 and #18 had medication that were not signed as given on their Medication Observation Records and stated that, "We have been using outside staffing agencies because we can't keep med techs." No explanation provided as to the reason that Resident #2 did not have prescribed medication for the months of 2018 and , 2018.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the Facility failed to update Medication Observation Records each time a medication offered to nine Residents (#2, #13, #14, #16, #18, #19, #20, #21, and #22) of nine sampled residents who need assistance with self-administration of medication.

Findings Included:

During a Medication Observation Records review for Resident #2 conducted on , revealed that Resident #2's Medication Observation Records had medications not documented as given (See Photographic Evidence4). No explanation on the back of Resident #2's Medication Observation Records as to why these medications not given. The medications not documented included:
- Iprat- 0.5-3 (2.5)mg/3ml on , , , , , , and at 5:00pm
- , 100,000units/gram Cream on 12:00pm; at 08:00am and 12:00pm; and, at 05:00pm
- , 75mcg on , , and at 06:30am

During a Medication Observation Records review for Resident #13 conducted on , revealed that Resident #13's Medication Observation Records had medications not documented as given (See Photographic Evidence3). No explanation on the back of Resident #13's Medication Observation Records as to why these medications not given. The medications not documented included:
- , 10mg on , , and at 09:00am
- 80mg on at 09:00pm

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During a Medication Observation Records review for Resident #14 conducted on , revealed that Resident #14's Medication Observation Records had medications not documented as given (See Photographic Evidence 1). No explanation on the back of Resident #14's Medication Observation Records as to why these medications not given. The medications not documented included:
- 25mcg on at 06:00am
- 2mg on , and at 04:00pm
- 500mg on at 04:00pm

During a Medication Observation Records review for Resident #16 conducted on , revealed that Resident #16's Medication Observation Records had medications not documented as given (See Photographic Evidence2). No explanation on the back of Resident #16's Medication Observation Records as to why these medications not given. The medications not documented included:
- on at 04:00pm
- 0.5mg on at 07:00pm
- Extra Strength 500mg on at 12:00pm and at 05:00pm
- 12% Cream on , and on the 7-3 shift
- D-3 5000iu on at 08:00am

During a Medication Observation Records review for Resident #18 conducted on , revealed that Resident #18's Medication Observation Records had medications not documented as given (See Photographic Evidence5). No explanation on the back of Resident #18's Medication Observation Records as to why these medications not given. The medications not documented included:
- 10mg on and at 09:00pm
- 80mg on at 09:00pm

During a Medication Observation Records review for Resident #19 conducted on , revealed that Resident #19's Medication Observation Records had medications not documented as given (See Photographic Evidence11). No explanation on the back of Resident #19's Medication Observation Records as to why these medications not given. The medications not documented included:
- 10mg on at 09:00pm
- 15mg on at 09:00pm

During a Medication Observation Records review for Resident #20 conducted on , revealed that Resident #20's Medication Observation Records had medications not documented as given (See Photographic Evidence9). No explanation on the back of Resident #20's Medication Observation

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Records as to why these medications not given. The medications not documented included:
- , 100mg on at 06:00am; at 02:00pm; and, and at 09:00pm
- Voltaren 1% Gel on at 02:00pm; , and at 05:00pm; and, , and at 09:00pm

During a Medication Observation Records review for Resident #21 conducted on , revealed that Resident #21's Medication Observation Records had medications not documented as given (See Photographic Evidence10). No explanation on the back of Resident #21's Medication Observation Records as to why these medications not given. The medications not documented included:
- , 81mg on at 09:00am
- 100mg on at 09:00am
- , 2.5mg on @09:00am
- 150mg on @09:00am

During a Medication Observation Records review for Resident #22 conducted on , revealed that Resident #22's Medication Observation Records had medications not documented as given (See Photographic Evidence6&7). No explanation on the back of Resident #22's Medication Observation Records as to why these medications not given. The medications not documented included:
- 50mcg on , and at 09:00am; and, @09:00pm
- 50mg on at 09:00am and at 09:00pm

During a Staff interview with the Health and Wellness Director conducted on at 04:30pm, the Health and Wellness Director acknowledged the lack of documentation aforementioned. The Health and Wellness Director stated that. "We have been using outside staffing agencies because we can't keep med techs (Medication Technicians)."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Facility failed to keep all centrally stored medication in a locked cabinet, cart, or other storage receptacle at all times.

Findings Included:

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During resident care observation of Resident #2 conducted on at 04:00pm, revealed that the Facility does not keep prescribed centrally stored medication in a locked cabinet, cart, or other receptacle at all time. There were two prescribed medicated creams lying on Resident #2's dresser. No Staff present. Resident #2 on Hospice services with limited mobility.

During an interview with Staff A conducted on at 04:00pm, revealed that Staff place it there "so that it is easier for the med techs (medication technicians)."

During an interview with the Health and Wellness Director conducted on at 04:30pm, revealed that all centrally stored medications should be locked at all times unless it is in use in the presence of staff.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interview, the Facility failed to:
1. Obtain a physician order when changing the direction of use of a medication for which the facility is providing assistance with self-administration of medication for one Resident (#) of four sampled residents who need assistance with self-administration of medication; and,
2. Make every reasonable effort to ensure that prescriptions for resident who receive assistance with self-administration of medication refilled in a timely manner.

Findings Included;

During a medication observation for Resident #20 conducted on , revealed that the Facility does not give medication as prescribed by the physician. Staff J observed assisting Resident #20 with prescribed , 100mg at 11:56am. This medication scheduled at 02:00pm (See Photographic Evidence9). No orders obtained to change the medication scheduled time.

During a Medication Observation Record review for Resident #2 conducted on , revealed that Resident #2's prescribed medication , circled as not given. The back of Resident #2's Medication Observation Record gave the reason as 'not available'. No documentation as to who was notified of this medication not available found.

During an interview with Staff F conducted on at 12:15pm, revealed that the Facility never received Resident #2's medication , and stated that, "the office knew about it."

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During a Staff interview with the Health and Wellness Director conducted on at 04:30pm, the Health and Wellness Director unable to provide a Physician's order to change the time of Resident #20's prescribed medication . The Health and Wellness Director unable to explain the reason that Resident #2 did not receive the medication , for two months.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure that all staff (6 of 6 reviewed in facility with 69 in-house residents) submitted a statement from a health care provider, based on an examination conducted within the previous six months, that the person does not have any signs or symptoms of a communicable including .

Findings included:

Six employee records were selected for review on beginning at 9:30am. Record reviews and interview with the facility Training & Development Coordinator on at 10:15am revealed the following:

Staff A was hired as a Resident Care Aide on and provides Assisted Living residents personal care services including assistance with medications. Staff B was hired as a Resident Care Aide on (terminated ; last day worked) and provided Assisted Living Memory Care residents personal care services including assistance with medications. Staff C was hired as a Resident Care Aide on and provides Assisted Living Memory Care residents personal care services. Staff D was hired as a Certified Nursing Assistant (CNA) on , rehired on , and provides Assisted Living Memory Care residents personal care services including assistance with medications. Staff E was hired as a Resident Care Aide on and provides Assisted Living residents personal care services including assistance with medications. Staff F was hired as a Resident Care Aide on and provides Assisted Living Memory Care residents personal care services including assistance with medications.

None of the 6 employee files (Staff A, B, C, D, E, and F) contained a statement from a health care provider that the person does not have any signs or symptoms of a communicable including . Three of 6 employee files (Staff C, D, and F) did not contain documentation of testing.

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Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the facility failed to ensure that required training certificates are documented in the facility's personnel files and include title and subject matter/agenda of the training, trainee's name, dates of participation, location of the training, number of hours of the training, and training provider's name, dated signature and credentials, including professional license number, if applicable.

Findings included:

Six employee records were selected for review on beginning at 9:30am. Record reviews and interview with the facility Training & Development Coordinator on at 10:15am revealed the following:

Staff A was hired as a Resident Care Aide on and provides Assisted Living residents personal care services including assistance with medications. Staff B was hired as a Resident Care Aide on (terminated ; last day worked) and provided Assisted Living Memory Care residents personal care services including assistance with medications. Staff C was hired as a Resident Care Aide on and provides Assisted Living Memory Care residents personal care services. Staff D was hired as a Certified Nursing Assistant (CNA) on , rehired on , and provides Assisted Living Memory Care residents personal care services including assistance with medications. Staff E was hired as a Resident Care Aide on and provides Assisted Living residents personal care services including assistance with medications. Staff F was hired as a Resident Care Aide on and provides Assisted Living Memory Care residents personal care services including assistance with medications.

None of the 6 employee files contained all required training records; online learning certificates were printed on the day of visit and provided throughout the day ( ). The Human Resources/Business Office Coordinator printed and provided Staff C's online training certificates at 12:40pm and stated that Staff B is no longer in the system. The Human Resources/Business Office Coordinator printed and provided Staff D's online training certificates at 1:55pm. Nursing staff provided a separate notebook with Medications training, First Aid, and , training at 2:48pm. The Human Resources/Business Office Coordinator printed and provided training certificates for Staff A, E, and F at 6:00pm.

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An interview with the Training and Development Coordinator on . . . . . at 10:00am revealed that she just began in this position on and is in process of reviewing staff training needs. An interview with the Director of Nursing on . . . . . at 2:15pm revealed that she just began in this position on . . . . . and is working with facility nurses to ensure all staff receive required trainings. Interviews with the Human Resources/Business Office Coordinator throughout the day of survey confirmed Corporate operational policies have not effected provision and documentation of employee trainings as required.

Surveyor discussed the specific requirements of staff in-service training and documentation requirements with the Administrator, Director of Nursing and Assistant Director of Nursing, Training and Development Coordinator, and Human Resources/Business Office Coordinator throughout the day of survey and at exit conference conducted on . . . . . beginning at 5:55pm.

Class III