| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965634** | R<br>**07/10/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ELMCROFT OF CARROLLWOOD** | **2626 WEST BEARSS AVENUE CARROLLWOOD, FL 33618** |

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

**0000 - Initial Comments**

A Revisit to a 04/30/18 Complaint Survey (CCR#: 2018003328 and 2018002523) was conducted in conjunction with a Revisit to a 04/30/18 Change of Ownership Survey and in conjunction with a Complaint Survey (CCR#: 2018005192) at Elmcroft of Carrollwood Assisted Living Facility on 07/10/18. Elmcroft of Carrollwood had deficiencies at the time of survey.

(License#: 9981)

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation and interview, the Facility failed to ensure proper assistance with self-administration of medications according to the required steps in 429.256 Florida Statutes. In addition, the Facility failed to assist with medications according to safe practice in control for four Residents (#10, #11, #12, and #14)) of five sampled residents.

Findings included:

During an observation of the Facility's medication pass, conducted on at 05:30am, Staff G failed to wash or sanitize own hands before and after assisting Resident #10 with oral medications. Staff G brought Resident #10 prescribed / , dose to Resident #10. Resident #10 had to tell Staff G that one pill was missing from the morning dose of medications. Staff G returned to the medication cart and obtained the missing medication 50mcg. Staff G did not read the medication labels to Resident #10 while assisting with self-administration of medication.

During an observation of the Facility's medication pass, conducted on at 05:40am, Staff G, an unlicensed Medication Technician failed to wash or sanitize own hands before and after assisting Resident #11 with oral medication. Staff G did not read the medication label to Resident #11 while assisting with self-administration of medication.

During an observation of the Facility's medication pass, conducted on at 05:45am, Staff G failed to wash or sanitize their own hands before and after assisting Resident #12 with oral medication. Staff G also did not read the medication label aloud to Resident #12 while assisting with self-administration of medication.

During an observation of the Facility's medication pass, conducted on at 08:03am, Staff C, an

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| NAME OF PROVIDER OR SUPPLIER<br>**ELMCROFT OF CARROLLWOOD** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2626 WEST BEARSS AVENUE**<br>**CARROLLWOOD, FL 33618** | |

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

unlicensed Medication Technician, did not read the medication label aloud to Resident #14 while assisting with self-administration of medication.

During an interview with the Assistant Director of Nursing, conducted on at 04:15pm, the Assistant Director of Nursing stated that it is the expectation that unlicensed Medication Technicians "should wash their hands before and after the med pass and should sanitize their hands in between residents." The Assistant Director of Nursing agreed that medication label should be read to residents when assisting with medications.

Class III

**0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC**

Based on record review, observation, and interview, the Facility failed to ensure class III deficiencies regarding medications were corrected.

Findings Included:

A review of the Class III deficiencies cited during a Revisit to 04/30/18 Complaint Survey (CCR#: 2018003328 & 2018002523) in conjunction with a Revisit to 04/30/18 Change of Ownership Survey, conducted on 07/10/18, revealed that the Facility continues to have uncorrected deficiencies in regards to medication. The Facility was cited for Tags A0052, A0053, A0054, A0055, and A0056 during the surveys conducted on . The Facility was re-cited for Tags A0052 and A0054 during the surveys conducted on . The Facility will be required to employ the consultant services of a licensed Pharmacist, or a licensed Registered Nurse to provide medication oversite.

During an Exit Conference, conducted on at 05:00pm, the Administrator acknowledged and confirmed the requirement to employ the consultative services of a licensed Pharmacist, or a licensed Registered Nurse to provide medication oversite.

Class III

**0081 - Training - Staff In-Service - 58A-5.0191(2) FAC**

Based on record review and interview the facility failed to ensure 5 of 6 ( A, B, C, D, E,) direct care staff received the required training within 30 days of employment.

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings Included:

During record review conducted on at 11:00 A.M. it was noted that the employees' records only had documentation of online training for emergency procedures including change of command, recognizing and reporting resident , neglect and , , ( ) and Elopement. The training was from a computer class and not specific to the facility with their policy and procedures.

The Resident Care Director stated on at 12:00pm that she had just completed her core training and now understands the requirement. She stated the training will be corrected and she will have a plan in place to assure the training meets requirements.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC**

Based on record review and interview, the facility failed to ensure for 2 of 4 unlicensed persons ( A, C ), providing assistance with self administered medications, had documentation that the employees received training to meet requirements.

Findings Included:

During a review of employee training records on at 11:00 am it was revealed that staff A, who has a hire date of and assists residents with self administered medication only had a 2 hour update in her file. The 4 hour initial training certificate was not available for review.

The Bussiness Office Director reviewed the file and confirmed the training was not in the employees' file. The Director stated that the employee might have had the training before she came to the facility.

Staff C, who had a hire date and assists residents with self administered medications did not have documentation available to indicate she had the 4 hours of medication training and 2 -hour update
In an interview conducted with the Resident Care Director on at 11:30 am, it was stated that someone must have "thinned" the employees' file and moved her training.

Class III

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

**0090 - Training - [redacted] - 58A-5.0191(11) FAC**

Based on record review and interview the facility failed to ensure the required training for 5 of 6 direct care staff ( A, B, C, D, E ) was facility specific and included the facility's policy and procedures.

Findings Included:

During a review of staff training records it was revealed that the training for the [redacted] was conducted online, a computer class. The training was not facility specific and did not include the facility's policies and procedures.
The administrator stated on at 2:30pm that the computer training was just part of the training and that the staff also received additional information. The staff's file only had a certificate from the on line training and there was no other documentation that shows the facility provided facility specific training.

Class III