STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965634	**07/10/2018**
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

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

(License#: 9981)

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

Based on observation and interview, the facility failed to ensure residents were provided care and services as required to meet their needs and failed to have an awareness of the general health, safety, and physical and emotional well-being of residents residing in the Facility.

Findings Included:

During an entrance to the Facility on at 05:00am, the front doorbell was rung three times. The Facility was phoned and facility staff answered after many rings. Staff came to open the door at 05:13am. At 5:13 AM on , Staff H informed Surveyors that Staff G was in charge and was on break in a privately owned vehicle. Staff H said they were unable to contact Staff G. Staff H also said they were unable to contact the Administrator. At 5:25 AM, Staff G was observed in the hallway passing medications. Staff G's hair and clothing appeared disheveled. Surveyor requested Staff G to contact the Administrator. Staff G continued passing medications. After the medication observation at 05:45am, Surveyor requested that Staff G to notify the Administrator. Staff G told Surveyor to get Staff H to do it. Surveyor returned to Staff H and Staff H took Surveyor to two Staff present on the Memory Care Unit. Both Staff said they were unable to contact the Administrator. Staff H took Surveyor to the medication . Another Staff was then able to contact the Memory Care Supervisor. Surveyor was told by Staff H that the Memory Care Supervisor stated that all the managers will be here at 09:00am.

A Facility tour, conducted on at 05:20am, revealed that when entering the staff's break contained a television, a sofa that had a Walkie-Talkie, and a recliner that had a blanket in it. The Walkie-Talkie is used by Staff to communicate with each other and respond to residents' needs for assistance. When asked who was sleeping in the recliner, Staff H stated it was Staff G and that "[Staff G] was on break." Staff H stated that Staff G left the Walkie-Talkie on the sofa.

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An interview with Resident #9's Power of Attorney, conducted on , revealed that on a number of occasions Resident #9 would phone to tell the Power of Attorney that the call bell had been used "over and over" and the Staff did not respond. Resident #9's Power of Attorney stated that they would call the Facility to get assistance from staff and the calls would go unaswered and the phone would just ring and ring. On one occassion, Resident #9's Power of Attorney stated they came to the Facility between 2:00 AM and 3:00 AM because the phone was never answered by Staff. Resident #9's Power of Attorney entered the Faciltiy and found Staff sleeping in the employee's .

An interview with Resident #10, conducted on at 03:25pm, revealed that on one recent occasion, Resident #10's call bell went unanswered. Resident #10 got out of bed to look for Staff because the scheduled 02:00am pain medication was due. Resident #10 said they found Staff sleeping in the employee's .

A review of the facility's license issued by the Agency confirmed the facility is licensed for 133 beds so a staff member must be awake at all times.

Class III