STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11942812	**02/01/2019**
NAME OF PROVIDER OR SUPPLIER **ELMCROFT OF SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **730 SOUTH OSPREY AVENUE** **SARASOTA, FL 34236**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #201900095 was conducted through at Elmcroft of Sarasota, an assisted living facility (license #8261) in Sarasota, Florida.

The complaint contained 2 allegations, of which 1 was substantiated with deficiencies.

The following is a description of the deficiencies:

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on record review and staff interview, the facility failed to maintain policies to ensure coordination of care with third party providers. This led to delay in executing medical orders for 1 (Resident #13) of 1 residents reviewed.

The findings included:

On , record review of Resident #13 revealed an order from the Advanced Registered Nurse Practitioner (ARNP) of a medical practice dated for an as soon as possible (Stat) . The order was sent to the facility by an internet communication portal. The was not completed until .

On at approximately 10:00 a.m., in an interview the facility Resident Services Director ( ) confirmed facility staff did not check the portal until Resident #13's daughter came to the facility on and asked about the . After checking the portal, the was ordered and completed on .

Record review on revealed no evidence of a policy in place for monitoring the portal to ensure coordination of care with 3rd party services.

On at 9:40 a.m., in a phone interview, the said there was no policy in place for monitoring of the portal on and there is no policy in place at present for monitoring the portal to ensure coordination of care with 3rd party services.

Class III

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

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

Based on record review and staff interview, the facility failed to promptly record a direction for change in medication for 1 (Resident #3) of 1 residents reviewed. This has the potential for residents to receive medications that have been discontinued.

The findings included:

On , record review of Resident #3' record revealed a direction change from a physician, dated to discontinue and , (medications that treat fluid retention). A review of the Medication Observation Record (MOR) for , of 2019 for Resident #3 revealed the orders for spironlactone and had not been discontinued.

On at approximately 11:30 a.m., in an interview Resident #3 said she had talked with her physician and has not taken or , for months. She said it was not good for her as it made her "weepier."

On at approximately 11:00 a.m., in an interview The Heartland Village leader, Licensed Practical Nurse Staff D, confirmed the direction change from the physician to discontinue the and , dated had never been processed. She said if Resident #3 ever went to the hospital, the current MOR would show and , as being active orders and they could potentially be administered.

Class III