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
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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018003328, 2018005010, and 2018002523) was conducted in conjunction with a Change of Ownership survey at Elmcroft of Carrollwood Assisted Living Facility on . Deficient practice was identified during the survey.

(License#: 9981)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the facility failed to honor resident rights in providing a safe living environment, including following universal precautions for control.

Findings Included:

During a medication observation with Staff F conducted on at 12:13pm,

During an observation conducted with Staff F conducted on at 02:00pm, it was observed that Staff F did not use Universal Precautions, which is a set Universal Standard to prevent the spread of while passing medication. Staff F was observed exiting a resident the Memory Care Unit, close to the laundry crumpled up clothing (not contained in a bag or other protective containment) within gloved hands. The crumpled up clothing touched Staff F's clothing. Staff F walked down the hall, opened the door to the laundry , and placed the dirty clothing into the dirty linen hamper and removed gloves. Staff F did not wash or sanitize hands and proceeded with passing medication.

During a medication observation with Staff F conducted on at 02:00pm, while passing medications, upon return to the medication cart after performing resident care duties, Staff F disposed of garbage into trash receptacle on the medication cart. Staff F removed the full bag of trash from the receptacle, and placed the unsealed full bag of trash on top of the medication cart. Staff F placed an empty garbage bag into the trash receptacle on the medication cart. Staff F carried the unsealed full bag of garbage over to the sink and placed it on top of the counter. Staff F then washed hands at the sink. After washing hands, Staff F tied the full bag of trash closed. Staff F proceeded to carry sealed bag of

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trash to the television and changed the channel and over to the empty wheel chairs and began to rearrange the wheel chairs with the full garbage bag swinging and bumping into other wheel chairs. Staff F then took the garbage bag to the laundry area and placed it in a bin. Staff F did not wash hands and began assisting residents.

During an Staff interview with the Health and Wellness Director conducted on at 04:30pm, the Health and Wellness Director acknowledged and confirmed that placing and carrying an unsealed garbage bag of trash from place-to-place and setting it on top of medication cart and sink counter is a potential control risk. The Health and Wellness Director stated that the expectation of handwashing is before beginning and after finishing a medication pass and any time there is a question or potential for contamination. Hands should be sanitized between residents when passing medications.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that four of four sampled residents received assistance with self-administration of medication in compliance with the parameters outlined in 429.256 Florida Statutes.

Findings included:

During an observation of Staff F (an unlicensed staff) assisting Resident #2 with self-administration of medication conducted on at 2:00 PM, Staff F was observed to take Resident #2's prescribed 500 mg medication, put it on a spoon and insert the spoon with applesauce into Resident #2's mouth. Staff F did not tell Resident #2 the name of the medication being given.

On at 3:15 PM, two prescribed medicated creams were observed lying on Resident #2's dresser, not secured in a locked receptacle and in full view.

During an observation of Staff A (an unlicensed staff) assisting Resident #20 with assistance with self-administration of medication on at 11:56 AM, Staff A gave Resident #20 their prescribed medications without telling Resident #20 the name of the medication. Staff A was also observed giving Resident #20 100 mg at 11:56 AM. Resident #20's Medication Observation Record (MOR) indicated that the was scheduled for 2:00 p.m.

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During a medication observation conducted with Resident #19 and Staff A on at 12:05 PM, Staff A did not state the name of the medication to Resident #19. Staff A did not observe Resident #19 take and swallow medication. Per record review, Resident #19 needs assistance with self-administration of medication.

During an interview with Resident #14 conducted on at 02:18 PM, Resident #14 stated that medications are usually late. Resident #14 indicated that staffing for assistance with medication is not consistent and that, "There is different people (referring to Staff) passing meds (medications) every day." Resident #14 stated that Staff do not state the medication that they are giving and Resident #14 is legally . Per Resident #14, when asked, often Staff state that they do not know what medication it is.

A review of the Facility's Resident Contract under Section B-3 stated that for medication assistance, steps will include, "in the presence of the Resident, reading the label, opening the container, removing the prescribed amount of medication from the container, and closing the container ..."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, record review, and interview, the facility failed to have a licensed staff administer medications for one Resident (#2) of four sampled residents.

Finding Included:

During a medication observation for Resident #2 conducted on at 12:13pm, Staff F was observed to administer Resident #2 prescription for Extra Strength 500mg medication. Staff F placed a spoonful of applesauce and crushed medication into Resident #2's mouth. Staff F did not read the label or identify the medication to Resident #2.

During a record review for Staff F conducted on , it was revealed that Staff F's Job Description is Medication Technician. Staff F's employee record did not include a nursing license.

During a Staff interview with the Health and Wellness Director at 04:30pm, the Health and Wellness Director stated that, "Med Techs should hand the resident the spoon with the medication and applesauce or they can guide the Resident's hand" if needed.

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Class III

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

Based on record review and interview, the facility failed to ensure that all staff who provide direct care to residents (6 of 6 reviewed in facility with 69 in-house residents), receives in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment, a minimum of 1 hour in-service training within 30 days of employment that covers the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation, a minimum of 1 hour in-service training within 30 days of employment that covers reporting major and adverse incidents, a minimum of 1 hour in-service training within 30 days of employment that covers Residents Rights in an Assisted Living Facility and recognizing and reporting resident , neglect, and , , , and a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. The facility failed to ensure that all staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides (5 of 5 reviewed), receive 3 hours of in-service training within 30 days of employment that covers Resident behavior and needs and providing assistance with activities of daily living.

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

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Staff B is no longer in the system, printed & provided Staff D's online training certificates at 1:55pm, and printed and provided training certificates for Staff A, E, and F at 6:00pm. Employee Records and Certificate reviews revealed the following:

Staff A's records contained a training certificate entitled "Preventing & Responding to Elopement" (dated , not within 30 days of hire). Staff B's file did not contain any evidence of training regarding the facility's resident elopement response policies and procedures. Staff C's records contained a training certificate entitled "Preventing & Responding to Elopement" (dated). Staff D's records contained a training certificate entitled "Preventing & Responding to Elopement" (dated , not within 30 days of hire). Staff E's records contained a training certificate entitled "Preventing & Responding to Elopement" (dated , not within 30 days of hire). Staff F's records contained a training certificate entitled "Preventing & Responding to Elopement" (dated , not within 30 days of hire). There was no indication that the online training provided the facility's resident elopement response policies and procedures and no indication that facility staff demonstrate understanding and competency in implementation of the facility's elopement response policies and procedures.

Online training records provided for Staff A, C, D, E, and F included a certificate entitled "Workplace Emergencies and Natural Disasters: An Overview." There was no indication of training in the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation. Staff B's file did not contain any evidence of training regarding the facility's emergency procedures. None of the employee files contained, and no certificates for online training included, training in reporting major and adverse incidents. There was no indication of Incident Report training provided Staff A, B, C, D, E, and F.

Online training records provided for Staff A, C, D, E, and F all included a certificate for 0.75 hours entitled "Preventing, Recognizing, and Reporting ." Staff A's file contained a signed Resident Bill of Rights, no training certificate in file. Staff B, C, and D files contained unsigned Resident Bill of Rights and no training certificates. Staff E and F files contained online learning certificates entitled "Protecting Resident Rights in Assisted Living Facilities." There was no indication of a minimum of 1 hour in-service training provided Staff A, B, C, D, E, and F within 30 days of employment that covers Residents Rights in an Assisted Living Facility and recognizing and reporting resident , neglect, and , .

Online training records provided for Staff A, C, D, E, and F all included a certificate for 0.50 hours entitled "Safe Food Handling." Staff B's file did not contain any evidence of training in safe food handling practices. There was no indication of the required minimum of 1 hour in-service training within 30 days of employment in safe food handling practices provided Staff A, B, C, D, E, and F.

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Staff A, B, C, E, and F are Resident Aides, not nurses, certified nursing assistants, or home health aides, and are required to receive 3 hours of in-service training within 30 days of employment that covers Resident behavior and needs and providing assistance with activities of daily living. Online training records provided for Staff A contained a certificate for 1 hour of training dated . Staff B's file did not contain any evidence of training in Resident behavior and needs and providing assistance with activities of daily living. Online training records provided for Staff C contained 2 1-hour trainings dated and . Online training records provided for Staff E contained 2 1-hour trainings dated and . Online training records provided for Staff F contained 2 1-hour trainings dated and . There was no indication of the required minimum of 3 hours of in-service training within 30 days of employment provided Staff A, B, C, E, and F.

An interview with the Training & Development Coordinator on at 10:00am revealed that she just began in this position on and is in the 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 ensured provision and documentation of employee trainings as required.

The specific requirements of staff in-service training and documentation requirements were discussed with the Administrator, facility nursing staff, and Human Resources/Business Office Coordinator throughout the day of survey and at exit conference conducted on beginning at 5:55pm.

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 that 2 of 5 staff (Staff A and B) who provide residents assistance with self-administration of medications completed the required initial 4-hour training on providing assistance with self-administration of medications.

Findings included:

Six employee records were selected for review on beginning at 9:30am. Five of the 6 selected employees provide residents assistance with self-administration of medications. Two of the 5 employees who provide residents assistance with self-administration of medications did have not evidence of required training as follows:

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Staff A was hired as a Resident Care Aide on and provides Assisted Living residents personal care services including assistance with medications. Staff A's file contained a training certificate for completion of an annual 2-hour update in providing residents assistance with self-administration of medications dated . Staff A's file did not contain a training certificate evidencing completion of initial 4-hour training in providing residents assistance with self-administration of medications in an Assisted Living Facility.

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 B's file contained a training certificate for completion of an annual 2-hour update in providing residents assistance with self-administration of medications dated (prior to facility employment). Staff B's file did not contain a training certificate evidencing completion of initial 4-hour training in providing residents assistance with self-administration of medications in an Assisted Living Facility.

An interview conducted with the facility Training and Development Coordinator on at 10:15am confirmed both Staff A and Staff B were responsible for providing residents assistance with self-administration of medications.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record reviews and interviews, the facility failed to ensure that all direct care staff (6 of 6 reviewed in facility with 69 in-house residents) receive at least one hour of training in the facility's policies and procedures regarding ( ) within 30 days after employment.

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

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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 documentation of training in the facility's policies and procedures regarding ( ). Two of the 6 employee records reviewed (Staff D and Staff F) included training certificates entitled " , Advanced Directives and Incident Reporting," dated for 0.50 hours training.

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.

Class III