STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953701	**03/31/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHTON PLACE	**4151 ASHTON ROAD SARASOTA, FL 34233**	

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

0000 - Initial Comments

An unannounced Extended Congregate Care (ECC) survey on [redacted] at Ashton place, an Assisted Living Facility (ALF) in Sarasota, Florida.

The following is a description of non-compliance:

E207 - ECC - Services - 58A-5.030(8) FAC

Based on observation, record review, and interview the facility failed to provide Extended Congregate Care (ECC) services in accordance with the residents' service plans, for 2 (Residents #2 and #3) of 4 residents sampled.

The findings included:

Residents #2 and #3 were observed receiving [redacted] via nasal cannula not at the prescribed flow. Resident #2's [redacted] flow meter was observed at 1/2 liter of [redacted], prescribed by health care provider was 3 liters. Resident #3's [redacted] flow was noted to be at 3 and 1/2 liters, prescribed by the health care provider was 3 liters.

During an interview on [redacted] at 10:45 a.m. Staff A said, "The correct [redacted] flow for resident #2 should be 3 liters."

During an interview on [redacted] at 10:25 a.m. the Administrator said, "There must have been something wrong with the flow meter, I will call and have it serviced immediately."

During an interview on [redacted] at 2:15 p.m. Staff C he said, "We apply the [redacted] tubing to the residents, fix the regulators if they are leaking [redacted], and we switch the [redacted] tanks from the main tank the resident is using to a portable tank if the resident is going to the dining [redacted]."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Ashton Place
4151 Ashton Road
Sarasota, FL 34233

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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