STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965858	01/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON GARDENS AT PELICAN MARSH LLC	**4750 ASHTON GARDENS WAY NAPLES, FL 34109**

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

0000 Initial Comments

An unannounced Change of Ownership survey was conducted / / through / / at Aston Gardens at Pelican Marsh, an Assisted Living Facility in Naples, Florida.

The following is a description of the deficiencies found at the time of the visit.

0056 Medication - Labeling and Orders

Based on observation, record review, and interview the facility failed to have a revised order for 5-325 mg (pain med) for 1 (Resident #9) out of 4 residents sampled.

The facility failed to have the Medication Observation Record (MOR) for 1 (Resident #9) out of 4 residents sampled match the label 5-325 mg (pain med) and the Health Care Provider Order.

The findings included:

Observed during Medication Review on / /, Resident #9's medication labeled: " 5-325 mg, take one tablet 3 times a day as needed for pain." The Health Care Provider Order dated / / revealed: , one tablet by mouth 3 times a day as needed for pain." The label on the (pain medication) did not match the MOR which revealed: " mg tab, take one tablet by mouth three times daily for pain." This medication was scheduled by the facility staff for 9:00 a.m., 1:00 p.m., and 5:00 p.m.

Staff B reported on / / at 2:30 p.m. she was not aware the (pain med) label and the Health Care Provider Order for Resident #9 did not match the MOR. She reported she was not aware the pain medication needed clarification by the Health Care Provider for as needed length of time schedule.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and resident and staff interview, the facility failed to maintain a safe, clean living environment for 92 out of 92 residents residing in the facility.

The findings included:

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

During a tour of the facility conducted on 1/ ./ at 10:15 a.m., the following was observed:

a) In the Doctor's exam , there were stains on the ceiling tiles, a trash can lid was lying on the floor with no trash can and there was a small hole in the floor, where staff stated they believed there used to be a toilet in the .
b) In the activity , there was no caulking around the sink basin and sink top, observed 3 baking sheets and a muffin pan with food particles on them in the oven and several dark pink fabric chairs had stains on the armrests, seats, and cushions.
c) In the medication the second floor, also used as the "Ice Cream ," the counter had several small live ants. There were also several knobs missing from the drawers and there were water stains on the ceiling tiles.
d) Multiple stained ceiling tiles and cracked ceiling tiles in the hallways on the second floor. Also a large stain on the carpet outside resident .
e) Multiple areas along walls on first and second floor hallways with black scuff marks and paint missing, also observed a board protruding out from the wall next to the elevator with a nail sticking out of it.
f) Vents in the hallways and sitting had black particles in them.

During an interview with the Assisted Living Administrator on 1/ / at 11:05 a.m., she stated, "It looks horrible."

During an interview with Resident #7 on 1/ ./ at 11:00 a.m., she stated that there have been buckets placed in the hallway several times since she moved in.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Aston Gardens At Pelican Marsh LLC
4750 Ashton Gardens Way
Naples, FL 34109

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representatives 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyors. 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

XG90

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