STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969015	**06/28/2017**
NAME OF PROVIDER OR SUPPLIER **WALTON PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **501 S WALTON AVE TARPON SPRINGS, FL 34689**	

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

0000 - Initial Comments

Assisted Living Facility

Four unannounced complaint surveys, (CCR# 2017003572, CCR# 2017003770, CCR# 2017005725 & CCR# 2017005745) were conducted on - at Walton Place, (License #12859), an assisted living facility, in Tarpon Springs, Florida. There were deficiencies identified at the time of the visit.

(License # 12859)

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

Based on observation and interview, the facility failed to (1) provide privacy while assisting one resident (#4) with changing clothing and adult brief; (2) remove gloves or washed hands in between assisting two observed residents (#4 and #22) or while providing medications assistance to six (#3, #7, #8, #9, # 11, and #19) of six observed residents; (3) ensure a hazard-free environment for two residents (#7 and #10) who stored tanks in their , and; (4) ensure the protection of confidential medication information for three (#8, #7 and #19) of six residents observed during medication observation.

Findings included:

On at 09:22a.m., Staff A was observed assisting Resident #4 changing of brief and clothing with the door opened. Resident was seen from the hallway partially covered and partially exposed. Staff A stated, " She is not completely naked at all. " Staff A stated that she leaves the door open while changing the resident to hear what is going on in the common area.
On at 09:25a.m., while responding to another residents ' request who was locked out of their , Staff A opened Resident #4 ' s door with a used brief on her gloved hand. At 09:31 a.m., Staff A walked out of Resident #4 ' s the used brief in a bag and threw the brief away. Staff A did not wash her change her gloves or washed her hands. Staff A continued unlocked door for Resident #22 with her gloved had touching the door handle.
During interview with Staff A on at 09:50 a.m., she confirmed observation and confirmed that she has not changed her gloves since changing Resident #4.
An observation conducted on at 11:03am discovered one unsecured freestanding tank (Evidence1) in Resident #7 ' s the potential to of falling thus turning it into a dangerous projectile. There was no notification on doorway that indicated in-use.

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An observation conducted on at 02:30pm, discovered there was no indication on resident #10 ' s door of in-used. Resident #10 has an order for portable and five secured portable tanks stored in .

During medication review observation conducted with Staff E on , between 11:20am - 11:55am, Staff E did not wash or sanitize hands before assisting with medication, or after medications were offered, and provided to residents #3, #7, #8, #9, #11, and #19. During continued medication review and observation conducted with Staff E on , Staff E walked away from the medication cart, leaving the computer screen with resident confidential medication information displayed for Resident #8 at 11:25a.m., Resident #7 at11:35 a.m., and Resident #19 at 11:50 a.m. At 11:55a.m., Staff E placed resident #11's inhaler back in the medication cart after use without sanitizing the mouthpiece having the potential to contaminate a clean medication cart.
During an interview conducted on at 01:10pm, he stated that the facility does not have an Control Policy & Procedure and that the staff should go by their training in regards to control. The Administrator stated that the resident ' s store their own , they are responsible for their own storage, and the facility did do anything with . The Administrator stated that the facility doid not have a Policy and Procedure for storage of portable tanks.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview, the facility failed to ensure that facility menus were reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule.

Findings included:

Review of the facility scheduled for meals, on revealed that facility menu on display for the residents and original menu, maintained by the facility, was reviewed and validated from through .

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SUMMARY STATEMENT OF DEFICIENCIES
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During interview with the Administrator, conducted on at 04:35pm, he confirmed that the facility menu, reviewed by the registered dietitian, was dated - . Administrator stated that he noticed it when it was requested by surveyor and has requested a new on from license dietitian.

Class III