STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953701	R 12/28/2017
NAME OF PROVIDER OR SUPPLIER **ASHTON PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4151 ASHTON ROAD** **SARASOTA, FL 34233**	

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

0000 - Initial Comments

An unannounced revisit survey was conducted through at Ashton Place, an assisted living facility (license #8686) in Sarasota, Florida.
This was a follow-up to the relicensure and extended congregate care survey completed on . A complaint investigation was conducted in conjunction with this follow-up survey.

Two deficiencies were not corrected. The following is a description of the deficiencies found at the time of the visit.

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

Based on observation, record reviews, and staff interview, the facility failed to ensure proper of glucometers during glucose monitoring for 2 (Resident #23 and #19) of 2 residents requiring in the facility. The failure to properly glucometers increases the risk of transmitting harmful organisms and risk of to residents and staff in the facility.

The findings included:

1. According to the Centers for Control, (https://www.cdc.gov/injectionsafety/ -glucose-monitoring.html): "...The Centers for Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting , ( ) and other during assisted glucose (sugar) monitoring and administration. CDC is alerting all persons who assist others with glucose monitoring and/or administration of the following control requirements:

*Fingerstick devices should never be used for more than one person
*Whenever possible, glucose meters should not be shared. If they must be shared, the device should be cleaned and after every use, per manufacturer ' s instructions. If the manufacturer does not specify how the device should be cleaned and then it should not be shared..."

2. Review of the physician's orders for Resident #23 dated prescribed (sugar monitoring) before breakfast and before the evening meal.

Review of the physician's orders for Resident #19 dated prescribed an in the morning weekly while fasting.

During an observation on at 9:40 a.m., in the presence of the Health and Wellness Director

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(HWD), who is also a Licensed Practical Nurse (LPN), found two glucometers inside a pouch with wipes. The HWD said after she obtains the sample from the residents, she usually cleans the glucometers with either an wipe or Clorox wipes. She said she uses the glucometers on the Resident #23 and #19, but neither glucometer is strictly dedicated for that resident.

The label on the Clorox wipes indicated it kills 99.999% of including , Klebsiella , human coronavirus, A2 , 0157-H7, (Staph), , and , pyopenes; , was not listed.

When asked for the manufacturer's specifications for of the glucometers, she didn't have any. The HWD said she didn't know what the manufacturer recommended to use for proper of the glucometers.

*photographic evidence on file

Class III

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

Based on observation, record review, and staff interview, the facility failed to ensure medications were given in accordance with physician's orders for 3 (Resident #13, #21, and #22) for 3 residents reviewed.

The findings included:

1. During an observation of the main dining at 6:15 p.m., found two white pills resting inside of a pill cup on a table labeled with the first name of Resident #13.

At 6:40 p.m., the Health and Wellness Director (HWD), who is also a Licensed Practical Nurse (LPN), came to the facility. She was shown the pills inside of the pill cup in the main dining . The HWD said the pills should not have been left unattended.

Review of the physician's order for Resident #13 prescribed , 325 mg., 2 tablets, by mouth every 8 hours. The Medication Observation Record (MOR) showed the medication was to be given at 6 a.m., 2 p.m., and 10 p.m.

During an interview on at 11:15 a.m., Medication Technician (MT) Staff O said Resident #13 complained of a very bad so she gave the medication ahead of the scheduled time. Staff O

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admitted she did not call the physician for a change in the timing of the medication and gave Resident #13 the medication. Staff O did not stay with Resident #13 when offered the medication and wasn't aware Resident #13 never took the medication.

2. During an observation on at 6:15 p.m., found a tray of uneaten pureed food in a bowl and a pill cup filled with crushed medication and pureed food for Resident #21 resting on top of the nurse's station.

During this observation, Resident Care Assistant (RCA) Staff M walked up to the nurse's station and acknowledged the crushed medication resting next to the pureed food. Staff M said she had to feed Resident #21 and had been asked by the medication technician, Staff O, to give Resident #21 his medication. Staff M admitted she was not a medication technician. Staff M said Staff O had left the facility.

On at 6:40 p.m., the Health and Wellness Director (HWD) was not aware the crushed pills were left unattended.

On at 11:15 a.m., Resident #21's Medication Observation Record (MOR) was reviewed with Medication Technician (MT) Staff O. Staff O confirmed Resident #21 was supposed to receive Lactaid tablets before his meal at 5:00 p.m. In addition, Resident #21 was to receive an 40 mg. tablet and Mucosa 400 mg. tablet at 5:00 p.m. Staff O confirmed Resident #21 did not receive the medication as prescribed.

3. Review of the 1823 Health Assessment for Resident #22 showed a list of medications to be administered to the resident through her ⌄ ⌄ tube. (A ⌄ ⌄ tube is a device inserted through the abdomen and used to provide nutrition to residents who cannot swallow safely.) The assessment did not give clear and specific orders as to how the medications were to be administered.

During an interview on at 10:30 a.m., the Health and Wellness Director (HWD), who is a Licensed Practical Nurse (LPN), said she crushed the medications, mixed them in water, and then administered the medications. The HWD admitted there were no orders for the amount of water to mix the medications in, or to flush between or after medication administration. The HWD said she would notify the physician for specific orders.

*photographic evidence on file

Class III

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0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Due to an uncorrected deficiency in the area of medications (A 0053) under Chapter 429.256 F.S, and Chapter 58A-5.0185 F.A.C. in accordance with Florida Administrative Code 58A-5.033 (3) (a) the facility must:

Employ a Licensed Consultant Pharmacist other than the pharmacist currently consulting for the facility. The initial onsite Consultant Pharmacist visit must take place within 7 days of the facility receiving this report.

The facility must have available for review by the Agency a copy of the Consultant Pharmacist's license.

The Consultant Pharmacist must develop a written plan of action for addressing the deficient medication practices identified in the statement of deficiencies.

The facility must submit the Consultant Pharmacist's corrective action plan to the Agency no later than 10 working days subsequent to the initial onsite consultant visit.

The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has
been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.