STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953701	**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 complaint investigation for CCR#2017013788 was conducted through at Ashton Place, an assisted living facility (license #8686) in Sarasota, Florida.

The complaint contained 5 allegations; of which 4 were unsubstantiated and 1 was substantiated.

The following is a description of the deficiency cited.

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

Based on observation, record review, and staff interview, the facility failed to observe 2 (Resident #3 and #21) of 3 residents take their medications during assistance with self-administration of medications. This failure contributed to the residents not receiving their medications as prescribed by the physician.

The findings included:

1. During an observation of the main dining at 6:15 p.m., two white pills were found 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 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.

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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.

During an interview on at 6:40 p.m., the Health and Wellness Director (HWD) said she 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 admitted Resident #21 did not receive the medication as prescribed.

Class III