STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953701	**10/25/2017**
NAME OF PROVIDER OR SUPPLIER **ASHTON PLACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **4151 ASHTON ROAD** **SARASOTA, FL 34233**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced relicensure and extended congregate care survey was conducted through at Ashton Place, an assisted living facility (license #8686) in Sarasota, Florida.

The following is 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 observations, record review, staff interview, and review of guidelines from the American Association, the facility failed to ensure 1 (Resident #16) of 3 residents reviewed was free from neglect during showers. This failure contributed to the resident being in the shower which resulted in emergency transport to a hospital unit for a skin and rehabilitation. The facility failed to implement a monitoring system for checking hot water temperatures after Resident #16 was , failed to educate staff on prevention; and failed to put measures in place to prevent a reoccurrence. In addition, the facility failed to ensure resident showers were repaired and the environment was clean and sanitary.

The findings included:

1. The American Association, Scald Injury Prevention at (http://www.ameriburn.org/Prevent/ScaldInjuryEducator%27sGuide.pdf): "Although scald can happen to anyone, young children, older adults and people with are the most likely to incur such injuries... The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed... Older adults, like young children, have thinner skin so hot liquids cause deeper with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred...Scald injuries result in considerable pain, prolonged treatment, possible lifelong scarring, and even ."

2. Closed record review on documented Resident #16 was admitted to the facility on with diagnoses including 's and . The health assessment dated revealed Resident #16 had memory loss, was wheelchair dependent, and her behavior was unpredictable. Resident #16 was dependent on 1 person to assist her with bathing.

Review of the progress note dated at 6:40 a.m. included: "...Resident in shower shower, resident aide turned on shower head and had it positioned between grab-bar and the wall, the aide turned away with the water on to pick up towels etc off the floor the water squirted on the resident's

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knee. [Administrator] notified, 911 called resident transported to [hospital emergency]. Resident's son [name] notified...Dr. [name] office called to inform us that resident has been transferred to [a different hospital]..."

Review of the hospital records dated at 7:43 a.m. included: "...spoke to nurse from Ashton Place who states that this morning, patient was placed in a chair in the shower. The water on a extendable shower head was turned on and placed on a grab bar. They state the aid turned around and the shower head moved, turning the hot water onto the patient's leg, resulting in the ...Skin: around right knee with unroofed [intact] , two intact large to right anterior and medial thigh, small to left medial thigh, small area of 2nd degree are to anterior pubic region..." Because of the severity of the , Resident #16 was transferred to a second hospital specializing in treating victims.

Review of the hospital records dated included: "... female with 2nd degree partial thickness scald to bilat thighs and , area... noted to bilat thighs...was taken into the shower on with assistance when the water became too hot, the patient on the lower extremities and , area. She was initially taken to [first hospital] for the and then transferred here [hospital] for further care. The patient was debrided [removal of unhealthy tissue from a to promote healing] in the OR [operating] on with application of a allograft [skin]...discharged on to [nursing home]."

During an interview on at 1:00 p.m., the Administrator (ADM) said the aide (Resident Care Aide Staff P) responsible for failing to monitor the temperature of the water during Resident #16's shower was no longer working at the facility. He stated, "I fired her for her stupidity." He said they (ADM and maintenance worker) immediately checked the water temperature in the shower read 118 degrees F. (Fahrenheit) and he lowered the water heater to 110 degrees F. He said 101-116 are supplied by one water heater, and 117-134 are supplied by a different water heater. The ADM said they checked the water temperatures in every none of them were above 118. The ADM could not provide documented evidence of monitoring the water temperatures after Resident #16 was . There was no system in place for checking water temperatures prior to this event and no system put into place after.

On at 1:12 p.m., Certified Nursing Assistant (CNA) Staff O said she came to the facility when Resident #16 was already in the ambulance. Staff O said she was told by Staff P she took Resident #16 into the shower, turned the water on, and had the shower head down behind the grab bar and the wall. Staff P turned around to pick up items off of the floor and the shower head must have turned around right onto the resident and her leg. Staff O said Resident #16 wasn't very verbal and her leg was

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turning red. Staff O said if she was giving a shower, she wouldn't have turned the water on until she was ready to give the shower.

On at 2:10 p.m., the ADM was asked how he checked water temperatures the day Resident #16 was . He explained he uses a pool thermometer, runs the hot water, fills a large cup with the hot water, and submerses the pool thermometer into the water in the cup. He confirmed he does not hold the thermometer under the running hot water.

On between 2:18 p.m. and 3:30 p.m., water temperatures of the "front" shower (where Resident #16 was) as well as random resident shower and were taken by the surveyors using a calibrated probe thermometer. The ADM was present and preferred to use his pool thermometer (uncalibrated) and his technique for taking water temperatures. The ADM said 16 residents use the "front" shower .

The water temperatures revealed the following:

Front shower -hot water felt very hot and could not keep hand under water. While using a probe thermometer-122 degrees F. ADM's pool thermometer-112 degrees F. (ADM temped water with pool thermometer submerged in cup of water).

- (shower in disrepair, closest to water heater)-probe thermometer: 120 degrees F. ADM's temp was 110 degrees F.

- (shower in disrepair, furthest from water heater)-probe thermometer: 119 degrees F. ADM's temp was 110 degrees F.

Random temperatures of the back hallway were taken and revealed they were not over 120 degree F. However, those temperatures recorded with the calibrated probe thermometer were 8-10 degrees higher than the ADM's uncalibrated pool thermometer temperatures.

On at approximately 3:30 p.m., the ADM said going forward he will need to check water temperatures periodically and ensure adequate training of staff related to bathing .

During interviews on between 1:28 p.m. and 2:54 p.m., Resident Care Aides (RCA's) Staff B, C, J, K, L and N said they had "heard" about what happened to Resident #16 but did not receive any formalized inservice or education on preventing residents from being while in showers. Each of the staff said they learned how to give showers from another caregiver at the facility . There was no

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formal training on how to properly give showers.

On at 8:55 a.m., a plumber was observed removing the thermostat from a hot water heater that supplies resident between 117 and 134. The plumber said the thermostat could not be turned any lower than 120 degrees F but could go as high as 181 degrees F. The ADM, who was present, said he called the plumber based on the new findings of hot water temperatures. The ADM admitted he did not know the thermostat could reach that high.

On at 2:29 p.m., the ADM said he lowered all of the water heater thermostats to 110 degrees F. He said new staff are oriented for 4 days when they are first hired. He has new staff take a binder of information home to review. The ADM said staff are monitored for the first couple of months by a supervisor, which could be another RCA in charge. He showed a guideline staff are to use for care, but did not have any guidelines for giving showers.

2. Observations during the tour of the facility on between 9:00 a.m. and 11:30 a.m. found the shower in 101, 108, 109, 110, 111, 113, and 114 in disrepair. In , the carpet was heavily stained and soiled. (The resident in this she recently had a bed bug infestation and the administrator refused to replace the carpet.) The ceiling in the atrium was stained brown in various areas and the door was missing off of the TV .

In an interview on at 2:00 p.m., the ADM acknowledged the shower in disrepair, the soiled and stained carpet in , the stained ceiling in the atrium; and the missing door to the TV . He did not have a specific plan in place for the repairs.

Class II

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

Based on observations, record review, and staff interview, the facility failed to ensure 2 (Resident #12 and #13) of 4 residents reviewed for treatments, received their treatments as ordered by the physician.

The findings included:

1. During an observation on at 9:00 a.m., found 2 with medication inside the chambers resting on top of a table in the TV . Seven residents were observed in this . While in the , Certified Nursing Assistant (CNA) Staff A said the nurse gets the

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residents' treatments ready and they bring down the residents to have their treatments in a group setting. Staff A said the nebulizing treatments observed on the table were for Resident #12 and #13. Staff A then left the the residents remained unattended.

Observations continued through 10:50 a.m. and found the same 2 on top of the table unattended in the TV . Medication was observed inside of the chambers.

In an interview on at 10:55 a.m., Licensed Practical Nurse (LPN) Staff D said Resident #12 and #13 were supposed to get their treatments at 8:00 a.m. She confirmed they did not receive their medication as ordered.

Review of the 2017 physician's orders for Resident #12 and #13 confirmed the missed doses of the treatment.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on record review and staff interview, the facility administrator failed to ensure compliance with level 2 background screening for 1 (Staff F) of 5 staff sampled for level 2 background screening. This has the potential for employment of staff with a qualifying offense being in contact with residents.

The findings included:

On , record review for maintenance man Staff F with a date of hire of revealed no documented evidence a level 2 background screening was completed prior to employment.

On at approximately 10:30 a.m., Staff F said he had been employed at the facility since the end of , 2017.

During an interview on at 11:50 a.m., the administrator confirmed a level 2 background screen had not been completed for Staff F prior to employment and stated "He's on his way now to get it done".

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and staff interview, the facility failed to ensure an annual freedom from

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( ) or a statement of freedom from communicable . . . . including within 30 days of employment was documented for 2 (Staff A and B) of 4 staff sampled. This has the potential for spread of a communicable .

The findings included:

On , record review revealed CNA Staff A last documented evidence of freedom from was on . . . . . Further review revealed resident aide Staff B date of hire as . . . . . There was no documented evidence of freedom from communicable including for Staff A and Staff B.

During an interview on at 10:24 a.m., the administrator confirmed the absence of an annual freedom of statement for CNA staff A and absence of a freedom from communicable including statement within 30 days of hire for resident aide staff B. He stated "We just missed it".

Class III

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

Based on observation and staff interview, the facility failed to ensure storage of a 3-day emergency supply of water sufficient for drinking and food preparation or have a plan for delivery of water in an emergency. This has the potential to lead to severe health related concerns.

The findings included:

On at approximately 3:30 p.m., observation revealed 4, 45 gallon trash can type containers in facility maintenance area that the administrator said he fills for use as drinking water after he has sterilized the containers. He said they are utilized as part of the 3-day emergency water supply.

On at 12:10 p.m., during an interview with the administrator, he said the facility has portable 5-gallon collapsible containers, which will hold 75 gallons of water. He said, in addition, the facility had 4 trash can type containers they sterilized with; first, dish detergent, then they add a bit of bleach (a tablespoon) to the water, let them soak for 10 minutes. They then fill them up with water, cover with lids and store them in the front shower . The administrator said the facility would have used this as drinking water if needed and confirmed the facility did not have a contract with anyone to supply water in the event of an emergency.

On at 1:15 p.m., observation revealed only 7 portable 5 gallon collapsible containers were available for filling with water if needed.

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On at approximately 2:30 p.m., during an interview, when asked what plan for obtaining water in the event of an emergency had been submitted with their County Emergency Management Plan (CEMP), the assistant administrator (Staff Q) said they have never submitted any plan for obtaining water in an emergency.

On , record review of the facility CEMP confirmed there was no plan for obtaining water in an emergency.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations, staff interview, and review of the Florida Building Code for Assisted Living Facilities, the facility failed to ensure a safe living environment as evidenced by exceeding for a live-in family member; stained carpets, and showers in disrepair in resident ; and stained ceiling tiles in common area visited by residents and visitors.

The findings included:

1. Review of the building code for Assisted Living Facilities, Section 434, included: "...434.1 Scope. Assisted living facilities shall comply with the following design and construction standards as described herein...434.4.4.5 All resident shall be for the exclusive use of residents. Live-in staff and their family members shall be provided with sleeping space separate from the sleeping and congregate space required for residents..."

The census at the time of the survey was 39 residents and the total capacity of the facility was licensed for 44 residents.

During the initial tour of the facility on between 9:00 a.m. and 11:30 a.m., 2 people were observed in . Resident #11 confirmed she pays rent and lived in the . She said her cousin moved into her a private duty caregiver and lives with her in as well. Resident #11 said her cousin helps her with bathing, , dressing, transfers and with doctor's appointments.

In an interview on at 12:30 p.m., the Administrator confirmed Resident #11's cousin lives in the receives her mail at the facility. He said Resident #11's cousin could be considered a private duty caregiver and does not pay rent. The Administrator said the cousin has lived at the facility for 1-2

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years and they did not offer a separate sleeping space for Resident #11's cousin.

2. Observations during the tour of the facility on between 9:00 a.m. and 11:30 a.m. found the shower in #101, #108, #109, #110, #111, #113, and #114 in disrepair. In #109 and #118, the carpet was heavily stained and soiled. Resident #11, in #, said she recently had a bed bug infestation and the administrator refused to replace the carpet. The ceiling in the atrium was stained brown in various areas and the door was missing off of the TV .

In an interview on at 12:56 p.m., the Administrator acknowledged the shower in disrepair, the soiled and stained carpets in #109 and #118, the stained ceiling in the atrium, and the missing door to the TV . He did not have a specific plan in place for the repairs.

**Pictures on file

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and staff interview, the facility failed to ensure a level 2 background screen (BGS) was completed prior to employment for an employee who interacts with residents for 1 (Staff F) of 5 staff sampled. This has the potential for employment of staff with a qualifying offense being in contact with residents.

The findings included:

On , record review for maintenance man (Staff F) with a date of hire of revealed no documented evidence a level 2 background screening was completed prior to employment.

On at approximately 10:30 a.m., Staff F said he had been employed at the facility since the end of , 2017.

During an interview on at 11:50 a.m., the administrator confirmed a level 2 background screen had not been completed for Staff F prior to employment and stated "He's on his way now to get it done."

Unclassified