

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure survey, Complaint (#2021016673), and a Generator Monitoring survey were conducted on _____ at Pelican Garden LLC. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 010	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a ...-to-... medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a ... may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined that the facility failed to have a new Health Assessment (AHCA Form 1823) completed for 1 of 1 sampled residents (Resident #6) who had a significant change in their condition. The findings included: On _____, Resident #6's Health Assessment (AHCA Form 1823) dated _____ was reviewed. The Health Assessment did not document that the resident received hospice services. Further review of the resident's record show that the resident was admitted to hospice on _____, a significant change in the resident's condition. On _____ at 1:00 PM, the Administrator was notified of these findings. The facility provided no documentation of a Health Assessment completed when Resident #6 had a significant change in condition for review at this time. Class III	A 010			
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 054	Continued From page 5 and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known _____ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical _____, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure the Medication Observation Record (MOR) was completed for 3 out of 3 sampled residents reviewed (Residents #1, Resident #2 and Resident #7) who required assistance with the self-administration of medications. The findings included: During review of the _____ MOR's on _____, the following omissions and errors were identified:	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PELICAN GARDEN, LLC

**177 EMPRESS AVE
SEBASTIAN, FL 32958**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 6 1) Resident #1 a. 8:00 PM doses on _____ were not initiated as given for _____ and _____ 2) Resident #2 a. 8:00 AM dose on _____ had not been initiated as given for _____ 3) Resident #7 a. 8:00 AM doses on _____ and _____ were not initiated as given for _____ and _____ b. 9:00 PM doses on _____ and _____ were not initiated as given for _____ and _____ c. 12:00 PM doses on _____ and _____; and, 9:00 PM doses on _____ and _____ _____ were not initiated as given for _____ d. 12:00 PM doses on _____ and _____; and, 9:00 PM dose on _____ were not initiated as given for _____ _____. This medication also had "three" changed to "two" for the times of day that the resident was to receive the medication with no date of change or notification to see a change in the medication order. e. 12:00 PM doses on _____ and _____ _____ were not initiated as given for _____ The Administrator was notified of these findings on _____ at 1:00 PM. The facility provided no additional information for review at this time. Class III	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 7	A 078		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 078	Continued From page 8 responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure 1 out of 3 sampled employees (Staff A) had submitted an annual negative () statement signed by a health care provider. The findings included: During review of the personnel file on for Staff A, date of hire, a signed statement by a health care provider dated within the previous year verifying this employee was	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 9 free from . . . could not be found. The last statement on file indicating the employee was free from . . . was dated The Administrator was notified of these findings on . . . at 1:00 PM. The facility provided no additional documentation for review at this time. Class III	A 078		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PELICAN GARDEN, LLC

**177 EMPRESS AVE
SEBASTIAN, FL 32958**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 084	Continued From page 10 include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____, _____, and _____ dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with _____ syringes that are prefilled with the proper dosage by a pharmacist and _____ that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 084	Continued From page 11 i. Assist with _____; j. Use a _____ to perform _____ testing; k. Assist residents with _____ and continuous positive airway pressure (CPAP) devices, excluding the titration of the _____ levels; l. Apply and remove _____ stockings and hosiery; m. Placement and removal of _____ bags, excluding the removal of the _____ or manipulation of the _____ site; and, n. Measurement of _____ rate, temperature, and _____ rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 084	Continued From page 12 minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 1 out of 1 sampled unlicensed staff members (Staff A), who provided assistance with self-administration of medications, had successfully completed a minimum of 2 hours of annual update training in assistance with self-administration of medications. The findings included: The personnel file for Staff A was reviewed on for documentation of 2 hours of medication assistance update training completed annually. The last completed training documentation on file was a 6 hour training certificate dated Staff A was observed assisting residents with self-administration of medications on at 12:00 PM. The Administrator was notified of these findings on at 1:00 PM. The facility provided no additional documentation for review at the time of the survey. Class III	A 084			
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 162	Continued From page 13 must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed	A 162			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 14 consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
NAME OF PROVIDER OR SUPPLIER PELICAN GARDEN, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 177 EMPRESS AVE SEBASTIAN, FL 32958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 15 plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by:	A 162		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PELICAN GARDEN, LLC

**177 EMPRESS AVE
SEBASTIAN, FL 32958**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 162	Continued From page 16 Based on record review and an interview, the facility failed to ensure that 2 out of 2 sampled residents (Resident #1 and Resident #6) who received assistance with activities of daily living (ADL's) had their _____ recorded on admission and semi-annually. The findings included: a) Review of the _____ record for Resident #1 on _____ showed no recorded _____. The resident was admitted to the facility on _____ On _____ at 11:00 AM, the Administrator was notified of this finding. Resident #2 was _____ at this time and her _____ b) Review of the _____ record for Resident #6 on _____ showed no recorded _____ from _____ (_____) through _____ (_____). On _____ at 1:00 PM, the Administrator was notified of these findings. The facility provided no additional documentation for review at this time. Class III	A 162		