STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966236	08/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Pelican Garden, Llc	177 Empress Ave Sebastian, FL 32958	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Extended Congregate Care (ECC) Monitoring survey was conducted at the Pelican Gardens Assisted Living Facility. The facility had deficiencies identified at the time of the survey.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to ensure that a medication technician followed community standards for the handling of resident medication including handwashing and disposal of contaminated medication, for 5 of 5 residents. (R 1, R 2, R 3, R 4, R 5)

Findings include:
1) An observation of medication pass was conducted on [redacted] starting at 8:10 AM. The medication technician was observed placing a medicated patch on a resident's leg with her ungloved hand and then chart the administration in the resident's record. The Medication Technician was not wearing gloves and did not wash or sanitize her hand when she finished applying the medicated patch.

The surveyor informed the Medication Technician that she wanted to conduct a medication Pass observation. The Technician removed the medications for Resident # 1 from the cabinet at 8:18 AM and poured or popped pack) the medications into her ungloved hand and then placed the pills in a medication cup. The Technician poured a total of 7 pills in this same manner. The Technician then handed the cup of medications to Resident # 1 with a cup of water. When the resident had finished the medications, the Technician disposed of the cup at 8:29 AM.

The Technician then began to pour 5 medications into her ungloved hands and into a medication cup for Resident # 2. She did not wash or sanitize her hands. The Technician handed the medication cup to the resident, who accidentally spilled the cup and two medications [redacted] onto the floor. The Technician took the pill cup from the resident, picked up the pills from the floor, placed them in the medication cup and

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handed them back to the resident to consume. The surveyor asked the Technician if she intended to have the resident consumed the spilled pills. The technician nodded her head in the affirmative and said "yes". The surveyor then instructed the Technician to repour the medications and discard the pills, in the cup as she had mixed the ones that were on the floor with the ones that didn't ..... onto the floor. The Technician repoured the medications and again the resident spilled some on the floor. The Technician poured the medications for a third time and gave them to the resident who consumed them. The Technician did not wash or sanitize her hands after this.

At 8:37 AM, the Technician proceeded to pour 6 medications for Resident # 4 into her hand and then place them into the medication cup. The Technician handed the medication cup to Resident # 4 who consumed them at 8:53 AM.

Immediately after, the Technician poured a single medication for Resident # 5 into her hand, which she then put into the medication cup. The Technician handed the medication to the resident and with her ungloved hand administered a prescribed eye drop medication to each of the resident's eyes touching the bottle to the eye itself. When asked how to administer eye drops. The Technician stated that since the resident has trouble opening her eyes, she has to touch the eye to be sure that the medication gets inside the lower eye lid. The Technician then removed a bottle of sanitizer from the medication cabinet and sanitized her hands

The surveyor asked how often she should wash her hand, the technician stated she should do it every three or four residents. The technician was unaware that she should use gloves when handling medicated patch medications or eye glove to prevent cross contamination.

At 9:00 AM an interview was conducted with the Administrator. She was asked if medications that are spilled on the floor should be administered. The Administrator confirmed that any pills spilled on the floor should be discarded and repoured as they were contaminated. The Surveyor asked the Administrator to describe the facilities policy regarding handwashing.
She confirmed that handwashing and/or sanitizing should occur between administration of medications to each resident and gloves should be worn as part of contact precautions, when administering eye drops or patch medications. The Administrator asked the technician if she was going to administer the spilled medications to the resident and the technician confirmed that she was going to do so until the surveyor stopped her.

Class III

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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation and interview, the facility failed to verbally prompt/ inform the resident of the medications that were being administered, for 5 of 5 sampled residents (R# 1, R#2, R# 3, R# 4, R#5).

Findings include:
1) A medication pass observation was conducted on starting at 8:18 AM. The Medication Technician poured 7 medications for Resident # 1 and handed them to the resident. She did not inform and/or identify the medications to the competent resident.

At 8:29 AM, the Medication Technician poured 5 medications for Resident # 2 and handed them to the resident. She did did not inform and/or identify the medication to the competent resident.

At 8:37 AM the Technician poured six medications and handed them to Resident # 3 , who is competent . She did not inform and/or identify the medications to the resident.

At 8:45 AM, the Technician poured 12 medications and promptly handed them to Resident # 4, who is competent. Again, she did not identify or inform the resident of the names of the medications.

At 8:53 AM, the Technician poured 1 oral medication and a bottle of eye drops for Resident # 5. She handed the oral medication to the resident and then proceeded to administer the eye drop. She failed to inform the resident of the name of the two medications.

At 8:58 AM, the surveyor asked the Medication Technician if she should identify the medications to the resident. The technician stated that he was unaware that she should do.

An interview was conducted with the Administrator following the medication pass observation. She confirmed that the technician should identify the resident the medication which which are being administered.

Class III

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0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and interview, the facility failed to ensure that the Medication Observation Records (MORs) was accurate, for 1 of 5 sampled residents (Resident# 4)

Findings include:
1) A comparison of the Medication Observation Record (MOR) to the actual medications prescribed for Resident # 4 was conducted on following the Medication Pass observation . The label on the bottle indicated that Resident # 4 was to receive 5mg one tablet once daily. Review of the MOR revealed documentation as follows," Take one tablet by mouth once daily. There was no documentation of the dose to be administered.

Review of the Resident's record did not reveal evidence of a prescription for the . The Administrator was informed and requested that the Pharmacy fax to the facility a copy of the prescription. At 10:55 AM, the Pharmac7 faxed a copy of an electronic prescription which confirmed that the resident was to receive (5mg once daily.

The Administrator stated that she had just instructed her assistant to review the MOR's to verify that all medications were accurate on the MOR as this has occurred in the past. She confirmed that the dose on the MOR should accurately reflect the dose so that the technician can compare the label on the bottle to the order when administering medications.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Pelican Garden, LLC
177 Empress Ave
Sebastian, FL 32958

RE: Extended Congregate Care (ECC)

Dear Administrator:

This letter reports the findings of a Extended Congregate Care (ECC) survey that was conducted on , 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within ***thirty days*** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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