RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Emerald Gardens Properties, Llc
1012 N 72 Avenue
Pensacola, FL 32506

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 through , 2015 by representatives 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

for Donah Heiberg, M.S.W.
Field Office Manager

DH/kb

Enclosure XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
AHCA.MyFlorida.com

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967671	**09/02/2015**
NAME OF PROVIDER OR SUPPLIER **EMERALD GARDENS PROPERTIES, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1012 N 72 AVENUE** **PENSACOLA, FL 32506**	

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

0000 Initial Comments

An unannounced licensure survey with a limited nursing services monitoring visit was conducted on [redacted] at the Emerald Gardens assisted living facility. The facility had deficiencies found at the time of the visit.

0025 Resident Care - Supervision

Based on record review and staff and hospice interviews, the facility failed to notify either the physician or hospice for medical changes for 1 of 4 sampled residents (#8). The facility failed to provide physician notification for elevated [redacted] and failed to provide appropriate care and services, as needed [redacted] medications, for elevated [redacted].

The findings are:

Record review for sampled resident #8 revealed a physician order dated [redacted] for [redacted] 0.1 milligram (mg) by mouth every 4 hours as needed for [redacted] above [redacted], the Registered Nurse (RN) to take and record daily [redacted] ([redacted]) for 7 days. Continued record review revealed no physician orders discontinuing this order. Record review revealed the resident was a hospice resident.

Record review of the current [redacted], [redacted] and [redacted] medication observation record (MOR) revealed the continued order for [redacted] 0.1mg by mouth every 4 hours as needed for [redacted] above [redacted]. There was no documentation revealing the medication has been administered during these months.

Record review of the monthly [redacted] checks for 2015 recorded by the facility's registered nurse (RN) revealed [redacted] (no day date given) [redacted], [redacted] (no day date given) [redacted] recorded is [redacted] / [redacted], [redacted] (no day date recorded) [redacted], [redacted] (no day date recorded) [redacted] and [redacted] / [redacted] and [redacted] (no day date recorded) [redacted].

Record review of the monthly assessment for resident receiving limited nursing services completed by the registered nurse dated [redacted] revealed a [redacted], [redacted] of [redacted] with no documentation concerning the [redacted], [redacted] by the registered nurse. Record review of the monthly assessment for resident receiving limited nursing services completed by the registered nurse dated [redacted], [redacted] revealed a [redacted] of [redacted] with no documentation concerning the [redacted] by the registered nurse or noting notification of the physician or hospice concerning the elevated [redacted].

Record review of the hospice notes for revealed a , of , , , / , , / , / , / , , , , , , , , , / .

Interview with sampled staff G, medication technician, on / at approximately 3:30PM revealed that the registered nurse may obtain the in the mornings Monday through Friday when she is here.

Record review and interview with sampled staff H, assistant administrator, on / confirmed physician order.

Interview with the resident's Hospice registered nurse on / 4:40PM revealed her statement that the order was written in in which the residents , was elevated and she contacted the Hospice physician for an order for the .

Interview and record review with the facility registered nurse on at 9:12AM revealed she works at the facility Monday-Fridays from approximately 6AM -9AM only. She stated concerning the resident's elevated , she informed sampled staff F, the patient care coordinator of the elevated and she is responsible for contacting the hospice agency or the physician of the elevated . Record review revealed no documentation confirming this or any documentation of physician or hospice being notified of the resident's elevated .

Interview the Hospice nurse again at 9:20AM with review of these elevated , readings revealed her statement the facility only notified her of the elevated and this was by text. She reviewed her cell phone texts and she revealed on at approximately 7:11AM the ALF staff informed her of an elevated , and she instructed them to give the resident a , record review of the MOR revealed no documentation of the medication being administered, however review of hospice nurse's text revealed she received a text revealing the , was down to approximately 8:25am. She stated she does not recall being notified of the elevated obtained by the facility nurse in or , but she may not have been working on those days.

Interview with sampled staff F, patient care coordinator, at 9:52AM on revealed her statement she contacts the residents' home health, hospice or the physician if there is a medical concern for a resident. She stated if the medication technicians informed her that a resident is not feeling good she stated; if the registered nurse is here she will notify the nurse. If elevated , , the registered

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nurse does not contact the physician because she is not here all day. Review of the these elevated monthly was done and she stated she notified hospice of these elevated but could not provide documentation of such.

Interview with the facility administrator on at approximately 1:45pm revealed it is the facility's registered nurses' duties to perform monthly nursing assessments on all of the facility residents. The nurse would be expected to report any concerns to the patient care coordinator or herself for follow-up and the staff should document the results of the notification of the physician or the home health agency or the hospice agency whichever is applicable for the resident.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews, the facility failed to honor the residents' rights by failing to honor residents' choices during the dining observation for 1 of 1 observed meal.

The findings:

On /, an observation of meal service in the facility's back dining conducted beginning at 12:02PM. At 12:15PM, sampled resident #4 was served a glass of juice with ice in it. The resident told sampled staff #D that she did not like ice in her drinks. Sampled staff #D then told the resident that all the drinks already had ice in them and apologized. Sampled staff #D exited the dining all trays were delivered and did not replace the residents drink with one that did not contain ice. Observation continued thru 12:45PM. At no time was the drink replaced.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations, staff interviews and record reviews, the facility failed to follow physicians medication order for for 1 out of 2 sampled residents who were observed during medication pass (#10).

Finding are:

On / at approximately 11:10AM an observation of medication pass was conducted with medication technician, sampled staff #A. Observation revealed she provided sampled resident #10 with the medication labeled 0.083% solution. The instructions on the pharmacy label affixed to the

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medication package was written as, 0.083%, one vial every 2 hours as needed for short of breath and . The resident self-administered the medication without any concerns.

Review of the the resident's medication observation record (MOR) revealed the medication the physician ordered was Iprat-alb (/) 0.5mg-2.5mg/3ml inhale 1 vial via every six hours. Record review of the physician order dated / revealed an order for Solution 05.-2.5/3ml. 3ml inhale via every 6 hours.

On / an interview with staff #A was conducted at 2:00PM, she agreed that the medication administered was not the same medication that was on the MOR or the physician order.

Upon review of the facility's Medication Policy, section V states that for each medication order/label, the med tech must understand, accurately follow and keep a record of health care provider medication order. Do not administer medications that are not ordered or labeled properly for that resident.

Class III

0057 Medication - Over The Counter (OTC) Products

Based on observations and staff interviews, the facility failed to properly label over the counter medications stored in 2 of 2 medication carts.

Findings are:

On / inspection of the 300-400 hall medication cart began at approximately 2:05PM with sampled staff #A and # F. The inspection revealed one 15 ounce opened bottle of without the resident's name. Interview with sampled staff #A, a medication technician, was conducted on / at 2:13PM and confirmed these findings. Sampled staff #A stated the medication was for sampled resident #13. Continued inspection revealed an opened tube of USP 0.05% cream which was not labeled with a resident name. Interview with sampled staff #F at this time revealed the medication is for sampled resident #12.

Inspection of medication cart for 100 and 200 halls revealed 18 over-the-counter medications (OTC) on the cart. Six of the OTC bottles were identified with resident initials only. Three OTC bottles were not identified with any labeling of the resident names or initials. Interview with sampled staff #A revealed that one of the bottles belonged to sample resident #12. When asked how she knew this she said I see what you are saying, it's not labeled appropriately but I know it is his because he takes it all the time. Continued interview with sampled staff #G confirmed that none of the OTC bottles are labeled

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appropriately.

Another inspection of the medication cart for 300-400 halls was conducted on / at approximately 3:30PM. This inspection revealed thirty-one OTC bottles of medications. Inspection revealed eleven bottles were identified by initials alone. One bottle of OTC medication was not labeled or marked at all with residents name or initials. Interview at 3:40PM with medication technician sampled staff #E, confirmed the findings.

Class III

0092 Food Service - General Responsibilities

Based on observations and staff interviews, the facility failed to provide food service in a sanitary manner by failing to ensure residents' food was handled in a safe and sanitary manner during a dining observation for 1 of 1 observed meal.

The findings are:

1. Observations on / beginning at approximately 11:46 am revealed approximately 14 residents in the facility's main dining . Sampled staff #A, a patient care assistant, was observed to prepare drinks for various residents by using an ice scoop and placing the ice in the glasses. She was wearing blue disposable gloves. At approximately 11:55AM she was observed to enter the kitchen thru an open door off the main dining . The surveyor was located at the kitchen door which allowed for continuous observation of this staff while she was in the kitchen and when she entered the dining . Staff #A was observed in the kitchen and observed to begin preparing the residents plates with two other staff. She was observed to use the same gloved hands to handle and place food on the residents' plates. At times she was observed to touch her face with her gloved hand. She was observed to use her same gloved hands to place slices of fresh pineapples on each of the residents' plates. She was observed to move the food around on the plates to place shredded lettuce, using her gloved hands on the residents hamburgers and buns.

At approximately 12:05 a resident came to the kitchen door and asks her for a glass. Staff #A stepped into the dining her left gloved hand on the kitchen door frame as she left the kitchen. She was observed to assist the resident to get a glass and a straw, using the same gloved hands. She returned to the kitchen, opened the dishwasher using her same gloved hands then moved a dish rack that was lying flat on the floor under the dish machine and stood it up right, touching the area of the dish rack that was sitting/touching the floor with her gloved hands. She then returned to the serving line and continued to place slices of fresh pineapples on each of the plates, and then delivered the plates to

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random residents in the dining .

A random resident requested some mayonnaise and she returned to the kitchen and began looking for a packet of mayonnaise handling various cardboard boxes located under the serving table, using the same blue gloved hands. She exited the kitchen delivered the mayonnaise to the resident, touching the resident's shirt as she handed the resident the mayonnaise and then returned to the kitchen. She then continued to place pineapple slices on the plates, placed shredded lettuce on the hamburger and delivered the plates to the residents. At no time was she observed to wash her hands or change her gloves.

At approximately 12:15PM she was observed to remove her gloves and wash her hands and reglove. Interview with this sampled staff #A on / at approximately 12:18PM revealed her statement she washed her hands and donned gloves at the beginning of the meal and then just now washed her hands again and regloved, she stated at no other time did she change her gloves or wash her hands.

Interview with the facility administrator on at 2:19PM revealed the staff were to wash hands and change gloves anytime they have resident contact or leave the tray line. She stated she was aware of the above described observations and stated this staff has been inserviced before on changing her gloves and washing her hands and she apparently will need more education as she have washed her hands and changed her gloves.

2. On / , an observation of meal service in the facility's back dining conducted at 12:02PM. Two staff members arrived pushing a meal cart. They were wearing gloves when they arrived. No glove changes were observed between delivery of each meal to residents. No hand sanitizer or hand washing was observed between residents or touching the outside of tray cart. Sampled staff #D was observed exiting and reentering the gloves on. Beverages were pre-poured in a cart. Staff #D was observed, with gloves on handling the drink glasses by the rims where the glass touched residents' lips when drinking.

Class III