STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966236	09/22/2015
NAME OF PROVIDER OR SUPPLIER **PELICAN GARDEN, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **177 EMPRESS AVE** **SEBASTIAN, FL 32958**	

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

0000 Initial Comments

An unannounced complaint survey, CCR# 2015005908, was conducted on 9/2/15 and 9/22/15 at Pelican Garden LLC. The facility had deficiencies found at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews, the facility failed to ensure a safe environment for residents by not locking their laundry which contained detergents and stain remover. This had the potential to affect all residents currently living at the facility who were and able to ambulate or self-propel themselves in wheelchairs (photographic evidence obtained).

The findings include:

During a tour of the facility conducted / at 10:12 AM with Employee B present, the "left" laundry observed with a key in the door lock. A hook was located at the top left of the door for the key. A sliding lock was located at the top left of the door, and was unlocked. In an interview conducted at that time, Employee B stated the laundry is supposed to stay locked. She confirmed that and ambulatory residents have access to this area. This was discussed and acknowledged by the Administrator at 11:12 AM.

At 6:29 PM, the "right" laundry was observed to be unlocked. The key was located on a hook at the top left of the door. There was no additional sliding lock like the one on the "left" laundry . This was observed by, and discussed and acknowledged by the Administrator at 6:32 PM. This was further discussed with the Administrator on / at 2:38 PM.

Class III

0050 Medication - Self Administered Medications

Based on observations, interviews and record review, the facility failed to obtain written request to assist with self-administration of medications, for 1 of 10 sampled Residents (#4).

The findings include:

A tour of the facility was conducted with Employee B, a Medication Technician (MT), present. At 10:18 AM a partially used tube of 40% was observed stored in the resident's . During an interview conducted at the time of observation, Employee B stated she believed he

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required assistance with medications. Review of his and medication observation records revealed he received assistance with self-administration of all his other medications. Review of his AHCA Form 1823 (medical examination) dated / documented he was capable of self-administration of medications. Further review of his records revealed no documentation showing he provided a written request to receive assistance with self-administration of medications or that his medications were to be centrally stored.

This concern was discussed with and acknowledged by the Administrator in an interview conducted at 3:35 PM. This was further discussed with the Administrator on / at 2:38 PM.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications followed required standards of practice for 3 of 10 sampled Residents (#12, 13 and 14).

The findings include:

1. During observation of unlicensed staff assisting residents with self-administration of medications on / at 11:55 AM, Employee B, a Medication Technician (MT) was observed to prepare medications to assist Resident #12 with self-administration of medications. She failed to bring the medication containers and resident together when assisting with self-administration of medications. She also initialed the medication observation record (MOR) prior to the resident actually receiving the medications. In an interview conducted at the time of observation, Employee B stated she was taught to do it this way.

2. At 12:09 PM, Employee B was observed to prepare medications to assist Resident #13 with self-administration of medications. She failed to bring the medication containers and resident together when assisting with self-administration of medications. She also initialed the medication observation record (MOR) prior to the resident actually receiving the medications. In an interview conducted at the time of observation, Employee B stated she was taught to do it this way.

3. At 1:51 PM, during review of refrigerated medications with Employee B present, a specimen collected (23 days prior) was observed. When asked why a dated specimen was being stored, she looked in to it and later stated it was collected from Resident #14 in error, it should have been Resident #15 and at the time of collection, staff realized they collected from the wrong resident and

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collected it from the correct resident back in . She had no explanation as to why the incorrect specimen was not disposed of. She further acknowledged staff the two residents because they had the same name and collected a specimen from a resident in error.

These concerns were discussed with and acknowledged by the Administrator in an interview conducted / at 3:35 PM. This was further discussed with the Administrator on at 2:38 PM.

Class III

0054 Medication - Records

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications maintained accurate medication records for 3 of 10 sampled Residents (#8, 10 and 11).

The findings include:

Review of medication systems was conducted / beginning at 3:40 PM. The following concerns were identified:

1. A review of Resident #8's inventory sheet (NIS) for compared to her 2015 medication observation records (MOR's) revealed the following discrepancies:
a. On , the NIS documented one pill was removed from inventory but there was no corresponding entry on her MOR.
b. On / , the NIS documented a quantity of 57, on the MOR documented one pill was removed from inventory but the NIS documented a quantity of 55 pills left in inventory.
c. On , the NIS documented one pill was removed from inventory but the MOR had nothing documented on the front or reverse sides. It appeared it occurred on the 3:00 PM to 11:00 PM shift.
d. On , the NIS documented one pill was removed from inventory but the MOR had nothing documented on the front or reverse sides. It appeared it occurred on the 3:00 PM to 11:00 PM shift.
e. On / , the NIS documented one pill was removed from inventory but the MOR had nothing documented on the front or reverse sides. It appeared it occurred on the 3:00 PM to 11:00 PM shift.

2. A review of Resident #10's NIS for compared to her 2015 MOR revealed the following discrepancies:
a. On , her MOR was initialed to indicate one pill was given but it was not documented on her NIS.
b. On / , her NIS documented one pill was removed from inventory for her 2:00 PM dose but was

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not documented as given on the front or reverse of her 2015 MOR.
c. On 8/25/15, her NIS documented one pill was removed from inventory for her 2:00 PM dose but was not documented as given on the front or reverse of her 2015 MOR.
d. On , her NIS documented one pill was removed from inventory for her 2:00 PM dose but was not documented as given on the front or reverse of her 2015 MOR.

3. A review of Resident #11's NIS for Patch compared to her and MOR's revealed the following discrepancies:
a. On , her NIS documented one patch was removed from inventory but it was not documented on her MOR.
b. According to a written Health Care Provider order, one patch was to be applied every three days. On / , her MOR was incorrectly set up and the patch was applied one day early on when it should have been applied on .

This was discussed with and acknowledged by the Administrator in an interview conducted at 3:35 PM. This was further discussed with the Administrator on / at 2:38 PM.

Class III

0055 Medication - Storage and Disposal

Based on observations, interviews and record review, the facility failed to ensure medications for residents who require assistance with self-administration of medications were centrally stored in a secured area for 3 of 10 sampled Residents (#3, 6 and 7).

The findings include:

A tour of the facility was conducted with Employee B, a Medication Technician (MT), present. The following concerns were identified:

1. At 10:09 AM, Resident #3 was observed to have stored on top of her nightstand. A container of 25 milligrams (MG) and four partially used tubes of ointment were stored in a plastic bag in a basket on her . Review of her AHCA Form 1823 (medical examination) dated / documented she required assistance with self-administration of medications. A resident progress note dated documented she self-administered her . Further review of her records revealed no written Health Care Provider (HCP) order for her to self-administer these or any other medications. In an interview conducted at the time of observation, she

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confirmed these were her medications and she self-administered these medications. At the time of observation, Employee B stated she believed Resident #3 required assistance with self- administration of medications. (Photographic evidence obtained.)

2. At 10:27 AM, Resident #6 was observed to have numerous medications stored on her nightstand and in her . Her nightstand held:
a. Oral Balance which contains , Carbomer, , , Cellulose, , and Propylparaben
b. Moisturizing Mouth Spray which contains Polyglycitol, , Helianthus Annuus Oil, Xanthan Gum, Sorbate, Acesulfame K, , Thiocyanate, Lysozyme, Lactoferrin and Lactoperoxidase
c. Sinex Drops which contains
d. Relief tablets which contain and Stearate
In her , a plastic bin on a side stand contained:
e. pads which contain 0.1%
f. Top Care and Pain Relieving Ointment which contains , , , , B and
g. Prescription -HC 25 MG suppositories with prescription label dated
h. Polyethylene , 3350
i. Stool Softener with tablets
j. Stool Softener with softgels
k. Nasal Spray which contained 0.65%, Phenylcarbinol and
l. Equate Vaporizing Rub which contains , Eucalyptus Oil and
m. Jelly
Review of her AHCA Form 1823 (medical examination) dated documented she required assistance with self-administration of medications. Further review of her records revealed no written Health Care Provider (HCP) order for her to self-administer these or any other medications. In an interview conducted at the time of observation, she confirmed these were her medications and she self-administered these medications. At the time of observation, Employee B stated she believed Resident #6 required assistance with self- administration of medications.

2. At 10:27 AM, Resident #7 was observed to have C 1000 MG tablets, Vapoinhalor which contains and , and Balmex 11.3% stored on her nightstand. Review of her AHCA Form 1823 (medical examination) dated / documented she required assistance with self-administration of medications. Further review of her records revealed no written Health Care Provider (HCP) order for her to self-administer these or any other medications. In an interview conducted at the time of observation, she confirmed these were her medications and she self-administered these medications. At the time of observation, Employee B stated she believed

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Resident #7 required assistance with self- administration of medications.

3. Medications systems review was conducted 9/2/15 with Employee B, a Medication Technician (MT), present. At 10:45 AM, the medications refrigerator was observed to contain a bottle of belonging to Resident #16 that expired on . She had no explanation as to why it was not entirely used or why it was still present.

4. Medications systems review was conducted / with Employee B, a Medication Technician (MT), present. At 10:45 AM, the medications refrigerator was observed to not have a functional lock. Six vials of for two separate residents, two packages of Diluted , , a package of Lantus Glargine, / , 0.005%, , , Solution 0.005%, and a container of Milk of were stored in the unlocked refrigerator.

In an interview conducted at that time, Employee B stated the key broke and they were waiting for it to be repaired but was not sure how long it had been in disrepair. In an interview conducted at 2:45 PM, Employee C, a MT, stated she started assisting residents with self-administration of medications about one month prior and the refrigerator lock was not working since then. In an interview conducted / at 12:44 PM, the Administrator and the staff member responsible for maintenance stated they had not been told the refrigerator lock was not functional.

These concerns were discussed with and acknowledged by the Administrator on / at 3:35 PM. This was further discussed with the Administrator on / at 2:38 PM.

Class III

0056 Medication - Labeling and Orders

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications followed written Health Care Provider (HCP) instructions for medications, for 3 of 10 sampled Residents (#10, 12 and 13).

The findings include:

Observation of unlicensed staff assisting residents with self-administration of medications was conducted on . The following concerns were identified:

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1. At 11:55 AM, Employee B, a Medication Technician (MT) was observed to give Resident #13 one tablet of , ER 25 milligrams (MG). Review of her records revealed a written HCP order dated for ER 25 milligrams (MG) daily. Her 2015 medication observation record (MOR) documented a matching entry. The prescription label for this medication read, "... give three tablets daily". In an interview conducted at the time of observation, Employee B stated she believed the resident's HCP wanted to break up the dose. She further stated she was not familiar with or had any "alert" labels, used to indicate the instructions for the medications had changed.

2. Review of Resident #12's records revealed a written HCP order for Algin 4 MG daily. At 11:55 AM, Employee B was observed to review medications to be given to Resident #12, she referenced the Align and stated it had not yet been delivered by the pharmacy, that it was requested from the pharmacy on / but she was told the pharmacy had to order it and it should be received today. Review of Resident #12's record revealed no documentation showing facility staff made every reasonable effort to ensure timely refill of this medication.

3. At 3:40 PM, during review of Resident #10's medication records, her and 2015 MOR's revealed an order for 50 MG one tablet three times daily as needed for pain. Her MOR also documented she received doses three times daily. In an interview conducted at that time, Employee B stated she asks for it every day, three times a day. It also documented she did not receive any doses on through / . Employee B stated they ran out of the medication but had no explanation why it was not refilled on a timely basis. Further review of Resident #10's records revealed no documentation showing facility staff made every reasonable effort to ensure timely refill of this medication.

These concerns were discussed with and acknowledged by the Administrator in an interview conducted / at 3:35 PM. This was further discussed with the Administrator on / at 2:38 PM.

Class III

0162 Records - Resident

Based on record review and interviews, the facility failed to provide adequate informed consent information related to unliclensed staff assisting residents with self-administration of medications, for 3 of 10 sampled Residents (#3, 4 and 9).

The findings include:

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During review of medication systems conducted 9/2/15 beginning at 3:40 PM, the following concerns were identified. Review of records for Residents #3, 4 and 9 revealed informed consent forms signed / , and , respectively, revealed the section that disclosed, "In our facility, staff assisting residents with self-administration will or will not be overseen by a licensed nurse." was not checked off to indicated if the unlicensed staff who assist residents with self-administration of medications would or would not be overseen by a licensed nurse.

This was discussed and acknowledged by the Administrator in an interview conducted at 3:35 PM. This was further discussed with the Administrator on at 2:38 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015005908

Dear Administrator:

This letter reports the findings of a state complaint licensure survey that was conducted on , 2015 and Septemeber '22, 2015 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. **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 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 5000-3547

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com