STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966236	06/03/2016
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 Relicensure with Extended Congregate Care (ECC) survey was conducted on 06/02/2016 & 06/03/2016 at Pelican Garden (license #10510). The facility had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation, staff interview and resident record review, 1 of 2 staff observed providing medications failed to assist residents with self-administered medications in accordance with proper state regulatory procedures as outlined in mandatory annual training for assistance with self-administered medication (Staff A).

The findings include:

1. During assistance with self-administration of medications on / beginning at 8:40 AM, Staff A performed the following procedures while assisting Resident #11 with self-administered medications:
a) Staff A sanitized her hands;
b) She removed Resident #11's medication cards from locked cabinet; failing at this time to verify medication label with MOR;
c) She placed the resident's medications into a small plastic medication cup, without identifying each medication and its dosage to the resident;
d) She handed the medication cup to the resident along with a glass of water;
e) She observed the resident swallow the medications given;
f) She assisted Resident #11 back to her chair at the dining so she could eat her breakfast;
g) Staff A left the medication area to wash her hands;
h) When she returned, she placed a call to the Administrator to notify her of the Relicensure survey being conducted; and
i) Then, after approximately 10 minutes, Staff A placed her initials next to all of Resident #11's 8:00 AM meds in the Medication Observation Record (MOR).

2. Staff A proceeded to follow steps 1 -5 for Resident #6 and Resident #1, failing to compare medication labels with MOR and not informing residents of each medication and its dosage being provided.

A review of Resident #6's MOR and medication label for , 1 mg , documents medication is to be given to the resident every "PM". However, this medication is documented in the MOR as given at 8 AM, and was given on / with morning medications. A review of the physician order dated , 2016 documents medication is to be taken "once daily", and does not specify a time of day. When Staff

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A was asked why there was a discrepancy between the directions on the label and the time the medication is actually given, she stated, "It must be an error by the pharmacy. We have always given this medication in the morning." When asked why the pharmacy was not contacted to verify the timing and, if a mistake, get the label and MOR corrected, Staff A stated, "Normally, we do contact the pharmacy, but I have been out, and I am just trying to get caught up with everything,"

An interview was conducted with the pharmacist on at approximately 9:25 AM. He stated, "I directed the PM dose on the label because of potential side effect of and lightheadedness, but since the resident has been on the medication for more than a month, the facility is free to change the medications time to best suit the resident."

On , an interview was conducted with the administrator regarding the medication observation. She was notified Staff A did not follow the proper state regulatory procedures as outlined in mandatory annual training for assistance with self-administered medication regarding verifying medication labels with the MOR before removing the medications from their original, labeled container, and contacting pharmacy if there is a discrepancy between label and MOR, and notifying residents of the medications being provided, and initialing the MOR immediately after providing medications to the residents. The administrator acknowledged the failure by staff to follow all of the proper procedures related to medication assistance.

Class III

0054 Medication - Records

Based on observation, staff interview and resident record review, 1 of 2 Medication Technicians [Staff A] failed to 1) immediately update the Medication Observation Record at the time the medication was offered, and 2) incorrectly documented receipt of a medication that was not received, for 1 of 5 residents whose meds were observed [Resident #11].

The findings include:

1) During assistance with self-administration of medications on beginning at 8:40 AM, Staff A provided Resident #11 with all of her pills contained in her bubble-packed medication cards and observed the resident swallow the medications. Staff A, then, assisted Resident #11 back to her chair at the dining so she could eat her breakfast. Staff A left the medication area to wash her hands, and when she returned, she placed a call to the Administrator to notify her of the Relicensure survey

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being conducted; and then, After approximately 10 minutes, Staff A placed her initials next to all of Resident #11's 8:00 AM medications in the Medication Observation Record (MOR).

2) After Staff A initialed the MOR, this surveyor reviewed the MOR to verify medications with the medication label. It was noted that Resident #11 was due to receive eye drops in her right eye along with her morning medications, but no eye drops had been seen given to Resident #11 at this time. The MOR contained Staff A's initials next to the eye drop medication for date of , signifying the eye drops had been given. When Staff A was questioned about the eye drop medication on at 8:55 AM, she stated, "Oh, I forgot to give her the eye drops because I was nervous; I just put my initials next to all of her morning medications ."

On , an interview was conducted with the Administrator regarding the medication observation. She was notified Staff A had not initial the MOR immediately after providing medications to Resident #11, and had initialed eye drop medication that had not been given. The Administrator acknowledged the failure by staff to follow the proper procedure related to updating the medication observation record.

Class III

0093 Food Service - Dietary Standards

Based on observation, facility record review and staff interview, the facility failed to ensure portion sizes were indicated on the menus or on a separate document utilized by dietary staff. This affects all residents whose meals are provided by the facility.

The findings include:

During review of the weekly menu, reviewed and signed by Registered and Licensed Dietitian on , it was noted that the majority of food items on the menu did not have the portion size listed.

On at approximately 10:00 AM, the Administrator stated she was unaware as to why there were no serving sizes listed on the new menu. She confirmed there were no other documents used by the kitchen staff which contained the serving sizes for foods listed on the menu reviewed and approved by the Registered/Licensed Dietitian (RD/LD). When asked how the Kitchen Manager assures residents are receiving the required nutrition if serving sizes are not listed, she responded, "I don't know, but the residents are given generous portions of food at each meal.."

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On 6/02/16 at approximately 11:00 AM, the Administrator provided a copy of the previous menu which had been provided by the same RD/LD, and this previous year's menu did list serving sizes for all foods on the menu. The administrator stated, "I don't know why the Dietitian removed the serving sizes, but I will contact her and get her to correct the menu."

Class III

0162 Records - Resident

Based on interview and record review, it was determined the facility failed to have documentation of the appointment of a power of attorney, for 1 of 2 sampled resident records reviewed (Resident #3).

The Findings included:

During resident record review and interview conducted with the Administrator, on beginning at approximately 9:30 AM, she was provided the opportunity to locate Resident #3's spouse's appointment of Power of Attorney. The Administrator acknowledged that the spouse of Resident #3 signed all admission paperwork for this resident at the time of admission on . She stated that Resident #3's spouse was to fax a copy of her appointment of Power of Attorney and that it was never received by the facility.

Class

Z814 Background Screening Clearinghouse

Based on interview and record review, it was determined the facility failed to ensure each staff member's employment status was maintained with the clearinghouse and that any initial employment status and changes in status were reported within 10 business days for 5 of 6 sampled staff reviewed related to clearinghouse status (Staff A, Staff B, Staff C, Staff G, and Staff H).

The Findings included:

During staff record review and interview conducted with the Administrator, on beginning at approximately 9:00 AM, the background screening clearing house roster was compared to the staff

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sample and the following staff employment status was not maintained on the roster within 10 business days:

a) Staff A: a CNA (Certified Nursing Assistant) with a date of hire noted as was not listed on the current background clearing house roster that was printed on /

b) Staff B: a CNA with a date of hire noted as was not listed on the current background clearing house roster that was printed on /

c) Staff C: a DCS (Direct Care Staff) with a date of hire noted as / was not listed on the current background clearing house roster that was printed on /

d) Staff G: a DCS with a date of hire noted as and a termination date noted as was not listed on the current background clearing house roster that was printed on /

e) Staff H: a food service worker with a date of hire noted as and a termination date noted as was not listed on the current background clearing house roster that was printed on /

The Administrator acknowledged that not all staff have been entered into the roster and that she was not aware of the requirement to update their status within 10 business days. She stated she was only recently informed of the background screening clearing house roster.

Unclassified

Z815 Background Screening: Prohibited Offenses

Based on interview and record review, it was determined the facility failed to ensure that current level 2 background screenings were maintained for 1 of 4 sampled staff reviewed related to background screenings (Staff F), specifically related to individuals for whom the last screening was conducted between 01/01/2009 - / , must be rescreened by / .

The Findings included:

During employee record review and interview conducted with the Administrator on beginning at approximately 11:00 AM, Staff F's (date of hire noted as /) file was reviewed. The last level 2 background screening on file for this DCS (Direct Care Staff) was noted as . The

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Administrator reviewed the background screening website at this time and confirmed this was the most recent level 2 background screening that was obtained for Staff F. As Staff F's last background screening was conducted between / - / (date of last screening was), she is past due for a level 2 backgrounds screening by approximately 10+ months (due /). The Administrator acknowledged that she was not aware a new screening was due for Staff F.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on , 2016 through , 2016 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 , 2016.** 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
Enclosure

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