STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966236	**11/20/2017**
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 licensure complaint survey, CCR# 2017009942, was conducted on at Pelican Garden, License # 10510. The allegation was substantiated. The facility had deficiencies at the time of the investigation.

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on interview and record review, it was determined the facility failed to develop a detailed written policies and procedures for responding to a resident elopement; specifically related to the identification of staff responsible for implementing each part of the elopement policies and procedures including specific duties and responsibilities; the identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1; and the continued care of all residents within the facility in the event of an elopement.

The findings include:

During entrance conference conducted with the Administrator, on beginning at approximately 9:15 AM, she was asked for a copy of the facility's Elopement policy and procedure. She provided a copy of the facility's Missing Person Procedure and indicated this is the facility's Elopement policy and procedure. This one page document reflects the following:
1) Make an announcement on the intercom to every once. Indicate the name of the missing person and wait for a response.
2) Check sign-out sheet to see if he/she signed out.
3) Inspect the entire facility inside and out. This requires all hands on deck, all employees on the given shift. Determined who is looking where and then divide up and decide on a meeting place once completed.
4) Call family member to see if they have taken the resident out of the building and forgot to sign out.
5) Contact police! Have a full description of the resident and be prepared to answer question regarding the resident and where they were the last time you saw or someone saw them. Have a picture of the resident to give to the police or identification as well as provide the police with all information regarding the resident's family contact names and numbers, health status and current medications and times to take.
6) Call the administrator/assistant administrator.
7) Administrator should complete an incident report with full explanation of the events that happened, step by step detail. Make three copies and send one to the insurance company, one to the State and the final copy should be placed in the resident's chart.

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During subsequent interview and record review conducted with the Administrator, on beginning at approximately 10:00 AM, she was provided the opportunity to locate the incident report and Adverse Incident Report for Resident #1's elopement on . The Administrator acknowledged that an Adverse Incident Report and and incident report were not completed for this elopement.

During interview and review of Missing Person Procedure (the facility's Elopement policy and procedure) conducted with the Administrator, on beginning at approximately 11:40 AM, she was asked to locate in this procedure which staff is responsible for what specific duties (i.e. for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1; and the continued care of all residents within the facility in the event of an elopement). The Administrator acknowledged that this procedure does not indicate which staff assume what roles during an elopement.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on interview and record review, it was determined the facility failed to maintain documentation verifying direct care staff and Administrator participation in resident elopement drills pursuant to paragraph 58A- (8)(c), F.A.C. for the only 2 elopement drills noted for 2017, for 2 of 2 sampled residents (Resident #1 and Resident #2).

The findings include:

During entrance conference conducted with the Administrator, on beginning at approximately 9:15 AM, she was asked for documentation of all elopements and elopement drills for the past 6 months. She provided the following:
1) An elopement drill, dated , that noted the person in charge and four other staff on duty. This document is not signed by any staff that were noted to be in charge or on duty. (The first names of the four other staff on duty was all that was noted).
2) An elopement drill form (however, this was an actual elopement per Administrator), dated , that noted person in charge and two other staff on duty. This document is not signed by any staff that were noted to be in charge or on duty.
The Administrator was asked if she had any documentation verifying participation in the drills by the direct care staff or by the Administrator. She acknowledged that she did not. She also acknowledged that these forms were the only noted elopement drill forms for 2017.

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Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, it was determined the facility failed to file an Adverse Incident report, specifically related to an elopement, for 1 of 1 residents that eloped from the facility during the first 10 months of 2017 (Resident #1).

The findings include:

During entrance conference conducted with the Administrator, on beginning at approximately 9:15 AM, she was asked to provide any Adverse Incident reports that had been filed with the State for the past 6 months. She stated there had not been any. She was asked for documentation of any resident elopements for the past 6 months. She provided for review an Elopement Drill Report, dated regarding Resident #1's elopement from the facility. She stated this was an actual elopement, but an Elopement Drill Report form was also completed. At this time she asked the Director of Resident Care and Placement (the former Administrator until mid 2017) to join this conversation. This Elopement Drill Report for Resident #1 was reviewed and indicated he had been located walking down the street. They were asked why an Adverse Incident report was not filed for this elopement. The Director of Resident Care and Placement stated it was because this resident was located. She was reminded that an elopement that "places a resident at risk of harm or injury" is reportable and that this resident's whereabouts were unknown to facility staff and he was found walking down the street which would place him at risk of harm or injury. The Director of Resident Care and Placement (former Administrator) repeated Resident #1 was located and was fine.

Class III