STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969009	**04/17/2018**
NAME OF PROVIDER OR SUPPLIER **PELICAN LANDING ASSISTED LIVING AND MEMORY CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **13085 US HWY 1** **SEBASTIAN, FL 32958**	

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

0000 - Initial Comments

An unannounced Re-Licensure survey with Limited Nursing Services (LNS) was conducted on , and 17th, 2018 at Pelican Landing Assisted Living and Memory Care, License #12820 . The facility had deficiencies at the time of the visit.

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interviews, the facility failed to maintain an accurate Medication Observation Record (MOR) for 1 out of 1 sampled residents (Resident #8).

The findings included:

On at 10:00 AM, Resident #8 stated during interview that she had not received her sleep medication last night ( ).

During review of Resident #8's , 2018 electronic Medication Record, it was revealed that the "sleep medication" , ( ) 15mg, to be given "as needed" was documented incorrectly on the Medication Record. The current health care provider's order on file dated shows the resident is supposed to receive this medication "every bedtime", not "as needed". The Medication Record had not been updated to show the current order for , . Further review of the Medication Record showed the facility did not document that the resident received the medication on or as ordered. Review of the Medication Notes for , 2018 revealed no documentation to show why the resident did not receive the medication on , or .

Staff E's initials were documented on , indicating that the resident did receive this medication on this date. However, Staff E stated during interview on at 12:00 PM that she had not given the resident the medication on because it was "not available", and that she "had not documented that she gave the resident the medication". It is unknown how this staff member's initials were documented on the Medication Record for , 15mg, on at 8:00 PM.

Additionally, review of the , 2018 Medication Record on showed no staff initials to indicate the resident received , tablet 25mg on Monday, at 8:00 AM. The resident did not indicate she had missed any other medications on . The Medication Record had not been documented by staff to show the resident received this medication.

These findings were reviewed with the Resident Wellness Director at 12:30 PM on , and again

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with the Administrator on at 1:30 PM. The facility provided no additional documentation for review at this time.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review and interviews, the facility failed to ensure that medications are secured at all times and the facility failed to dispose of medications for a resident who had been out of the facility for more than 30 days for 1 of one medication carts and one of one medication . (secure unit)

Findings include:
1) On at 925 am , Nurse F poured the medications from four cards and then left the four cards on the top of the medication cart. The nurse then picked up the cup with the medications and turning her back to the cart walked over to the resident. The nurse assisted the resident to consume the medications one by one. The nurse with her back to the cart, then walked over to the Kitchen sink to wash her hands and at 9:32 AM returned to the medication cart. The surveyor asked the nurse if she should have left the medications on top of the cart, unsecured. The nurse confirmed that she failed to ensure that the medications were secure before she left the medication cart.

2) An observation of the medication storage unit was conducted on at 10: 11 AM, accompanied by Nurse F. The nurse informed the surveyor that over the counter medications and discharge medications were stored in locked cabinets inside the locked medication . The nurse opened the locked cabinet and the following discharge medications were identified belonging to a resident who had been discharged to the Hospital on /1
50 mg tablets
/ / caps
fish oil capsules 1000 mg
81 mg tablets
10 mg tablets

The Nurse confirmed that all medications prescribed for a resident who has been discharged from the facility for more than 30 days should be returned to the responsible party or destroyed. The nurse confirmed that the facility failed to do this within the specified time frame.

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Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and interviews, the facility failed to obtain medication refills in a timely manner for 1 out of 1 sampled residents (Resident #8).

The findings included:

On at 10:00 AM, Resident #8 stated during interview that she had not received her sleep medication last night ( ). She stated that the facility runs out of her medication at times, but obtain the refills of medications within a day after realizing they are out.

During review of Resident #8's , 2018 electronic Medication Record, it was revealed that the "sleep medication" , ( ) 15mg, to be given "as needed" was documented incorrectly on the Medication Record. The current health care provider's order on file dated shows the resident is supposed to receive this medication "every bedtime", not "as needed". Further review of the Medication Record showed the facility did not document that the resident received the medication on or as ordered. Review of the Medication Notes for , 2018 revealed no documentation to show why the resident did not receive the medication on , or .

Staff E's initials were documented on , indicating that the resident did receive this medication on this date. However, Staff E stated during interview on at 12:00 PM that she had not given the resident the medication on because it was "not available", and that she "had not documented that she gave the resident the medication". It is unknown how this staff member's initials were documented on the Medication Record for , 15mg, on at 8:00 PM.

These findings were reviewed with the Resident Wellness Director at 12:30 PM on , and again with the Administrator on at 1:30 PM.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review it was determined the facility failed to ensure within 30 days after beginning employment, newly hired staff submitted a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 3 of 4 sampled staff (Staff A, Staff B, and Staff C).

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The findings include:

During interview and personnel record review conducted with the BOM (Business Office Manager), on beginning at approximately 10:10 AM, the following staff members did not have a written statement from a health care provider documenting the individual does not have any signs or symptoms of communicable within 30 days after beginning employment:

1) Staff A: date of hire noted as ; communicable statement dated (4 months after beginning employment).
2) Staff B: date of hire noted as ; communicable statement dated (13 months after beginning employment).
3) Staff C: date of hire noted as ; communicable statement dated (21 months after beginning employment).

The BOM acknowledged the communicable statements, noted above, were not conducted in a timely manner.

Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on interview and record review it was determined the facility failed to ensure each employee had a signed Attestation referenced in subsection 59A-35.090(2), F.A.C. ,was in the employee's personnel file that is maintained by the provider for 1 of 4 sampled staff (Staff C).

The findings include:

During interview and personnel record review conducted with the BOM (Business Office Manager), on beginning at approximately 10:10 AM, she was provided the opportunity to locate a signed Attestation form for Staff C (date of hire noted as). The BOM located an incomplete, undated, and unsigned Attestation form in Staff C's personnel file. The BOM could not provide an explanation as to why this required documentation was not completed, dated, and signed by Staff C.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

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Based on interview and record review it was determined the facility failed to ensure that each staff member that is subject to a level 2 background screening had not had a break in service from a position that requires a level 2 screening for more than 90 days for 1 of 4 sampled staff (Staff C).

The findings include:

During interview and personnel record review conducted with the BOM (Business Office Manager), on beginning at approximately 10:10 AM, she was provided the opportunity to establish that the facility had verified if Staff C (date of hire noted as ; most recent eligible level 2 background screening dated) had a break in service that exceeded 90 days. The BOM acknowledged there was no employment reference checks verifying date of employment in Staff C's personnel file.

During subsequent telephone interview conducted with Staff C, on beginning at approximately 12:15 PM, she verified that prior to her employment with this facility that she had been unemployed for approximately 9-12 months.

Unclassified