STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966236	**05/09/2018**
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 survey with Extended Congregate Care (ECC) was conducted on [redacted] 8th, and 9th, 2018 at Pelican Garden, LLC, License #10510. The facility had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and an interview, the facility failed to ensure the health assessments (AHCA Form 1823) were accurate and up-to-date for 2 out of 2 sampled residents (Residents #2 and #6).

The findings included:

1. The health assessment for Resident #2 dated [redacted] indicated that the resident had "no pressure sores; healing [redacted] (pressure [redacted])" on page 2, section C. Additionally, the assessment did not have documented the type of diet that the resident is supposed to receive on page 2, section B. The Administrator stated during interview on [redacted] at 1:00 PM, that the resident did not have a "healing [redacted] pressure [redacted]", and that the resident received a regular diet.

2. The health assessment for Resident #6 dated [redacted] documents that the resident is to receive a "no concentrated sweets ([redacted]) diet" on page 2, section B. During interview with the Administrator on [redacted] at 1:00 PM, she stated the resident received a regular diet, with regular desserts (concentrated sweets).

AHCA Form 1823 information was not accurate or complete for these residents. The omitted information may be obtained orally from the health care provider and documented on the assessment by facility staff, with the name of the provider, name of facility staff recording the information, and the date the information was provided. The assessments did not have the erroneous or omitted information obtained and documented. The facility provided no additional documentation for review at this time.

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC

Based on record review and interviews, the facility failed to ensure adequate coordination of care between third party services and the facility for 1 out of 2 sampled residents (Resident #2).

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The findings included:

On at 9:45 AM, Resident #2 stated during interview that she had a on her right lower extremity (RLE) that required care from a care center once a week. The Administrator stated during interview at 9:30 AM that the was not a pressure and that it was a nonstageable .

On at 2:00 PM, the home health agency nurse treating the stated that the resident has two pressure sores on her RLE, and that she changed the bandages twice a week at the facility. There was no documentation of the assessment and treatment of the wounds by the home health agency available at the facility at this time.

Review of the resident's record on revealed the following documentation:

a) : resident was sent to the hospital
b) : resident returned from the hospital
c) : ALF (assisted living facility) requested treatment and assessment of right
d) : on right side of leg noted in observation notes
e) : observation note documents that the doctor send nursing to assess and treat leg
f) : fax cover sheet from ALF, requests doctor to send nursing "back out to assess on right /leg"
g) : observation note documents that resident started treatment at care center, negative test for (,)
h) : resident sent to hospital for and possible
i) : AHCA Form 1823 health assessment documents examination from health care provider at rehabilitation center, indicating "no pressure sores; healing (pressure)"

During interview with the home health agency Administrator on at 12:25 PM, she stated that the agency was treating the resident for an "unspecified " with no information about a pressure .

These findings were discussed with the Administrator on at 2:00 PM. The clarification of the conflicting documentation of the source of the wounds, the date of onset for each of the two wounds, and the coordination of care with the ALF and the home health agency was not evident. The facility provided no additional documentation for review at this time.

Class III

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

Based on record review and an interview, it was determined the facility failed to ensure the Medication Observation Record (MOR) was up-to-date for 4 out of 4 sampled residents (Residents #1-#4) who required assistance with the self-administration of medication.

The findings included:

During review of the , 2018 MOR's on , the following omissions and errors were identified:

1) Resident #1
a. 12:00 PM doses for and were not initialed as given for and ER.
b. nasal spray, to be given three times a day, was initialed as given four (4) times each day on -
c. 8:00 PM dose for was not itialed as given for nasal spray.
d. ( ) 2mg, 4mg to be given Wednesday and Sunday, had no time documented to indicate what time of the day the medication was to be given.
e. ( ) 2mg, 3mg to be given Monday, Tuesday, Thursday, Friday and Saturday, had no time docuemented to indicate the time of day it was to be given.

2) Resident #2
a. 12:00 PM dose of Ferrex was not initialed as given on .
b. 9:00 PM dose of was not initialed as given on .
c. 7:00 AM dose of was not given until at 9:40 AM (time was later changed on MOR with doctor's approval to allow later dose).
d. 8:00 AM doses on were not initialed as given for and Stress Formula.
e. 9:00 AM dose of on was not initialed as given.
f. sugar test, once daily: There was no documentation on the MOR, based on a health care provider's order, that the resident could administer without assistance.
g. , cream to right lower leg three times a week-There was no documentation on the MOR to indicate that a home health agency was to administer this medication, or that the resident did not require assistance with this medication.

3) Resident #3
a. 8:00 AM dose of was not intialed as given on .

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4) Resident #4
a. 1:00 PM dose of , was not initialed as given on .
b. 10:00 AM doses of Zohydro was not initialed as given on and .
c. , , to be given once a day at 8:00 AM, was documented as given twice (duplicate) from - .

The Administrator was notified of these findings during interview on at 1:30 PM. The facility provided no additional documentation for review at this time.

Class III

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

Based on record review and interviews, the facility failed to ensure an Adverse Incident report was completed and filed with the Agency for 1 out of 1 sampled residents (Resident #6) who sustained a at the facility.

The findings included:

On at 11:00 AM, Resident #6 stated she from her recliner and sustained a foot. The Administrator stated during interview on at 1:00 PM that she had not completed a one or fifteen day Adverse Incident report for this resident's .

Review of the resident's record revealed an observation note dated that indicated the resident "rolled her ankle this morning. There was a knot and some on the outside of her foot...she was diagnosed with misplaced ankle and got order for a to be worn".

Upon further review of records, there was no Adverse Incident report filed with the Agency, documenting the facility's internal investigation of this incident that resulted in a . The facility provided no additional documentation for review at this time.

Class

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and an interview, the facility failed to ensure the contract for care and services between the resident and the facility was completed for 1 out of 2 sampled residents (Resident #6).

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The findings included:

On , the contract for care and services between Resident #6 and the facility was reviewed. Upon review, it was revealed that the contract did not have a daily/weekly/monthly rate charged to the resident listed on page 2. Additionally, the signature page (page 9) did not have the resident's signature or the facility's representative's signature documented. The resident's signature was documented on page 10, under "Guaranty" for payment only. These findings were discussed with the Administrator during interview at 11:00 AM on . The facility provided no additional documentation for review at this time.

Class