Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967587	A. BUILDING: _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENNITY AT MELBOURNE (THE)	7365 ORCHESTRA LN MELBOURNE, FL 32940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint Investigation #2020018428 was conducted on . . . . . Brennity at Melbourne had a deficiency at the time of visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of . . . . . or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . . . or . . . . . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making . . . . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide appropriate care and services that included supervision and maintaining a general awareness of the resident's whereabouts for 2 of 3 residents who eloped from the memory care unit (#1 & 2), and failed to notify the resident's responsible party of a (#2). Findings: 1. On at 11 AM, the facility Registered Nurse identified residents #1 and #2 as elopement risks. The facility's elopement policy and procedure, dated , described an elopement	A 025		

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A 025	Continued From page 2 as an instance in which a resident leaves the community without the knowledge of the associates. This applies especially when the resident has , decision-making abilities and is unaware of his/her own safety and needs. Resident #1 had a health assessment report, dated , that listed diagnoses of Slow Paroxymal (SPAT), right , and unsteady gait. He required memory care and was an elopement risk. He was independent with ambulation, transferring, eating, grooming and toileting. Supervision was needed with bathing. The 1-Day Adverse Report indicated the resident eloped on . According to the report, on at 1:40 PM, when wife came to visit after lunch, the resident wasn't in the Memory Care Unit (MCU). An inside search was conducted. Then an outside grounds search was done. He was found on a side street within the community, sitting on the sidewalk with a on his but in good spirits. He was sent to hospital for observation. He returned later that day. In an interview on at 2:11 PM, the MCU nurse said that the resident was observed sitting on the sidewalk, seems he was headed to his former home, where his wife currently lived. Facility notes indicated at 2:24 AM, the resident was up most of the night, walking around, going into other's rooms, looking for his wife. at 7:15 AM, it was reported by nurse that at approximately 6:45 AM, she heard the alarm, observed the resident walking towards the gate. The resident was eventually re-directed to the facility.	A 025		

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A 025	Continued From page 3 , the resident had a 11:15 AM; no injury was noted. at 3:45 PM, the resident "had a and hit while walking, , complained of / , 911 called." , the resident returned at 11 PM with 5 on the forehead. , ( ) was ordered but his wife refused . , the resident was pacing, looking for his wife. , the resident "eloped from MCU today, exited from the dining room at 12:55 PM" was located on a side street within the community, sitting on sidewalk." The resident had a to the left , to and the left . 911 was called. The resident returned to the facility with 5 to the left , . His wife and daughter were informed of his return. An order dated indicated , 25 milligrams (mg.) one twice daily, dispense 60 x allow 2 refills. The Medication Observation Record (MOR) listed , 25 mg. one tablet two times a day at 9 AM and 9 PM. The medication was marked as given on at 9 PM, twice daily from /20 and and AM, and then discontinued. The review revealed no written notations as to why the resident was put on , . There was no evidence the resident was seen by a healthcare provider, and that the responsible party was made aware of a new medication. 2. Resident #2 had health assessment form 1823 dated that listed diagnoses of and memory . Special precautions needed were for . She was independent with eating and transferring; supervision was needed with ambulation, bathing,	A 025		

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A 025	Continued From page 4 . . . . ., grooming and toileting. According to the health assessment she was not at risk of elopement. A 15-day Adverse report dated 11/09/20 indicated that on the resident walked out of the MCU at approximately 3:11 PM. She pushed the magnet door which allowed her to get out. She proceeded to walk to the next available door, which was the ALF household. She was allowed in and brought . . . to MCU at 3:20 PM. The facility is a gated community with independent living, private homes and the Assisted Living Facility. The facility has "communities". One of the communities is a Memory Care Unit. The MCU is located on the first floor. There is a patio outside the MCU that can be accessed by the residents by simply going through the door. The patio is gated and has a egress door that can be opened by pushing the magnet door and holding it by 15 seconds. Both residents left the facility by pushing the exit magnet door. Once you go through that door, you are outside the MCU. Right next door, the is another "community", which is not secured. Resident #2 went through the magnet door, turned left, walked down a small walkway and ended up next door to the MCU. The staff saw her, recognized her as a resident from the MCU, and took her . . . to the MCU. A facility note dated . . . . . indicated the resident went to the emergency room on for a . with . . . injury. She returned to the facility on /202 at 10:30 AM with to the right forehead above the right , ... The facility staff spoke with the son because the resident was not at . . . . . treatment. The resident was unable to have treatment because the . . . . . mask would not fit due to the of the because of the injury	A 025		

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A 025	Continued From page 5 from the . . There was no evidence to confirm the resident's representative was contacted when the . occurred. There were no notes that documented the circumstances of the which resulted in injury. There were no notes regarding the elopement. In an interview on at 2:11 PM, the MCU nurse who worked until 9 PM on . . . , said when she returned to work in the AM, she found out resident #2 was at hospital. She said she called the resident's son to say she was at the facility. The son told the nurse he knew the resident had . On , the Executive Director and acting Resident Care Director voiced no concerns about the above findings. Class II	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children	A 032		

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A 032	Continued From page 6 and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. 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,	A 032		

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A 032	Continued From page 7 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that 2 of 2 residents assessed at risk for elopement and with any history of elopement were identified so staff could be alerted to their needs for support and supervision (#1 & 2), and that as part of its resident elopement response policies and procedures, the facility made, at a minimum, a daily effort to determine that at risk residents had identification on their persons that included their name and the facility's name, address, and telephone number. Findings: On . . . . . at 11 AM, the facility Registered Nurse identified residents #1 and #2 as elopement risks. Observations on . . . . at 12 PM noted resident #1 sat in small dining room, along with 2 other residents and a staff who fed one resident. He was clean and well-groomed. He wore a "necklace" that had a plastic pocked with his name written on a card. He wore it under his shirt. The card did not have the facility's name, address and phone number. The Memory Care Unit (MCU) nurse said the resident had that necklace before he eloped, and had it for a while. Resident #2 ate lunch as well, in another area	A 032		

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A 032	Continued From page 8 where more residents ate. The MCU nurse said the resident did not have identification on her person. Resident #1 had a health assessment report dated that listed diagnoses of right , unsteady gait. He required memory care and was elopement risk. He was independent with ambulation, transferring, eating, grooming and toileting. Supervision was needed with bathing. The 1-Day Adverse Report indicated the resident eloped on . According to the report, on /12020 at 1:40 PM when the resident's wife came to visit after lunch, the resident wasn't in the MCU. An inside search was conducted. Then an outside grounds search was done. He was found with a on his . He was sent to hospital for observation. He returned later that day. Facility notes indicated that on at 2:24 AM up most on night - walking around, going into other's rooms. Said he was looking for wife, as he knew she was there. 7:15 AM was report by nurse that at approximately 6:45 AM that she heard alarm, observed resident walking towards gate. Eventually re-directed to facility. new order received and carried out. had a 11:15 AM - no injury noted 3:45 had a and hit while walking, , complained of / , 911 called returned at 11 PM last night. Had 5 on forehead, , ( ) ordered, wife refused pacing due to , looking for wife eloped from MCU today, exited from the	A 032		

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A 032	Continued From page 9 dining room at 12:55 PM was in a side street within the community, sitting on sidewalk, [redacted] to left [redacted], [redacted] to [redacted] and left [redacted], 911 called. Per usual not aware of time or situation. [redacted] returned to facility. Had 5 [redacted] to left [redacted]. Wife and daughter informed of return. 2. Resident #2 had health assessment report 1823 dated [redacted] that listed diagnosis of [redacted], and had memory [redacted]. Special precautions were needed for [redacted]. She was independent with eating and transferring; supervision was needed with ambulation, bathing, [redacted], grooming and toileting. According to the health assessment, she was not at risk of elopement. The 15-day Adverse Report, dated [redacted], indicated that on [redacted], the resident went out of the MCU at approximately 3:11 PM. She pushed the magnet door which allowed her to get out. She proceeded to walk to the next available door, which was the assisted living facility (ALF) household. She was allowed in and brought [redacted] to MCU at 3:20 PM. In an interview on [redacted] at 3 PM, the Executive Director confirmed the findings. Class III	A 032		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible,	A 055		

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A 055	Continued From page 10 residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the	A 055		

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A 055	Continued From page 11 refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit	A 055		

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A 055	Continued From page 12 issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure discontinued medication that was not expired were returned to the resident/resident's representative, as appropriate, or centrally stored for future use by the resident at the resident's request for 1 of 3 samples residents (#1). Findings: Resident #1 had a health assessment report, dated [redacted], that listed diagnoses of SPAT, right [redacted], unsteady gait. He required memory care and was elopement risk. He was independent with ambulation, transferring, eating, grooming and toileting. Supervision was needed with bathing and administration of medications was needed. Facility notes indicated on [redacted], a new order was received and carried out. On [redacted], the physician ordered [redacted], 25 milligrams (mg.) one twice daily, dispense 60 and allow 2 refills. The [redacted] Medication Observation Record (MOR) listed [redacted], 25 mg. one tablet two times a day at 9 AM and 9 PM. The medication was marked as given on [redacted] at 9 PM, twice daily from [redacted]/20 and [redacted], and [redacted] AM, and then discontinued. There was no evidence that the resident's representative was contacted regarding the discontinuation of [redacted]. On [redacted] at 2 PM, the facility Registered	A 055		

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A 055	Continued From page 13 Nurse/acting Resident Care Director said she had no further documentation about the , . Class III	A 055		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of .	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967587	A. BUILDING: _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENNITY AT MELBOURNE (THE)	7365 ORCHESTRA LN MELBOURNE, FL 32940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 160	Continued From page 14 (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with . . . . 's . . . . or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section	A 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 160	Continued From page 15 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations and interview the facility failed to maintain the facility's documented resident elopement response drills (records) in a manner that made such records readily available at the licensee's physical address for review by the Agency. Findings: In an interview with the Executive Director (ED) on [redacted] at 11:30 AM who said he had recently taken the position with the facility. They (facility) had been trying to access the former executive director's computer where most likely he kept the facility documents but had been unsuccessful. An opportunity was given to locate the elopement drills and submit them via e mail to the Agency surveyor by the end of closing on [redacted]. An	A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 160	Continued From page 16 e- mail was not received. Class III	A 160		