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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| | AL11967587 | A. BUILDING: _____ B. WING _____ | R 08/17/2021 |

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| BRENNITY AT MELBOURNE (THE) | 7365 ORCHESTRA LN MELBOURNE, FL 32940 |

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| {A 000} | Initial Comments<br><br>A revisit to the Relicensure survey and Complaint Investigation #2021003631 were conducted on and . Brennity at Melbourne had deficiencies were found at the time of the visit. | {A 000} | | |
| {A 008} SS=D | 429.26( .) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be made available to the agency during inspection or | {A 008} | | |

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| {A 008} | Continued From page 1 | {A 008} | | |

upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.
(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special

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| {A 008} | Continued From page 2<br>needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , require such assistance.<br><br>59A-36.006<br>(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection.<br>(a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following:<br>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,<br>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,<br>3. Any nursing or services required by the individual,<br>4. Any special diet required by the individual,<br>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,<br>6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff,<br>7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, | {A 008} | | |

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| {A 008} | Continued From page 3<br>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.<br>(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.<br>1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.<br>2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.<br>3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.<br>(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. | {A 008} | | |

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| {A 008} | Continued From page 4<br><br>(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).<br>(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule.<br>(f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or .<br>(g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.<br><br>This Statute or Rule is not met as evidenced by: | {A 008} | | |

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| {A 008} | Continued From page 5<br>THIS DEFICIENCY REMAINED UNCORRECTED<br><br>Based on record review and interview, the facility failed to ensure that 5 of 12 sampled resident records contained a completed health assessment (AHCA form 1823) (#1, 8, 9, 12 & 13).<br><br>Findings:<br><br>1. Review of the record for resident #12, admitted on [redacted], revealed a health assessment dated [redacted]. The assessment reflected diagnoses including trans-[redacted] ([redacted]), and [redacted]. The form indicated she used a walker due to [redacted]. She was assessed to require assistance with bathing, [redacted], and grooming. On page 4 of the assessment, it was documented she did not require assistance with self-administration of her medications, and that she required medication administration. Photographic evidence was obtained.<br><br>2. Review of the record for resident #13 revealed a health assessment dated [redacted]. The assessment was completed on an outdated version of the form from [redacted], and did not include documentation if the resident was assessed to be at risk for elopement. Photographic evidence was obtained.<br><br>On [redacted] at 1:30 PM, the administrator confirmed the findings.<br><br>3. Resident #1 had a health assessment dated [redacted]. In section A page 4, it reflected "Please see attached" for medication list. A medication list was not attached and was not available for | {A 008} | | |

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| {A 008} | Continued From page 6<br><br>review. Section B did not contain the resident's name, and did not address whether the resident needed assistance with self -administration of medications or administration or was able to self-administer.<br><br>4. Resident #9 had a health assessment report 1823 dated . . Page 1 did not contain any of the facility information.<br><br>5. Resident #8 had a health assessment report 1823 dated . that listed diagnoses of . . . and type II . . . . . According to the health assessment, she needed administration of medications by licensed staff, however she received assistance with self -administration of medications from the facility's unlicensed staff.<br><br>On . . . . . at 2 PM, the nursing director said resident #8 was able to assist with her medications. As for the health assessments, she was unable to locate any addition documentation.<br><br>Class III | {A 008} | | |
| {A 010} SS=D | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations | {A 010} | | |

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| {A 010} | Continued From page 7<br>in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.<br>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:<br>a. Move, turn, or reposition without total physical assistance;<br>b. Transfer to a chair or wheelchair without total physical assistance; or<br>c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . | {A 010} | | |

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| {A 010} | Continued From page 8<br><br>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.<br>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.<br>(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.<br>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.<br><br>59A-36.006<br>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. | {A 010} | | |

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| {A 010} | Continued From page 9<br><br>Exceptions to the requirement to meet the criteria for continued residency are:<br>(a) The resident may be bedridden for no more than 7 consecutive days.<br>(b) A resident requiring care of a [illegible] may be retained provided that:<br>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,<br>2. The condition is documented in the resident's record; and,<br>3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility.<br>(c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;<br>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;<br>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,<br>4. Documentation of the requirements of this paragraph is maintained in the resident's file.<br>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. | {A 010} | | |

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| {A 010} | Continued From page 10<br><br>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.<br>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.<br>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on resident record review and interview, the facility failed to ensure a health assessment was obtained after a significant change for 2 of 12 sampled residents (#3 & #5), and an interdisciplinary care plan was developed and implemented by hospice services in consultation with the facility to specify the services being provided by hospice and those being provided by the facility for 1 of 2 sampled residents (#10).<br><br>Findings:<br><br>1. Review of the record for resident #3 revealed an admission date of . . . . . . The only health assessment in the record was dated and documented diagnoses including . . . . . , and gait instability. She required assistance with bathing and grooming. She received assistance with self-administration of medications. The assessment did not document resident #3 to be at risk for elopement. Review of facility notes and | {A 010} | | |

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| {A 010} | Continued From page 11<br><br>reports revealed that resident #3 had had been exit-seeking since she arrived and did elope from the facility on [redacted] and [redacted]. Elopement is a significant change in condition which requires a new health assessment from a licensed provider.<br><br>On [redacted] at 9:30 AM, the memory care coordinator confirmed resident #3 had eloped on [redacted] and did not have a new health assessment.<br><br>2. Review of the record for resident #5 revealed she was admitted to hospice services on [redacted]. Her most recent health assessment was dated [redacted] and documented diagnoses including lymphedema and [redacted]. The assessment noted she required ECC (extended congregate care) services for lymphedema [redacted]. The assessment noted she required assistance with most activities of daily living. There was no health assessment found dated after admission to hospice.<br><br>On [redacted] at 2:00 PM, the administrator confirmed there was no health assessment obtained after the start of hospice services.<br><br>3. Record review for resident #10 revealed a hospice re-certification, dated [redacted], an indication she had been under their care at least 3 months prior to that date. The continued review revealed a health assessment dated [redacted] which included a need for hospice services. A hospice document listing current medications was in the record and was flagged by a sticky note which read hospice care plan. There was no evidence to confirm that a hospice interdisciplinary care plan was developed in conjunction with the facility. | {A 010} | | |

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| {A 010} | Continued From page 12<br><br>On [redacted] at 3:30 PM, the nursing director stated she had placed the sticky note in the record and believed that was the document required. She confirmed they did not have the hospice interdisciplinary care plan as required for resident #10.<br><br>Class III | {A 010} | | |
| {A 025} SS=G | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal | {A 025} | | |

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| BRENNITY AT MELBOURNE (THE) | 7365 ORCHESTRA LN MELBOURNE, FL 32940 |

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| {A 025} | Continued From page 13<br><br>supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on observation, resident record review, Medication Observation Record (MOR) review, and interview, the facility failed to provide care and services to meet the needs of the residents and did not follow a healthcare provider's order for 6 of 12 sampled residents (#2, 5, 7, 8, 9 & 13).<br><br>Findings: | {A 025} | | |

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| {A 025} | Continued From page 14<br><br>On at 10 AM, the administrator stated none of the residents were receiving Extended Congregate Care (ECC) services. The administrator acknowledged the facility holds a specialty license for ECC.<br><br>1. Resident #2's record revealed an admission date of . Her health assessment (AHCA form 1823) was dated , and reflected diagnoses including , , , , , and . She was noted to have moderate to severe , with decreased range of mobility with and , . She was assessed to be alert and able to make her needs known. She required assistance with activities of daily living (ADLs). Review of the progress notes through revealed facility staff provided , care, including staff nurses changing the bag and as needed. "An ostomy is a piece of medical equipment that protects the skin around an ostomy site. It is necessary, as an ostomy site is responsible for eliminating fecal matter from the body after a patient has undergone a , . The wafers act as a gasket that sticks to the skin on one side and attaches to the , bag on the other." (180medical.com).<br><br>Resident #2 was not enrolled in ECC services. Two service plans, dated and , were reviewed. The plan reflected that resident #2 was dependent on staff for all ADLs and required -on assistance for most ADLs. The service plan was not signed by the facility staff or resident/responsible party. The logs to document resident's service needs were met were both blank. There were no service plans for , , or found. Photographic evidence was obtained. | {A 025} | | |

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| {A 025} | Continued From page 15<br><br>On [redacted] at 12:10 PM, the administrator provided a copy of an email she received which she believed indicated the facility did not have to provide ECC services for [redacted] care for resident #2. Review of the email from an Agency for Health Care Administration (AHCA) representative found the explanation addressed assisted living facilities with a standard license and nurses on staff. This facility holds a specialty license for ECC. Photographic evidence was obtained.<br><br>Review of the MORs for [redacted] and [redacted] for resident #2 revealed:<br>[redacted], a [redacted], 15 milligrams (mg.) after meal at 10 AM. This medication was noted to not have been given on [redacted], with notes that read, "awaiting pharmacy". This medication was marked as given on [redacted] and [redacted], and not given on [redacted] with a note that read, "don't start until [redacted]." The medication was given more than one hour after the dosage window on [redacted] (1:18 PM) and [redacted] (3 PM), with no explanation for the delay in administration noted.<br><br>On [redacted], a note reflected that a nurse practitioner placed an order for the [redacted] 500 mg. three times a day ([redacted]) for a [redacted] on the right [redacted] and right [redacted] warmth. The MOR read, "awaiting pharmacy" for all doses on the [redacted], and the first 2 doses on [redacted]. First dose given to resident #2 was on [redacted] at 8 PM.<br><br>2. Resident #5's record revealed she was admitted to hospice services on [redacted]. Her most recent health assessment was dated | {A 025} | | |

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| {A 025} | Continued From page 16<br>, and listed diagnoses including , , , , , lymphedema, and . The assessment noted she required ECC services for lymphedema , . The assessment noted she required assistance with most ADLs. There was no health assessment found dated after admission to hospice care. The resident's record revealed a physician's order dated for /INR ( clotting time) to be drawn every Monday and Thursday and to report the results to the physician. "A prothrombin time ( ) test measures how long it takes for a clot to form in a sample. An INR (international normalized ratio) is a type of based on test results." (medlineplus.gov). No notes were found to show the /INRs were drawn, and that results were reported to the ordering physician. The most recent results in the record were dated . Photographic evidence was obtained.<br><br>Review of the MORs for & for resident #5 revealed:<br>( ) 5 mg, daily (QD) at 6 PM was marked "awaiting pharmacy" for 13 days: , , through , and . It was marked as given on , and 7/2521. The medication was documented as given late (more than one hour after the dosage time) on (8:05 PM) with no explanation for the delay in administration noted.<br>, (for , ) 40 mg, twice a day ( ) at 10 AM and 6 PM. This medication was marked "awaiting pharmacy" on at 10 AM, , , , at 6 PM, , , , at 10 AM, at 10 AM, , , , and at 10 AM. It was marked as given on , and the PM doses on , | {A 025} | | |

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| {A 025} | Continued From page 17<br>... and ... .<br>Red Yeast Rice (for ) 600 mg, at 10 AM and 6 PM. This medication was marked "awaiting pharmacy" for the morning doses on ..., ..., ..., ..., ..., ..., ..., and ... but marked as given for the evening doses on the same days. It was marked "awaiting pharmacy" for both doses on ..., ..., ..., ..., ..., and . The medication was marked as given on ..., and .<br><br>3. Review of the record for resident #13 revealed a health assessment dated . Diagnoses included , type 2, ..., with history of ..., ..., ..., ..., and dyslipidemia. She required assistance with self-administration of medications.<br><br>Review of the MOR for revealed multiple medications not available or given outside the 1-hour time window allowed for medications with specific dosage times.<br>... 20 mg. QD at 6:30 AM. This medication was noted to have been given late on ... at 7:45 AM, .../21at 8:03 AM, .../21at 8:59 AM, /21at 10:43 AM, /21at 10:29 AM, .../21at 8:18 AM, and given more than 1 hour early on at 5:07 AM and /21at 5:05 AM.<br>75 micrograms (mcg.) QD before meal at 6 AM. This medication was noted to have been given late on /21at 7:45 AM, /21at 8:03 AM, .../21at 8:59 AM, .../21at 10:43 AM, /21at 10:29 AM, and /21st 8:18 AM. It was documented to be "DNA" (drug not available) on and . | {A 025} | | |

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| {A 025} | Continued From page 18<br><br>50 mg, QD at 6 PM. This medication was noted to have not been given on , and with comments "awaiting pharmacy". On and , the medication was signed as given.<br><br>On , an order for a with was noted in the resident's record. On at 1 PM, a small white paper was taped to the outside of the record which read, "We need ." Review of the progress notes for resident #13 did not reveal any notes regarding attempts to collect a sample. Photographic evidence was obtained.<br><br>On at 10:15 AM, the nursing director stated she did not know why a sample had not been collected on when the order was placed.<br><br>On at 1 PM, the nursing director confirmed the medication issues for residents #2, 5, and 13 and inconsistencies noted in the MORs.<br><br>4. Record review for resident #9 revealed a health assessment report form 1823, dated , that listed diagnoses of type 2 , high , hypertrophy, , and . He needed assistance with self-administration of medications. A healthcare provider order, dated , indicated puree meats only, crush pill in pudding or apple sauce.<br><br>The record revealed a healthcare provider's order, dated , that indicated to decrease mix 75-25 from 45 units (u.) to 40 u. at dinner and to check (BS) 3 | {A 025} | | |

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| {A 025} | Continued From page 19<br>times a day for 2 weeks before breakfast and dinner, and at bedtime. Results were to be faxed to a healthcare provider.<br><br>... inject 40 u. two times a day ( ) at 8 AM and 5 PM was written on the MOR. On ..., ..., ..., and ..., all at 5 PM, the MOR entry indicated "resident asked for 35 units". On ..., ..., ..., , , all at 5 PM, the MOR indicated the "resident asked for 30 units". On ... and , all at 5 PM, 25 u. was given. Per MOR entries, the resident refused his PM ... on , from to , and from ... to ... all 4:30 PM. He also refused on AM, , , and ... at 8 AM.<br><br>... Lispro ... at 8 AM and 4:30 PM was written on the MOR and a sliding scale before meals and bedtime every day at 8 AM, 11 AM, and 4:30 PM: 150-175 = 2 u., 176-200 = 3 u., 201-225 = 4u., 226-250 = 5 u., 251-275 = 6 u., 276-300 = 7 u., 301-325 = 8 u., 326-350 = 9 u., greater than 350 = 10 u., and greater than 400 = call MD (physician). When Lispro was given on ... and ..., there were no notations how many units were given. The MOR indicated "given" on ..., ..., and ... at 8 AM. On at 4:30 PM, ... was 241, and the resident needed to receive 5 u. of ... The only documentation on the MOR was "signed late". There was no documentation of the resident receiving any for that ...<br><br>The resident was on a ... and took Lispro based on ... readings, daily before meals and at bedtime, therefore 4 times daily. ... results were noted for | {A 025} | | |

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| {A 025} | Continued From page 20<br><br>... at 8 AM and 5 PM, ..., ... at 5 PM, ... at 8 AM and 4:30 PM, ... at 8:30 AM, ... at 8:30 AM, ... at 5 PM, ... at 5 PM, ... at 8:30 AM. On ..., ..., ..., ..., and ..., there were no other ... test results for review.<br><br>There was no evidence to confirm the order received on ... that indicated to decrease ... mix 75-25 from 45 u. to 40 u. at dinner had been changed to 40 u. ... at 8 AM and 5 PM as per the MOR. There was no evidence to confirm the presence of a healthcare provider's permission to allow the resident to use his judgment to decide how many units of ... to take on any given day.<br><br>The facility notes indicated that on ... at 3:10 AM, the writer contacted the physician regarding concerns with ... dropping about ... PM: "Nurse team will continue to follow." At 10 PM on ..., ... was 149, the resident stated he felt like he had low ... On ... at 10 PM, his ... was 173. He refused ..., and requested 30 u instead of 40 u.. The physician was faxed for updated orders. At 9:30 AM, ... was 127. On ... at 8:30 AM, his ... was 392. He needed 10 u., refused and requested 9 u. The physician was notified.<br><br>On ... at 1:30 PM, the nursing director said the order change for the ... was not followed. She was unable to locate any additional information.<br><br>5. Resident #7 had a health assessment report form 1823, dated ..., that listed diagnosis of ... replacement to right ... . She was a ... risk and had vision ... . According to the | {A 025} | | |

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| {A 025} | Continued From page 21<br><br>health assessment, she needed assistance with all the activities of daily living and with medications. Health care provider's orders, dated , indicated , , , ( ) and , , ( ) evaluation and treatment; diagnosis was atrophy. Facility notes indicated that on at 6:45 PM, the resident was found on the floor. Emergency medical services ( ) were called. She was taken to the local emergency room. On , she returned to the facility. On 11:27 PM, staff called the pharmacy regarding , "Pharmacy needs updated physician order sheet (POS) sent to doctor." On at 12:01 AM, staff wrote, "texted Advanced Practice Registered Nurse (APRN) for updated , 5 mg (milligrams) on ."<br><br>Order dated indicated drops instill 3 x daily to both , 3 times daily both to , and , tears times daily both , - faxed .<br><br>The , MOR listed the following: solution 3 times a day at 9 AM, 1 PM and 9 PM was not given because the medication was not available. The MOR indicated "waiting pharmacy" from at 9 AM to at 9 PM.<br> solution 2% 3 times a day at 9 AM, 1 PM and 9 PM. The MOR indicated that from at 9 PM to the medication was not given "awaiting pharmacy".<br> 10 mg at bedtime was marked as given on 7 /03, , , , and . Yet all the other days in , starting on the medication was marked as "awaiting pharmacy".<br><br>The listed the following: solution 3 times a day at 9 | {A 025} | | |

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| {A 025} | Continued From page 22<br><br>AM, 1 PM and 9 PM and was marked as "awaiting pharmacy" on at 9 AM to at 9 PM, at 9 PM, at 9 PM. The last page of the MOR indicated the medication was given on at 1 PM, and 9 PM, at 1 PM, at 9 AM. solution 2% 3 times a day at 9 AM, 1 PM and 9 PM and was marked as "awaiting pharmacy" on at 9 AM to at 9 PM. The last page of the MOR indicated the medication was not available "waiting on pharmacy from 9 PM to 9 PM and 9 PM, at 9 PM. 10 mg at bedtime was marked as was not given, not available, "awaiting pharmacy" on . Yet the medication was marked as marked as given on 80/3, ,<br><br>In an interview on at 3 PM the administrator stated that the order for / had not been done.<br><br>In an interview on at 1 PM with the nursing director who stated there had been a billing issue with the facility's preferred pharmacy.<br><br>6. On at 11: 30 AM, resident #8 said she used to get a lot of pills but lately she was only getting a few. The facility told her she did not have the medications, and that her daughter was looking into it.<br><br>Resident #8's health assessment report form 1823, dated , listed diagnoses of , , type 2 , and high , and that she needed administration of medications.<br><br>The MOR listed: | {A 025} | | |

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| {A 025} | Continued From page 23 | {A 025} | | |

100 mg. at 9 AM and 5 PM and were all mark as "awaiting pharmacy" from AM to PM.
5 mg. every day (QD) and was "awaiting pharmacy" from to .
100 mg. QD was "awaiting pharmacy" from to .
500 mg. at 9 AM and 5 PM was "awaiting pharmacy" from /21at 5 PM to at 5 PM.
5 mg. QD, and chewable 150 micrograms (mcg.) QD - "awaiting pharmacy" from to .
250 mg. and ER (extended release) 10 milliequivalents (mEq) QD "awaiting pharmacy" from to .
20 mg. "awaiting pharmacy" from to .

The MOR listed:
100 mg. , 500 mg. , 100 mg. QD, 5 mg. QD, ER 10 mEq QD, 5 mg. QD, 20 mg. QD, chewable 150 mcg. QD, Turmeric 450 mg. QD, and 250 mg. "awaiting pharmacy" from to
The review revealed a pharmacy enrollment form, dated , in which the resident chose the facility's preferred pharmacy.

Physician order sheet (POS), dated , listed all the resident's medications and allowed 11 refills for all.
A facility fax, dated , read "Can you fax a new script to the pharmacy 500 mg and 100 mg?"

A facility fax, dated , to the resident's

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| {A 025} | Continued From page 24<br><br>pharmacy indicated resident # 8 used them and no other pharmacy, and read, "Please refill all her medications."<br><br>On . . . . . at 2 PM, the nursing director said an in-service training was held. The pharmacy thought the resident used another pharmacy.<br><br>The MOR entries were inconsistent and made notations that medications were given on dates when it was clearly noted that the medication was not available, and rather than take action to see why the medications were not available, staff simply kept noting, "Med not given, awaiting pharmacy".<br><br>The facility notes did not mention the absence of the medications, and contact with the resident's healthcare provider, and responsible party. There were no notations as to the follow-up given when the medications did not arrive timely.<br><br>Class II | {A 025} | | |
| {A 032} SS=D | 59A-36.007(8) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(8) ELOPEMENT STANDARDS.<br>(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 032} | | |

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| BRENNITY AT MELBOURNE (THE) | 7365 ORCHESTRA LN MELBOURNE, FL 32940 |

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| {A 032} | Continued From page 25<br>(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>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.<br>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.<br>(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:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, | {A 032} | | |

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| {A 032} | Continued From page 26<br><br>guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on observation, facility record review and interview, the facility failed to 1) ensure all residents at risk for elopement had identification (ID) on their persons that includes their name and the facility's name, address, and telephone number, 2) ensure the facility made, at minimum, a daily attempt to verify identification was on each at risk resident, 3) ensure all staff were trained pursuant to paragraph 59A-36.011(10)(a) or (c), FAC, to be generally aware of the location of all residents assessed at high risk for elopement at all times, 4) develop and follow detailed written policies and procedures for responding to a resident elopement as required in 59A-36.007(8)(b) FAC., and 5) conduct and document resident elopement drills that included all facility staff a minimum of 2 times per year as required in 429.41(1)(a)3 and 429.41(1)(1) F.S.<br><br>Findings:<br><br>On at 10:00 AM, the administrator stated that all 21 residents in the memory care unit were at risk for elopement and all wore identification | {A 032} | | |

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| {A 032} | Continued From page 27<br><br>1. During a tour of the memory care unit on at 11:00AM with caregiver I, she identified all 21 current residents in the memory care unit. Residents #3, #11, #15, #16, and #17 did not have any identification on them at the time of the tour. At 11:20 AM, staff I confirmed these 5 residents were not wearing any identification.<br><br>2. On at 9:30 AM, the memory care coordinator stated she checked for identification on the days she worked. She confirmed that ID was not documented anywhere in the resident's records and that no other staff were assigned to check for identification.<br><br>3. Resident #3's record revealed an admission date of . The health assessment in the record was dated and documented diagnoses including , and gait instability. She required assistance with bathing and grooming. She received assistance with self-administration of medications. The assessment did not document resident #3 to be at risk for elopement. Review of facility notes documented resident #3 had been exit-seeking since she arrived and did elope from the facility on and . Notes documented she frequently walked around the facility with clothes draped over her arms and asking how she could leave. The most recent documented attempt to leave was noted on . There was one mental health status evaluation found in the record for resident #3 that was not dated and not signed by anyone in the facility or the responsible party. Facility reports noted she did elope on and was found by the regional operations director. The resident was found walking in the parking lot toward the cottages. The report documented that 2 of the 3 staff in the memory care unit on were agency staff and not | {A 032} | | |

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| {A 032} | Continued From page 28<br>familiar with facility protocols. Photographic evidence was obtained.<br><br>On at 9:30 AM, the memory care coordinator confirmed resident #3 had eloped on and was found in the parking lot walking toward the cottages by the regional operations director. She stated he returned her to the memory care unit. She confirmed resident #3 did not have any identification on her at the time of the survey. The memory care coordinator stated that agency personnel were given a tour of the memory care unit with all exit doors identified, and the overhead warning system for an open exit door was explained, but confirmed no other facility training was provided to agency caregivers regarding elopement procedures.<br><br>4. Review of the facility policies and procedures for elopement revealed a binder with an "Elopement/Missing Resident Policy", dated , when the facility was under previous ownership. Also revealed was an "Elopement Risk Guidelines" policy, dated 2013, which included the facility will assess residents for elopement risk prior to admission and every 6 months and the completed risk assessments would be kept in the resident's record. The policy also documented all residents identified to be at risk for elopement must have identification on their person at all times. Photographic evidence was obtained.<br><br>5. On , a request was made to review the facility records for elopement drills found documentation for drills conducted in the memory care unit on (1st shift), (2nd & 3rd shifts), and (1st shift). There was no documentation to show elopement drills were conducted at least two times per year for each | {A 032} | | |

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| {A 032} | Continued From page 29<br><br>staff member, and no documentation to show drills were conducted in the assisted living side of the facility at all. Photographic evidence obtained.<br><br>On at 4:15 PM, the administrator confirmed the findings.<br><br>Class III | {A 032} | | |
| A 054 SS=D | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.<br>(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include:<br>1. The name of the resident and any known the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical | A 054 | | |

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| A 054 | Continued From page 30<br><br>, the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, resident record review, Medication Observation Record (MOR) review, and interview, the facility failed to ensure the MOR was accurate for 4 of 12 sampled residents (#2, 5, 11 & 13).<br><br>Findings:<br><br>1. Resident #2's record revealed an admission date of . Her health assessment (AHCA form 1823) was dated and documented diagnoses including , , , , , and . She was noted to have moderate to severe , with decreased range of mobility with and , . She was assessed to be alert and able to make her needs known. She required assistance with self-administration of medications.<br><br>Review of the MORs for , and for resident #2 revealed:<br>, a , 15 milligrams (mg.) take one tablet daily after meal at 10 AM. This medication was noted to not have been given on , , , , , , , , and with notes that indicated "awaiting pharmacy." This medication was marked as given on , , and . Not given on with a note "don't start until ." The medication was given more than one hour after the dosage window on at 1:18 PM and at 3 PM with no explanation | A 054 | | |

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| A 054 | Continued From page 31<br><br>for the delay in administration noted. Photographic evidence was obtained.<br><br>2. Review of the record for resident #5 revealed a health assessment dated [redacted] which documented diagnoses including [redacted], lymphedema, and [redacted]. She required assistance with self-administration of medications.<br><br>Review of the MORs for [redacted] and [redacted] for resident #5 revealed:<br>[redacted], a [redacted], 5 mg. at 6 PM was marked "awaiting pharmacy" for 13 days: [redacted] through [redacted], and [redacted].<br>The medication was documented as given late, more than one hour after the dosage time, on [redacted] at 8:05 PM with no explanation for the delay in administration noted.<br>[redacted], an [redacted], 40 mg. twice a day ([redacted]) at 10 AM and 6 PM. This medication was marked "awaiting pharmacy" on [redacted] AM, [redacted] at 6 PM, [redacted] at 10 AM, [redacted] at 10 AM, [redacted], and [redacted] at 10 AM.<br>Red Yeast Rice, for [redacted], 600 mg. [redacted] at 10 AM and 6 PM. This medication was marked "awaiting pharmacy" for the morning doses on [redacted], and [redacted] but marked as given for the evening doses on the same days. t was marked "awaiting pharmacy" for both doses on [redacted], and [redacted].<br><br>3. Resident #13's health assessment, dated [redacted], reflected diagnoses including [redacted] type 2, [redacted] with history of [redacted] | A 054 | | |

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| A 054 | Continued From page 32<br><br>, and dyslipidemia. She required assistance with self-administration of medications. Review of the MOR for revealed multiple medications not available or given outside the 1 hour time window allowed for medications with specific dosage times.<br>20 mg, daily (QD) at 6:30 AM. This medication was noted to have been given late on /21at 7:45 AM, /21at 8:03 AM, /21at 8:59 AM, /21at 10:43 AM, /21at 10:29 AM, /21at 8:18 AM, and given more than 1 hour early on /21at 5:07 AM and /21at 5:05 AM.<br>75 micrograms (mcg.) before a meal at 6 AM. This medication was noted to have been given late on /21at 7:45 AM, /21at 8:03 AM, /21at 8:59 AM, /21at 10:43 AM, /21at 10:29 AM, and /21at 8:18 AM. It was documented to be "DNA" (drug not available) on and .<br>50 mg. QD at 6 PM. This medication was noted to have not been given on , and with comments "awaiting pharmacy". Photographic evidence was obtained.<br><br>On at 1 PM, the nursing director confirmed the medication issues for residents #2, 5, and 13 and inconsistencies noted in the MORs.<br><br>4. Resident #11 had a health assessment report 1823, dated that listed diagnoses of and . Per report she needed assistance with self-administration of medications.<br><br>The MOR listed both at bedtime at 7:45 PM and was blank from to , and from to and to . On , the MOR | A 054 | | |

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| A 054 | Continued From page 33<br><br>indicated the drug not given. The page of the MOR indicated the medication was given late on . On , the medication was "on route from pharmacy" and "done" on . " , , , is used to treat (a condition in which increased pressure in the can lead to gradual loss of vision) and ocular (a condition which causes increased pressure in the )." (medlineplus.gov).<br><br>A facility note, dated , indicated that a request had been sent to the healthcare provider for a prescription for .<br><br>Class III | A 054 | | |
| A 152 SS=D | 59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other<br><br>(3) OTHER REQUIREMENTS.<br>(a) All facilities must:<br>1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.;<br>2. Be maintained free of hazards; and,<br>3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.<br>(b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:<br>1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, | A 152 | | |

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| A 152 | Continued From page 34<br><br>2. A closet or wardrobe space for hanging clothes,<br>3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects,<br>4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and,<br>5. A comfortable chair, if requested.<br>(c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.<br>(d) Residents who use portable bedside commodes must be provided with privacy during use.<br>(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible].<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, resident [illegible] review and interview, the facility failed to ensure scales for obtaining resident [illegible] were maintained in good working order at all times, affecting lack of [illegible] for 1 resident (#3).<br><br>Findings:<br><br>Review of the [illegible] records for resident #3, admitted [illegible], found there were no [illegible] documented semi-annually for resident #3.<br><br>On [illegible] at 2:10 PM, the nursing director stated the scale had not been working since [illegible]. She said the scale in memory care had [illegible] and they brought the scale from the assisted living side into memory care, and then that also stopped working on [illegible]. She stated the maintenance person had left the facility and they were in between people. He said the | A 152 | | |

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| A 152 | Continued From page 35<br><br>memory care coordinator brought a bathroom scale in from home, but not all the residents' [illegible] were obtained. She confirmed they did not have a [illegible] for resident #3 since her admission in [illegible] due to the scales not working.<br><br>Class III | A 152 | | |
| A 160 SS=D | 59A-36.015(1) FAC Records - Facility<br><br>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.<br>(1) FACILITY RECORDS. Facility records must include:<br>(a) The facility's license displayed in a conspicuous and public place within the facility.<br>(b) An up-to-date admission and discharge log listing the names of all residents and each resident's:<br>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 [illegible]; and,<br>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 | A 160 | | |

Agency for Health Care Administration

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| A 160 | Continued From page 36 | A 160 | | |

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 .
(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

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| BRENNITY AT MELBOURNE (THE) | 7365 ORCHESTRA LN MELBOURNE, FL 32940 |

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| A 160 | Continued From page 37<br><br>to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years.<br>(l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years.<br>(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.<br>(n) The facility's resident elopement response policies and procedures.<br>(o) The facility's documented resident elopement response drills.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a complete and accurate admission-discharge log was maintained.<br><br>Findings:<br><br>Request to review he admission-discharge log found the facility utilized a computerized log. The admission-discharge log did not contain all the required information for each resident. The log did not include where a resident was admitted from, or when discharge, where they went after discharge and the reason for discharge.<br><br>On at 11:30 AM, the administrator confirmed the findings and stated this was all the | A 160 | | |

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| A 160 | Continued From page 38<br>information they had.<br><br>Class III | A 160 | | |
| A 161 SS=D | 429.275(2) FS; 59A-36.015(2) FAC Records - Staff<br><br>429.275<br>(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.<br><br>59A-36.015<br>(2) STAFF RECORDS.<br>(a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable:<br>1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C.,<br>2. Copies of all licenses or certifications for all staff providing services that require licensing or certification,<br>3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C.,<br>4. For facilities with a licensed capacity of 17 or | A 161 | | |

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| A 161 | Continued From page 39<br>more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C.,<br>5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C.<br>(b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity [redacted] to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C.<br>(c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations and interview, the facility licensed for more than 17 residents failed to ensure personnel records contained all the mandated documentation for 2 of 9 sampled staff (A & E) that included a job description, and job application completed attestation with BGS requirements for 1 staff (E).<br><br>Findings:<br><br>1. Personnel record review for staff A, hired [redacted], revealed no evidence that a copy of the job description was given to the staff. The Attestation with the BGS requirements was signed and dated [redacted], however page one was missing the facility information; that portion was blank. | A 161 | | |

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| A 161 | Continued From page 40<br><br>2. Staff E was identified as the extended congregate care (ECC) nurse. There was no evidence to confirm the existence of a contract, an application, or a job description. The Attestation with the BGS requirements was signed and dated [redacted], however page one was missing the facility information; that portion was blank.<br><br>On [redacted] at 3 PM, the director of nursing said she had no additional documentation to provide.<br><br>Class III | A 161 | | |
| {A 162} SS=D | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. [redacted],<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number,<br>7. Medicaid and/or Medicare number, or name of other health insurance [redacted],<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. | {A 162} | | |

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| {A 162} | Continued From page 41<br><br>(c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property | {A 162} | | |

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| {A 162} | Continued From page 42<br>disbursed as required in section 429.27, F.S.<br>(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.<br>(m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.<br>(o) The resident's , DH Form 1896, if applicable.<br>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:<br>1. A log listing the names of residents participating in this arrangement,<br>2. The resident demographic data required in this paragraph,<br>3. The health assessment described in rule 59A-36.006, F.A.C.,<br>4. The resident's contract described in rule 59A-36.018, F.A.C.; and, | {A 162} | | |

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| {A 162} | Continued From page 43<br><br>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.<br>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.<br>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on resident record review and interview, the facility failed to record a semi-annual for 1 of 12 sampled residents who received assistance with the Activities of Daily Living (#3).<br><br>Findings:<br><br>Resident #3's record revealed an admission date of . The only health assessment in the record was dated and documented diagnoses including , and gait instability. She required assistance with bathing and grooming. She received assistance with self-administration of medications. An admission was documented on the health assessment. No other were found in the record or the facility sheet. for | {A 162} | | |

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| {A 162} | Continued From page 44<br>resident #3.<br><br>On [redacted] at 2:20 PM, the nursing director confirmed she did not have a [redacted] for resident #3 since her admission.<br><br>Class III | {A 162} | | |
| {AE206} SS=D | 59A-36.021(6) FAC ECC - Service Plans<br><br>(6) SERVICE PLANS.<br>(a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, [redacted] and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs.<br>(b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, [redacted] and social needs and preferences; and how the facility will meet the resident's needs including the following if required:<br>1. Health monitoring,<br>2. Assistance with personal care services,<br>3. Nursing services,<br>4. Supervision,<br>5. Special diets,<br>6. Ancillary services,<br>7. The provision of other services such as transportation and supportive services; and,<br>8. The manner of service provision, and identification of service providers, including family | {AE206} | | |

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| {AE206} | Continued From page 45<br><br>and friends, in keeping with resident preferences.<br>(c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.<br>(d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.<br><br>This Statute or Rule is not met as evidenced by:<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on interviews and record review the facility failed to ensure the Extended Congregate Care (ECC) service plan was reviewed and updated quarterly for 1 resident who required ECC services (#2).<br><br>Findings:<br><br>On [redacted] at 10 AM, the administrator stated none of the residents were receiving ECC services. The administrator acknowledged the facility holds a specialty license for ECC.<br><br>Review of the record for resident #2 revealed an admission date of [redacted]. Her health assessment AHCA form 1823 was dated [redacted], and documented diagnoses including [redacted] | {AE206} | | |

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| {AE206} | Continued From page 46<br><br>She was noted to have moderate to severe , with decreased range of mobility with and . She was assessed to be alert and able to make her needs known. She required assistance with activities of daily living (ADLs).<br><br>Review of the progress notes from admission through revealed facility staff have been providing , care, including staff nurses changing the bag and as needed. Resident #2 was not enrolled in ECC services. Two service plans dated and were reviewed. The plan documented resident #2 was dependent on staff for all ADLs and required -on assistance for most ADLs. The service plan was not signed by the facility staff or resident/responsible party. The logs to document resident's service needs were met were both blank. A progress noted, dated , documented a "plan of care" was received from resident #2's healthcare provider. There were no facility ECC service plans for , , or found. Photographic evidence was obtained.<br><br>When asked if resident #2 was receiving ECC services, on at 12:10 PM the administrator stated she was not. She confirmed that monthly assessments were not being conducted. The administrator provided a copy of an email she received which she believed indicated the facility did not have to provide ECC services for , care for resident #2. Review of the email she received from an AHCA representative found the explanation addressed assisted living facilities with a standard license and nurses on staff. This facility holds a specialty license for ECC.<br>Photographic evidence was obtained. | {AE206} | | |

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| {AE206} | Continued From page 47<br><br>Class III | {AE206} | | |
| {AE207} SS=D | 59A-36.021(7) FAC ECC - Services<br><br>(7) EXTENDED CONGREGATE CARE SERVICES. All services must be provided in the least restrictive environment, and in a manner that respects the resident's independence, privacy, and dignity.<br>(a) A facility providing extended congregate care services may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends must be encouraged to provide supportive services for residents. The facility must provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan.<br>(b) A facility providing extended congregate care services must make available the following additional services if required by the resident's service plan:<br>1. Total help with bathing, [illegible], grooming and toileting,<br>2. Nursing assessments conducted more frequently than monthly,<br>3. Measurement and recording of basic vital functions and [illegible],<br>4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output,<br>5. Assistance with self-administered medications, or the administration of medications and | {AE207} | | |

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| {AE207} | Continued From page 48<br>treatments pursuant to a health care provider's order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed persons will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed written consent to provide such assistance as required in section 429.256, F.S.,<br>6. Supervision of residents with and<br>7. Health education and counseling and the implementation of health-promoting programs and preventive regimes,<br>8. Provision or arrangement for rehabilitative services; and,<br>9. Provision of escort services to health-related<br>(c) Nursing staff providing extended congregate care services may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, provided the nursing services are:<br>1. Authorized by a health care provider's order and pursuant to a plan of care,<br>2. Medically necessary and appropriate for treatment of the resident's condition,<br>3. In accordance with the prevailing standard of practice in the nursing community,<br>4. A service that can be safely, effectively, and efficiently provided in the facility,<br>5. Recorded in nursing progress notes; and,<br>6. In accordance with the resident's service plan.<br>(d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident must be conducted.<br><br>This Statute or Rule is not met as evidenced by: | {AE207} | | |

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| BRENNITY AT MELBOURNE (THE) | 7365 ORCHESTRA LN MELBOURNE, FL 32940 |

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| {AE207} | Continued From page 49<br>DEFICIENCY REMAINED UNCORRECTED<br><br>Based on interviews and record review, the facility failed to ensure ECC nursing assessments were conducted at least monthly and that nursing progress notes were maintained for 1 resident who required ECC services (#2)<br><br>Findings:<br><br>Resident #2's record revealed an admission date of . Her health assessment AHCA form 1823 was dated and documented diagnoses including , , , , , , . She was noted to have moderate to severe , with decreased range of mobility with and , . She was assessed to be alert and able to make her needs known. She required assistance with activities of daily living (ADLs).<br><br>Review of the progress notes through revealed facility staff have been providing , care, including staff nurses changing the bag and as needed. Resident #2 was not enrolled in ECC services. Two service plans dated and were reviewed. The plan documented resident #2 was dependent on staff for all ADLs, and required -on assistance for most ADLs. The service plan was not signed by the facility staff or resident/responsible party. The logs to document resident's service needs were met were both blank. A progress noted dated documented a "plan of care" was received from resident #2's healthcare provider. There were no facility ECC service plans for , , or found. There were no monthly assessments found for any month since | {AE207} | | |

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| {AE207} | Continued From page 50<br>admission.<br><br>When asked if resident #2 was receiving ECC services, on at 12:10 PM the administrator stated she was not. She confirmed that monthly assessments were not being conducted. The administrator provided a copy of an email she received which she believed indicated the facility did not have to provide ECC services for , care for resident #2. Review of the email she received from an AHCA representative found the explanation addressed assisted living facilities with a standard license and nurses on staff. This facility holds a specialty license for ECC.<br>Photographic evidence was obtaine.<br><br>Class III | {AE207} | | |
| {AE210} SS=D | 59A-36.011(8) FAC ECC - Training<br><br>(8) EXTENDED CONGREGATE CARE (ECC) TRAINING.<br>(a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , shall not be required to take the assisted living facility core training competency test.<br>(b) The administrator and the ECC supervisor, if different from the administrator, must complete a | {AE210} | | |

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| {AE210} | Continued From page 51<br><br>minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related .<br>(c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to have 1 of 9 direct care staff members (G), complete 2 hours of the required in service training for Extended Congregate Care within 6 months of hire.<br><br>Findings:<br><br>Personnel record review for Staff G, revealed she was hired on and as a direct care staff, who worked the secure memory care unit. There was no evidence to confirm she received 2 hours of Extended Congregate Care in-service training.<br><br>In an interview with the director of nursing on at 3 PM who said the human resources person was out of the facility during the revisit. She had no additional documentation to provide.<br><br>Class III | {AE210} | | |
| CZ814 SS=C | 435.12(2)(b-d), FS Background Screening Clearinghouse | CZ814 | | |

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| CZ814 | Continued From page 52<br><br>435.12(2) Care Provider Background Screening Clearinghouse.-<br>(b) Until such time as the [illegible] are enrolled in the national retained print [illegible] notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.<br>(c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.<br>(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain the employment status of all employees within the background screening (BGS) clearinghouse, and did not list 4 of 9 sampled staff (E, J, K & L).<br><br>Findings:<br><br>During the facility entrance on at 10 | CZ814 | | |

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| CZ814 | Continued From page 53<br><br>AM staff E was identified as the facility's Advance Practice Registered Nurse (APRN) who supervised the Extended Congregate Care Services.<br><br>Review of the facility BGS roster on at reveled staff E and J were not listed on the facility's roster.<br><br>Personnel record review for staff J revealed she was a caregiver hired .<br><br>On at 3 PM, the director of nursing said she had no additional documentation to provide.<br><br>Review of the facility's employee roster on the Agency's background screening clearinghouse website revealed staff K, a former administrator with a hire date of , and staff L, a nurse with a hire date of , were listed as current employees. No end date was listed on the roster.<br><br>On at 3:20 PM, the nursing director confirmed the finding and said neither of them worked in the facility at this time.<br><br>Unclassified | CZ814 | | |
| A 058 SS=D | 429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies<br><br>429.42 Pharmacy and dietary services.-<br>(1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during | A 058 | | |

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| A 058 | Continued From page 54<br><br>a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.<br>(2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.<br><br>58A-5.033(3)<br>(3) EMPLOYMENT OF A CONSULTANT.<br>(a) Medication Deficiencies.<br>1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency.<br>2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the | A 058 | | |

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| A 058 | Continued From page 55<br><br>consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.<br>3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review, medication review and interviews, the facility had an uncorrected class II deficiency regarding prescribed medicinal drugs and is therefore, required to employ the consultant services of a licensed registered pharmacist per 429.42 FS and 58A-5.033(3) FAC.<br><br>Findings:<br><br>On . . and . . , a revisit to the re-licensure survey and a complaint investigation were conducted. At the time of the revisit, the facility had an uncorrected class II deficiency related to resident medications when it 1) failed to follow a health care provider's medication order, 2) failed to make every reasonable effort to ensure medications were refilled in a timely manner, and 3) failed to ensure the electronic Medication Observation Record was accurate (#2, 5, 9, 11, 13) | A 058 | | |

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| A 058 | Continued From page 56<br>On . . . . . at 2:45 PM in a phone conversation with the administrator, she stated she understood.<br><br>Class III | A 058 | | |
| A 078 SS=D | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of<br>2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . . . | A 078 | | |

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| A 078 | Continued From page 57<br><br>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on personnel record review and interview, the facility failed to ensure 1 of 9 personnel records contained a healthcare provider statement that indicated freedom from communicable . . . . . (E). | A 078 | | |

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| A 078 | Continued From page 58<br><br>Findings:<br><br>Personnel record review for staff E, hired , did not reveal any evidence to confirm she obtained a statement from a healthcare provider that indicated freedom from communicable .<br><br>In an interview on at 3 PM, the director of nursing said the human resources person was out of the facility during the revisit. She had no additional documentation to provide.<br><br>Class III | A 078 | | |
| A 081 SS=D | 429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service<br><br>429.52(1)<br>(1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.<br><br>(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice | A 081 | | |

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| A 081 | Continued From page 59<br><br>training topics may be issued to a participating staff member if the training is provided in a single training course.<br><br>59A-36.011<br>(2) STAFF PRESERVICE ORIENTATION.<br>(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1).<br>(b) New staff must complete the preservice orientation prior to interacting with residents.<br>(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.<br>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:<br>1. Resident's rights; and,<br>2. The facility's license type and services offered by the facility.<br>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in . . . . control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its . . . . control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of | A 081 | | |

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| A 081 | Continued From page 60<br>29 CFR 1910.1030, relating to . . . . borne , . . , may be used to meet this requirement.<br>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Reporting adverse incidents.<br>2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Resident rights in an assisted living facility.<br>2. Recognizing and reporting resident , neglect, and , . . . . . . . The facility must use its prevention policies and procedures when offering this training.<br>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.<br>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. | A 081 | | |

Agency for Health Care Administration

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| A 081 | Continued From page 61<br><br>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.<br>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on personnel record review and interview, the facility failed to ensure 8 of 9 sampled direct care staff had received the required training within 30 days of hire (B, D, E, F, G, H, I & J).<br><br>Findings:<br><br>On at 12:30 PM, the administrator stated any facility staff can be moved from the assisted living side to the memory care as needed to fill shifts.<br><br>1. Review of the personnel record for staff B, caregiver hired on , revealed the 2-hour pre-service orientation did not contain resident rights training, and the training documentation was not signed by the staff member as required.<br><br>2. Review of the personnel record for staff D, caregiver hired on , revealed the 2-hour pre-service orientation did not contain resident rights training, and the training documentation was not signed by the staff member as required.<br><br>3. Review of the personnel record for staff F, licensed nurse hired on , revealed no facility training at all. The 2-hour pre-service orientation was not found. There was no | A 081 | | |

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| | AL11967587 | A. BUILDING: _____ B. WING _____ | R 08/17/2021 |

| 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 |
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| A 081 | Continued From page 62<br><br>documentation to show staff F had received training in the facility's policies and procedures for elopement, emergency procedures including evacuation, or recognizing and reporting , neglect, and . .<br><br>4. Review of the personnel record for staff H, caregiver hired on , revealed the 2-hour pre-service orientation did not contain resident rights training, and the training documentation was not signed by the staff member as required.<br><br>5. Review of the personnel record for staff I, memory care caregiver hired on , revealed the 2-hour pre-service orientation did not contain resident rights training, and the training documentation was not signed by the staff member as required. In addition, there was no documentation that she had received training regarding the facility's policies and procedures for elopement.<br><br>6. During the facility entrance on at 10 AM staff E was identified as the facility's Advance Practice Registered Nurse (APRN) who supervised the Extended Congregate Care Services.<br><br>Individual personnel record review revealed: Staff E, a nurse, hired revealed no evidence to confirm she received:<br>A 1-hour in-service training that covered: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br>3. An in-service regarding recognizing and reporting resident , neglect, and . . The facility must use its prevention policies and procedures when offering | A 081 | | |

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| A 081 | Continued From page 63<br><br>this training.<br>4. An in-service training regarding the facility's resident elopement response policies and procedures. 5. There was no evidence she received a 2 - hour pre-service orientation provided by the facility before interacting with residents. There was no evidence she attended ALF core and was exempt from the pre-service.<br><br>7. Staff G was hired and was a caregiver. There was no evidence to confirm she received an in-service training regarding recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training.<br><br>8. Staff J was hired and was a caregiver. There was no evidence to confirm she received a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. There was no evidence she was a Home Health Aide (HHA) or certified nursing assistant (CNA), therefore exempt from this requirement.<br><br>On at 3 PM, the director of nursing said the human resources person was out of the facility during the survey. She had no additional documentation to provide.<br><br>Class III | A 081 | | |
| A 082 SS=D | 59A-36.011(4) FAC Training - /<br><br>(4) . . . . . / . . . . . (. . . / . . .). Pursuant to section | A 082 | | |

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| A 082 | Continued From page 64<br><br>381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on personnel record review and interview, the facility failed to ensure 1 of 9 sampled direct-care staff had completed a one-time education course on ( , ) and (Acquired -Deficiency , ), including the topics prescribed in the Section 381.0035, F.S. within 30 days of employment. (F)<br><br>Findings:<br><br>Review of the personnel record for staff F, licensed nurse hired on , revealed no documentation to show staff F had received training in / .<br><br>On at 3:45 PM, the nursing director stated she did not have any other documentation to show.<br><br>Class III | A 082 | | |
| A 089 SS=D | 429.178 FS /Other - Special Care<br><br>429.178 Special care for persons with or other related .- | A 089 | | |

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| A 089 | Continued From page 65<br>(1) A facility which advertises that it provides special care for persons with 's or other related must meet the following standards of operation:<br>(a)1. If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night; or<br>2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.<br>(b) Offer activities specifically designed for persons who are<br>(c) Have a physical environment that provides for the safety and welfare of the facility's residents.<br>(d) Employ staff who have completed the training and continuing education required in subsection (2).<br>(2)(a) An individual who is employed by a facility that provides special care for residents who have or other related , and who has regular contact with such residents, must complete up to 4 hours of initial -specific training developed or approved by the department. The training must be completed within 3 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g).<br>(b) A direct caregiver who is employed by a facility that provides special care for residents who have or other related and provides direct care to such residents must complete the required initial training and 4 additional hours of training developed or approved by the department. The training must be completed within 9 months after beginning employment and satisfy the core training requirements of s. 429.52(3)(g). | A 089 | | |

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| A 089 | Continued From page 66<br>(c) An individual who is employed by a facility that provides special care for residents with [redacted] or other related [redacted], but who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with [redacted] or other related [redacted], within 3 months after beginning employment.<br>(3) In addition to the training required under subsection (2), a direct caregiver must participate in a minimum of 4 contact hours of continuing education each calendar year. The continuing education must include one or more topics included in the -specific training developed or approved by the department, in which the caregiver has not received previous training.<br>(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.<br>(5) The department, or its designee, shall approve the initial and continuing education courses and providers.<br>(6) The department shall keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with [redacted]'s or other related .<br>(7) Any facility more than 90 percent of whose | A 089 | | |

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| A 089 | Continued From page 67<br><br>residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.<br>(8) The department shall adopt rules to establish standards for trainers and training and to implement this section.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility that provided special care for residents who have or other related<br>failed to ensure 5 of 9 direct care staff (G, J, D, H & I) completed the required initial training and 4 additional hours of training developed or approved by the department (G, J, D, H & I).<br><br>Findings:<br><br>Individual personnel record review revealed:<br><br>1. Staff G was hired and was a caregiver. The review revealed two certificates dated that indicated she attended ADRD Level 1 and Level 2 training. A certificate dated indicated she attended ADRD level 2 training again. The certificate was signed by the facility's nursing director and the facility administrator, neither whom was an approved trainer.<br><br>2. Staff J was hired and was a | A 089 | | |

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| A 089 | Continued From page 68<br><br>caregiver. The review revealed two certificates dated that indicated she attended ADRD Level 1 and Level 2 training. The certificate was signed by the facility's nursing director and the facility administrator, both were not an approved trainer.<br><br>On at 3 PM, the nursing director of nursing said the human resources person was out of the facility during the revisit. She had no additional documentation to provide. She confirmed that neither was an approved ADRD trainer.<br><br>3. Review of the personnel record for staff D, caregiver hired on , revealed certificates for ADRD level 1 & level 2 training that were not signed by an approved ADRD trainer. Photographic evidence was obtained.<br><br>4. Review of the personnel record for staff H, caregiver hired on , revealed certificates for ADRD level 1 & level 2 training that were not signed by an approved ADRD trainer.<br><br>5. Review of the personnel record for staff I, memory care caregiver hired on , did not reveal any training in 's and Related .<br><br>On at 3:45 PM, the nursing director stated staff complete the ADRD training in a computer program and the facility then prints out their own certificate. She said she or the administrator had been signing the training certificates. She confirmed that neither she nor the administrator had completed the training to be approved ADRD trainers. She confirmed she did not have any documentation to show the trainer in the computer program was an approved trainer. | A 089 | | |

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| A 089 | Continued From page 69<br><br>Class III | A 089 | | |
| A 090 SS=D | 59A-36.011(11) FAC Training -<br><br>(11) [illegible] TRAINING.<br>(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding [illegible].<br>(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding [illegible] within 30 days after employment.<br>(c) Training shall consist of the information included in rule 59A-36.009, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on personnel record review and interview, the facility failed to ensure that 3 of 9 sampled direct care staff were trained in the facility's policies and procedures related to [illegible] {E, F & J).<br><br>Findings:<br><br>1. Review of the personnel record for staff F, licensed nurse hired on [illegible], revealed no documentation to show staff F had received training in the facility's policies and procedures related to [illegible].<br><br>2. During the facility entrance on [illegible] at 10 AM staff E was identified as the facility's Advance | A 090 | | |

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| A 090 | Continued From page 70<br><br>Practice Registered Nurse (APRN) that supervised the Extended Congregate Care Services.<br><br>Personnel record review for staff E, a nurse, hired revealed no evidence to confirm she received at least one hour of training in the facility's policies and procedures regarding<br><br>3. Personnel record review for staff J revealed she was a caregiver hired . There was no evidence to confirm she received at least one hour of training in the facility's policies and procedures regarding<br><br>In an interview with the director of nursing on at 3 PM who said the human resources person was out of the facility during the survey. She had no additional documentation to provide.<br><br>Class III | A 090 | | |