Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967587	A. BUILDING: _____ B. WING _____	R 01/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A third revisit to the re-licensure survey with Extended Congregate Care (ECC), and complaint investigation #2021003631 were conducted at The Brennity at Melbourne on . Deficiencies were found at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	{A 025}		

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{A 025}	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on observation, resident record review, electronic Medication Observation Record (eMOR) 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 3 of 5 sampled residents, (#2, #7 & #19). Findings: 1) Review of the . , eMOR for resident #2 revealed an order dated . . for Urea	{A 025}		

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{A 025}	Continued From page 2 external cream 20%, 1 disk two times per day, every day at 6:00 AM and 10:00 PM. Apply cream on both . On the following dates the eMOR document DNA (drug not available) or DNG (drug not given) for the 6:00 AM doses: , , , , , , , , , , . The medication was signed as having been given on all the same evenings (10:00 PM) when it was not available in the mornings. At 10 PM on and , and 6 AM on , no documentation was made at all as to whether the medication was given or not. Notes at the of the eMOR noted "reorder" or "on order" on , , , , , /, , , and . No documentation was present to indicate the facility nurse, pharmacy or physician were informed. The dates in-between the days the cream was marked as not available were documented as having been given. (Photographic evidence obtained) On at 12:00PM, the administrator confirmed the eMOR was not documented accurately when the medication was not available. She stated they were having issues getting the cream from the pharmacy and staff were signing when it was not actually given. She confirmed there was no documentation regarding contacting the resident's physician or family about getting the medication. 2) Review of the eMOR for resident #7 revealed orders: 1) , 5mg, 1 tablet per day at bedtime. Hold for less than 110mmHg or , 2) 12.5mg, take two times every day at 10:00 AM and 10:00 PM. Hold for , less than 110mmHg or . On at 10 PM the , was	{A 025}		

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{A 025}	Continued From page 3 documented as [redacted], but the [redacted] was marked as given. On [redacted] at 10 PM the [redacted] was documented as [redacted] and the [redacted], but the [redacted] was marked as held for "[redacted] low." In addition, there was an order for [redacted] 10mg, 1 tablet every day at 10:00 AM. The eMOR documented on [redacted], 5, 22, and 24, [redacted], was marked as "held per parameter" or due to low [redacted] rate. There were no orders to hold [redacted], for any parameters. (Photographic evidence obtained) On [redacted] at 12:00PM, the administrator confirmed the eMOR showed staff were not consistently following the give/hold orders accurately. She confirmed there were no hold orders for [redacted], and confirmed [redacted], was being held without a physician order to do so. 3) Review of the record for resident #19 revealed she was admitted to the facility on [redacted]. Her admission health assessment (AHCA form 1823) indicated diagnoses including [redacted] and acute and [redacted], distress. She had an order for [redacted] 3liters/minute via [redacted]. Her medication list included [redacted] inhaler 200-25mcg/inh, one puff daily at 9:00 AM; [redacted] extended release 600mg, 1 tablet two times a day (8:00 AM and 8:00 PM), and ProAir HFA inhaler 108mcg/act, one puff one time daily at 9:00AM. Another 1823 dated [redacted] was reviewed. This was post hospitalization for [redacted] and [redacted], distress. Review of the [redacted] and [redacted], eMORs revealed: [redacted], 200-25mcg inhaler one puff at 9:00AM was marked as given on [redacted] & [redacted].	{A 025}		

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{A 025}	Continued From page 4 It was marked as DNA (drug not available) or DNG (drug not given) from . In , this inhaler was marked as DNG or DNA from through1/1/22. From through the resident was marked as out of facility or LOA (leave of absence). The comments noted resident #2 was in the hospital. extended release 600mg, 1 tablet two times a day (8:00 AM and 8:00 PM) was marked as DNA or DNG for all morning doses through and for the evening doses on & . However, it was marked as given on the evening doses for through , & when it was not available on the same mornings. In , this medication was marked as DNG or DNA for the morning dose on through , , & . The evening doses in were DNG or DNA on through and . However, it was marked as given on in the morning and , & in the evening when it was marked as not available on the same days for the other dose. On , the evening dose was marked as given, but the resident had been admitted to the hospital earlier that same day. ProAir HFA inhaler 108mcg/act, one puff one time daily at 9:00AM was marked as DNG or DNA for all dates in & . Upon her return from the hospital on , the inhaler was marked as given on , and then DNG from through . All note indicated "awaiting pharmacy." There were no notes to indicate resident #2's physician or family were notified during the 24 days from admission to the facility until when she was admitted to the hospital with low saturation and diagnosed with	{A 025}		

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{A 025}	Continued From page 5 . After her return from the hospital on , ProAir inhaler was still unavailable. A note on - 7 days after her hospital discharge-indicated paperwork was sent to the pharmacy to refill all medications. On , at hospital discharge, resident #2 was prescribed 100mg capsule, every 12 hours; stop after 5 days. The eMOR showed a start date, but no end date was documented. The eMOR showed the facility gave this medication on through , both doses, as prescribed. However, after the 5 days, the medication was marked as DNA or DNG for the morning doses on through and , and the evening doses on , and . But was marked as given on the morning of and the evenings of , , & , even though the 5-day duration had ended on . (Photographic evidence obtained) On at 12:00PM, the administrator confirmed the eMOR was not documented accurately when the medication was not available. She stated they were having issues getting the medications from the pharmacy and staff were signing when it was not actually given. She said the eMORs documented they were "awaiting pharmacy" and confirmed there was no documentation to show the facility notified the resident's physician or family to attempt to get her necessary , , medications. The administrator confirmed the and eMOR showed the , medications for resident #2 were not available from admission on until she was admitted to the hospital on for , distress and low saturation.	{A 025}		

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{A 025}	Continued From page 6 Class II	{A 025}		
{A 054} SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (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. (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: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], 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. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED	{A 054}		

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{A 054}	Continued From page 7	{A 054}		

Based on observation, resident record review, electronic Medication Observation Record (eMOR) review, and interview, the facility failed to ensure the electronic Medication Observation Record was accurate for 3 of 5 sampled residents. (#2, #7 & #19)

Findings:

1) Review of the , eMOR for resident #2 revealed an order dated for Urea external cream 20%, 1 disk two times per day, every day at 6:00 AM and 10:00 PM. Apply cream on both . On the following dates the eMOR document DNA (drug not available) or DNG (drug not given) for the 6:00 AM doses: , , , , , , , , , , . The medication was signed as having been given on all the same evenings (10:00 PM) when it was not available in the mornings. At 10 PM on and , and 6 AM on , no documentation was made at all as to whether the medication was given or not. Notes at the of the eMOR noted "reorder" or "on order" on , , , , , /, , , , and . No documentation was present to indicate the facility nurse, pharmacy or physician were informed. The dates in-between the days the cream was marked as not available were documented as having been given.
(Photographic evidence obtained)

On at 12:00PM, the administrator confirmed the eMOR was not documented accurately when the medication was not available. She stated they were having issues getting the cream from the pharmacy and staff were signing when it was not actually given.

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{A 054}	Continued From page 8 2) Review of the [redacted] eMOR for resident #7 revealed orders: 1) [redacted], 5mg, 1 tablet per day at bedtime. Hold for [redacted] less than 110mmHg or [redacted], 2) [redacted] 12.5mg, take two times every day at 10:00 AM and 10:00 PM. Hold for [redacted] less than 110mmHg or [redacted]. On [redacted] at 10 PM the [redacted] was documented as [redacted], but the [redacted] was marked as given. On [redacted] at 10 PM the [redacted] was documented as [redacted] and the [redacted], but the [redacted] was marked as held for "[redacted] low." In addition, there was an order for [redacted] 10mg, 1 tablet every day at 10:00 AM. The eMOR documented on [redacted], 5, 22, and 24, [redacted], was marked as "held per parameter" or due to low [redacted] rate. There were no orders to hold [redacted], for any parameters. (Photographic evidence obtained) On [redacted] at 12:00PM, the administrator confirmed the eMOR showed staff were not consistently following the give/hold orders accurately. She confirmed there were no hold orders for [redacted], and confirmed [redacted], was being held without a physician order to do so. 3) Review of the [redacted] and [redacted] eMORs for resident #19 revealed: [redacted], 200-25mcg.ing inhaler one puff at 9:00AM was marked as given on [redacted] & [redacted]. It was marked as DNA (drug not available) or DNG (drug not given) from [redacted]. In [redacted], this inhaler was marked as DNG or DNA from [redacted] through1/1/22. From [redacted] through [redacted] the resident was marked as out of facility or LOA (leave of absence). The comments noted resident #2 was in the hospital.	{A 054}		

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{A 054}	Continued From page 9	{A 054}		

extended release 600mg, 1 tablet two times a day (8:00 AM and 8:00 PM) was marked as DNA or DNG for all morning doses through ... and for the evening doses on & . However, it was marked as given on the evening doses for ... through .. , & when it was not available on the same mornings. In .. ... , ..., this medication was marked as DNG or DNA for the morning dose on through .. , .. , .. & .... The evening doses in were DNG or DNA on through .. and ... . However, it was marked as given on in the morning and , & in the evening when it was marked as not available on the same days for the other dose. On , the evening dose was marked as given, but the resident had been admitted to the hospital earlier that same day.

ProAir HFA inhaler 108mcg/act, one puff one time daily at 9:00AM was marked as DNG or DNA for all dates in .... & .. ... , ... Upon her return from the hospital on , the inhaler was marked as given on ..... , and then DNG from through . All note indicated "awaiting pharmacy."

On ...., at hospital discharge, resident #2 was prescribed , , , 100mg capsule, every 12 hours; stop after 5 days. The , eMOR showed a start date, but no end date was documented. The eMOR showed the facility gave this medication on through ..., both doses, as prescribed. However, after the 5 days, the medication was marked as DNA or DNG for the morning doses on through and , , and the evening doses on , ... and .... But was marked as given on the morning of and the

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{A 054}	Continued From page 10 evenings of [redacted], even though the 5-day duration had ended on [redacted]. (Photographic evidence obtained) On [redacted] at 12:00PM, the administrator confirmed the eMOR was not documented accurately when the medication was not available. She stated they were having issues getting the medications from the pharmacy and staff were signing when it was not actually given. She said the eMORs documented they were "awaiting pharmacy" and confirmed there was no documentation to show the facility notified the resident's physician or family to attempt to get her necessary [redacted] medications. Class III	{A 054}		