Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967587	A. BUILDING: _____ B. WING _____	11/01/2022

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 Complaint Investigation #2022007315 and Generator Monitoring was conducted on . Brennity at Melbourne had a deficiency 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 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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: Based on record reviews, observations and interviews, the facility failed to observe residents' activities to prevent for 3 out of 3 residents (#1, #2 & #3), and failed to maintain a general awareness of a resident's whereabouts to prevent elopement (#2). Findings: 1. Resident #1's health assessment dated revealed a medical history of , Advanced 's , non-displaced stable greater left, , Health First Hospice and a risk. It also confirmed assistance with medication and	A 025		

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A 025	Continued From page 2 assistance with daily living for ambulation, bathing, , self-care, toileting, transferring, and eating. Facility notes for resident #1 revealed unwitnessed : On , the resident was observed on the floor by staff on his with the walker beside his bed away from resident. The resident stated he was mad because he . He sustained an to left cage area. No new orders were obtained at that time. The resident stated he did not hit his . He stated he off his bed and was scooting on the floor in his bedroom. The resident denied any , . On , the resident was in TV room, attempted to get up from his wheelchair, , and hit his . The resident sustained a hematoma on the right side of his and had displaced , . "A hematoma is a collection of outside of a ." (Retrieved from www.medicinenet.com on). On at 3:30 PM, the resident was found sitting on the floor mat next to the bed. Upon assessment resident was noted with a to his left and complained of , to the left , area. The resident stated, "I ." The resident was assisted to bed. The was cleansed and bandaged, and , medicine was given. Hospice was contacted and stated they would send a nurse to evaluate the resident. On , the hospice physician ordered a left , due to complaint of , . Results indicated an acute left . Hospice initiated new orders for bed rest with the placement of a . The resident , on .	A 025		

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A 025	Continued From page 3 2. Resident #2's health assessment dated revealed a medical history of 's , Essential due to protein calorie , Secondary Neoplastic . She ambulated without appliances, had gait disturbance, needed medication management, resided in the Memory Care unit, and was a risk elopement risk. The assessment also revealed she required assistance with activities of daily living for bathing, , self-care, eating, toileting and transferring. Facility notes dated revealed another resident's family member found resident #2 in the parking lot. The concierge went to the location and brought the resident to the Memory Care unit, did a count, and confirmed all residents were accounted for. At 7:48 PM on , the video was reviewed and found a team member walking across the Assisted Living Facility (ALF) area toward the main kitchen. At 7:50 PM, resident #2 entered the ALF lobby, sat in a chair, then got up and exited the community through the ALF entry/exit at 7:51 PM. While outside, the resident had a witnessed by the family member who discovered her. She sustained a to her left . At 7:55 PM, the concierge exited the ALF entry and found the resident in a standing position. At 7:57 PM, the resident was escorted into the community and into the Memory Care unit. The resident was evaluated by the nurse on duty and transported to the emergency room via Emergency Medical Services ( ). She was sent to the facility without new orders or injuries identified.	A 025		

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A 025	Continued From page 4 Resident #2 medical record revealed that on ..., the resident . trying to sit in a chair, missed the chair, and , hitting her on the wall behind her. No further information was written in those notes. Resident #2's medical record revealed that on ..., she was roaming down the halls with a blanket in her , which caused her to trip and to the floor, hitting her . The resident had a lump to the front of her on the right upper portion of her forehead. She did not loose of . No changes were noted to the resident's normal baseline. The facility called , and the resident was transferred to the hospital for further evaluation. On ..., resident #2 was observed with ... around her , and forehead. The Wellness Director stated it was from the on . 3. Resident #3's health assessment dated ... revealed a medical history of recent ., , and repair, status post ..., right ..., risk of , assistance with medication and assistance with bathing. Facility notes for resident #3 revealed unwitnessed ...: On .. ... at 12 PM, the resident sustained an unwitnessed in her room. She reported that she was walking, lost her balance, and to the floor hitting her . A hematoma was seen on the right side of her ... was called and transferred her to the hospital for evaluation. On ... at 12 PM, the resident complained of lower , she was transported to hospital.	A 025		

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A 025	Continued From page 5 ... to the ..., was performed which indicated closed nondisplaced lower ... . On ..., at 3:24 PM, the resident attempted to get up and lost her balance. She stated she didn't hit her ... and she landed on her left side. On ..., the resident's daughter stated the resident called her and told her she was on the floor and got ... up. Staff found her in bed. The resident complained of right ... from the ... . An ... was ordered. On ... at 10:35 AM, the resident had an old quarter size on her left ..., that was ... . The area was bandaged by the nurse. On , the resident was in her room yelling for help while in bed. The nurse went into the room and found her with a on her right arm and old ... on her right ... . On ... at 1:35 PM, the nurse heard the resident screaming and found the resident on the floor lying on her right arm. The resident stated she did not hit her and was able to move. The resident did not have any ..., bumps, , or , . On at 1:35 PM, the nurse heard the resident screaming and found the resident on the floor lying on her right arm. The resident stated she did not hit her ... and was able to move. The resident did not have any , bumps, ..., or , . On ... at 5:45 PM, the resident slid out of wheelchair with staff present. She stated she was not in ... . She sustained a small ... to her right , which was cleansed and covered with	A 025		

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A 025	Continued From page 6 gauze by the nurse. On . . . . . , the resident was found sitting upright on bathroom floor by staff. She stated she was fine and wanted to get up. The resident stated she from her wheelchair after trying to self-transfer to the toilet without assistance. The nurse assessed the resident, and there were no injuries. On . . . . . , the resident attempted to self-transfer from bed to the wheelchair, missed the wheelchair, and sat on the floor. The resident was assessed from to ; no injuries were noted. The resident did voice . . all over. On 10/182022 at 4:49 PM, the resident got out of bed on her own and into the wheelchair. She attempted to make a call when she dropped her phone, reached down to the floor to pick it up, and . . to the floor. No . . . . was noted by the nurse. On at 12:45 PM, both the Administrator and the Wellness Director confirmed the above findings. Photographic evidence was obtained. Class II	A 025		