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 _____	05/16/2023

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 #2023002173 was conducted on [redacted]. Brennity at Melbourne had deficiencies identified at the time of the survey.	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 [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. 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 59A-36.012, F.A.C.	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 4 of 6 sampled residents who experienced repeated with injuries (#1, #4, #5 & #6). Findings: 1. Resident #1's record revealed she was admitted on in Memory Care unit. Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included history of with repair, , right	A 025		

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A 025	Continued From page 2 , and . She was receiving hospice care. She required supervision with eating and assistance with all other activities of daily living. Review of the facility notes revealed: at 3:32 AM - The resident was found lying on her left side between toilet and wheelchair. at 3:30 PM - , medication was given for severe , at 8:35 PM - , was given for , at 10:36 PM - , were ordered. Resident complained lower , at 7:18 PM - , was given for severe , at 2:40 AM - The resident received , medication on the second shift with some effect. at 12:59 AM - The resident complained of some , at 2:38 PM - The resident complained of low , at 8:03 PM - The resident verbalized , with grimacing. medication was given, and an , was done. at 12:21 AM - , results reported a fx of the right pubic rami with mild displacement (appears old). at 12:26 PM - The resident complained of extreme , to the left side of the lower extremity. Hospice services advised the facility to transfer the resident to the hospital. at 7:44 PM - , was given for severe , at 10:51 PM - The resident complained of , in the lower . at 10:03 AM - , was given for severe , at 12:12 PM - The resident returned from the hospital. This was a late note for . at 6:21 PM - , was given for	A 025		

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A 025	Continued From page 3 severe , . at 5:13 AM and 5:06 PM - , was given for severe , . Review of the resident's Service Plan revealed frequent checks in room if the resident was not in the common area. 2. Resident #4's record revealed she was admitted on to the Memory Care unit. Her record contained an 1823 dated . Her diagnoses included , , , , , and gait instability. She was a risk. She required assistance with all activities of daily living. She used a wheelchair. Review of the facility notes revealed: at 7:30 AM - The resident was found on the floor on her left side. seen to the left and right . at 4:19 PM - The resident stood from her wheelchair in the movie area and had an unwitnessed . at 3:02 PM - The resident was found sitting on the floor in her bedroom. at 3:07 PM - The resident constantly attempted to ambulate without assistance. at 5:43 AM - The resident was found lying wrapped in a comforter, sleeping on the floor. at 12:17 AM - The resident was extremely combative and agitated and threw herself on the floor. at 6:38 AM - The resident was found sitting in front of her bedroom door with a left . at 6:27 PM - The resident observed throwing herself to the ground. at 9:34 PM - The resident was observed falling on her side.	A 025		

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A 025	Continued From page 4 at 7:20 PM - The resident was observed on the floor. at 1:21 AM - The resident was found sitting on the floor in the hallway. at 11:03 PM - The resident was observed in the corner of the courtyard on the ground. Resident #4's Service Plan reflected that she was 1 person assist, used the wheelchair to assist with ambulation, staff were to encourage the resident to ask for assistance, and frequent staff rounds were to be done to prevent . 3. Resident #5's record revealed he was admitted on to the Memory Care unit. His record contained an 1823 dated . His diagnoses included , , , and . He required supervision for all activities of daily living. Review of the facility notes revealed: at 11:11 PM - The resident had an unwitnessed in doorway of his room and sustained a to the left . at 3 PM - The resident had an unwitnessed in the hallway. He was sent to the emergency room (ER) and returned with no injury. at 11:35 AM - The resident was found lying on the bathroom floor. He was transferred to the hospital and returned on . at 1:18 PM - The resident was found lying on the bathroom floor. He was transferred to ER for evaluation and returned on . Resident #5's service plan reflected that staff were to offer toileting, do frequent resident	A 025		

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A 025	Continued From page 5 checks to prevent . . , resident was to use a walker to prevent , and staff were to encourage the resident to participate in activities. 4. Resident #6's record revealed she was admitted on in Memory Care unit. Her record contained an 1823 dated . . . . . . Her diagnoses included , . . , ... /short memory loss, and . . . . . . She used a walker. She required supervision with eating and assistance with all other activities of daily living. Review of the facility notes revealed: . . . . . at 3:28 PM - The resident was found sitting on the bathroom floor with no injury. . . . . . at 9:15 PM - The resident was found sitting on the floor with no injury. at 12:44 AM - The resident was found on the floor next to her bed. There was . . . . . from the top of her . She was sent to the hospital for evaluation and returned the same day with 3 staples to the top of her . Resident#6's Service Plan reflected that the resident was moved closer to the nurses' station as a prevention, she was seen by Hospice for admission, a rug was placed in front of recliner, she was to have a call bell next to her, she was to wear proper footwear, staff were to do a medication review, staff were to do frequent checks, staff were to redirect her, and assist with toileting. Review of the facility Policy dated indicated that after a , individualized interventions are considered, and the evaluation is part of the resident's record.	A 025		

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A 025	Continued From page 6 On . . . . . at 1 PM, the administrator confirmed residents #1, #4, #5, and #6's frequent . She said resident frequent checks, noted as a . . intervention for residents who had , are not timed or documented in the resident's record. Class II	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . . or 1(800)962-2873. The	A 030		

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A 030	Continued From page 7 telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. [illegible] and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and [illegible]; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical [illegible]. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there	A 030		

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A 030	Continued From page 8 must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or	A 030		

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A 030	Continued From page 9	A 030		

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the

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A 030	Continued From page 10 resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a	A 030		

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A 030	Continued From page 11 resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide a safe and decent living environment resulting in the loss or theft of personal items for 1 of 6 residents sampled (#2). Findings: On at 10:20 AM, staff B said resident #2	A 030		

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A 030	Continued From page 12 was missing her wedding ring in [redacted] and then in [redacted], her watch was missing. Neither had been found. This was reported to the administrator. The family was aware. She said when things are missing, they check all the resident rooms in memory care. Residents in memory care [redacted]. They also check the common areas. She verbally advised the administrator of any missing items or grievances. Resident #2's record revealed she was admitted on [redacted]. Her file contained a Resident Health Assessment for (1823) dated [redacted]. Her diagnoses included [redacted], and [redacted]. Review of facility notes found no notes related to a missing ring or watch. Review of the facility grievance policy dated [redacted] reflected that in the event a resident or resident responsible party has a grievance or concern they should discuss with associate and executive director (administrator). The Executive Director (Administrator) should provide a response to the resident or responsible party within 14 days. If unable to provide a response the administrator should report to the regional director. On [redacted] at 1 PM, the administrator confirmed resident #2's wedding ring was missing in [redacted] and her watch was missing in [redacted]. Neither had been found. The resident's family reported it to her. She confirmed she did not document either as a grievance as per the facility policy. Class III	A 030		