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 _____	09/17/2025

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
ZZ000	Initial Comments A complaint investigation #2025011410 and a generator monitoring were conducted at Brennity at Melbourne assisted living facility. There were deficiencies identified at the time of the survey.	ZZ000		
ZZ821 SS=D	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at:	ZZ821		

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ZZ821	Continued From page 1 https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers:	ZZ821		

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ZZ821	Continued From page 2 Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day)	ZZ821		

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ZZ821	Continued From page 3 is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to submit a day one incident report as well as a 15-day corrective action for a which resulted in an injury for resident #3. Findings: On (no incident time noted) resident #3 sustained an unwitnessed . She was transferred to the hospital where she was diagnosed with a left . A review of resident #3 record revealed she was admitted on . Her diagnoses included , , and . She was documented as a risk. On at 11:45AM the Director of Nursing confirmed she did not submit an Adverse Incident	ZZ821		

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ZZ821	Continued From page 4 Report to the agency for resident #3 after she and her . Class III	ZZ821		
A 000	Initial Comments A complaint investigation #2025011410 and a generator monitoring were conducted at Brennity at Melbourne assisted living facility. There were deficiencies identified at the time of the survey.	A 000		
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 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,	A 054		

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A 054	Continued From page 5 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 , 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: Based on record review and interview the facility failed to maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration for 1 of 5 residents sampled. A medication observation record must be immediately updated each time the medication is offered or administered (#3). Findings: A review of resident #3's record revealed she was admitted on . The resident's record contained a Resident Health Assessment form (1823) dated . Her diagnoses included , , , and . She required assistance with self-administration of medication. A review of resident #3's Medication Administration Record revealed she had an order from her Primary Care Provider (PCP) dated for , ER tablets 6.25 mg; give 2 tablets (12.5 mg) at bedtime. A review of resident #3's Individual Resident's Controlled Substance Record revealed on at 8PM the count for , ER tablets 6.25 mg was adjusted from 32 tablets to 30 tablets. The reason for the adjustment documented the 2 tablets were wasted. There was a line drawn through the entry without documentation to indicate why.	A 054		

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A 054	Continued From page 6 On at 1:30PM there was documentation on resident #3's Individual Resident's Controlled Substance Record that the count for , ER tablets 6.25 mg was adjusted from 32 tablets to 30 tablets. The reason for the adjustment again is that the 2 tablets were wasted. Under there was documentation by the Resident Care Coordinator and nurse (F) that 30 tablets were wasted. Indicating zero tablets remaining. Further review of resident #3's record revealed she was discharged to the hospital on . A note time stamped 7:46AM documented "Resident out of community". On at 12:45PM an interview with the Resident Care Coordinator was conducted. When asked about the Individual Resident's Controlled Substance Record for resident #3, she answered that maybe the package containing the 2 wasted pills was damaged and they were wasted because the pills could have out and been lost. She could not explain why it was adjusted twice. She explained that the remaining 30 tablets were wasted because the resident was out of the facility in rehab. When asked to review resident #3's Controlled Substance Records for , , and , she confirmed she was unable to provide any for resident #3's , ER tablets 6.25 mg. On at 3:30PM interview with a Pharmacy representative, she confirmed resident #3 was on , 6.25mg HS. This year it was filled with them on and monthly thereafter. (Photo Evidence Obtained)	A 054		

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A 054	Continued From page 7 Class III	A 054		