STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967815	01/23/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brennity At Tradition (the)	10685 Sw Stoney Creek Way Port Saint Lucie, FL 34987	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - E206 - 58a-5.030(7) Fac - Ecc - Service Plans S-S= D
St - A - E208 - 58a-5.030(9) Fac - Ecc - Records S-S= D
St - A - E210 - 58a-5.0191(7) Fac - Ecc - Training S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Relicensure survey with ECC (Extended Congregate Care) was conducted on & at The Brennity at Tradition. The facility had deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, interview, and record review, it was determined the facility failed to honor resident's rights specifically related to ensuring a resident's privacy/dignity was maintained for 2 of 5 sampled resident observed during medication observation (Resident #20 & Resident #5); that staff followed community standards for handwashing and donning gloves while providing medications to 2 of 5 sampled residents (Resident #19 & Resident #20) observed during medication observations; and failure to provide appropriate telephone access to 20 residents on the memory care unit.

The findings include:

1) During medication observation conducted with Staff A (caregiver/med tech with at date of hire noted as , conducted on beginning at approximately 8:50 AM, Staff A failed to wash or sanitize her hands prior to the application of one glove on her right hand (left hand did not have a glove applied). Staff A had left the door to this resident's open and this resident was sitting on the foot of her bed and was in full view of staff, other residents and visitors walking by in the hallway. Staff A then proceeded to obtain a triple ointment and applied it to a on the left hand of Resident #20. Staff A then unbuttoned and removed Resident #20's blouse (leaving her in

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her bra and slacks). She then proceeded, without changing the 1 glove on the right hand or applying another glove to the left hand, to apply Zeasorb powder under both of Resident #20's [redacted]. She was handling this resident's [redacted] with an ungloved hand while applying the powder with the gloved hand that had just been utilized to apply an ointment. Staff A then proceeded to lift the right arm of Resident #20 with her bare left hand and apply [redacted] 2% cream to the underarm of this resident. Staff A then repeated this process for the left side. This resident was noted to have a diagnosis of [redacted] and she resided on the memory care unit. Please refer to A052 for additional details.

2) During medication observation conducted with Staff A (caregiver/med tech with a date of hire noted as [redacted] conducted on [redacted] beginning at approximately 8:40 AM, Staff A failed to wash or sanitize her hands prior to providing the following oral medications to Resident #19:

a)Escitalpram 5mg daily
b) [redacted] 20mg daily
c) [redacted] /alsartin) 160mg daily
d) [redacted] 10mg twice daily
e) [redacted] D3 1000iu daily

Staff A then proceeded to conduct the medication observation noted in section 1) above without washing or sanitizing her hands.

3) During observational tour of the memory care unit conducted with the Administrator, on [redacted] beginning at approximately 10:05 AM, the advocacy numbers were posted in the entry to this unit. The Administrator was asked where a telephone that is accessible and in close proximity to these numbers was located. She replied the closest phone would be the hard wired phone located behind the nurse's station or the "walkie talkie" phone that the nurse carries. She was asked how a resident could obtain access to either of those telephones if they wanted to call one of the advocacy hotlines. She replied they would have to ask the nurse to provide them with the phone. She acknowledged that neither of these phones are in close proximity to the advocacy numbers.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview and record review, it was determined the facility failed to ensure that unlicensed staff that provide assistance with the self-administration of medications only provided assistance and not medication administration, for 1 of 5 residents observed (Resident #20) and 1 of 4 staff observed (Staff A).

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The findings include:

During medication observation conducted with Staff A (caregiver/med tech with at date of hire noted as conducted on beginning at approximately 8:50 AM, Staff A failed to wash or sanitize her hands prior to the application of one glove on her right hand (left hand did not have a glove applied). Staff A had left the door to this resident's open and this resident was sitting on the foot of her bed and was in full view of staff' other residents' and visitors walking by in the hallway. Staff A then proceeded to obtain a triple ointment and applied it to a on the left hand of Resident #20. Staff A then unbuttoned and removed Resident #20's blouse (leaving her in her bra and slacks). She then proceeded, without changing the 1 glove on the right hand or applying another glove to the left hand, to apply Zeasorb powder under both of Resident #20's She was handling this resident's with an ungloved hand while applying the powder with the gloved hand that had just been utilized to apply an ointment. Staff A then proceeded to lift the right arm of Resident #20 with her bare left hand and apply 2% cream to the underarm of this resident. Staff A then repeated this process for the left side.

During subsequent interview with the Administrator (also happens to be a nurse), conducted on beginning at approximately 10:00 AM, she acknowledged that due to Resident #20's diagnosis of (and resides in memory care unit) and her inability to participate any any portion of assisting with the application of these medications, that a nurse should have been administering these medications for Resident #20.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation, interview and record review, it was determined the facility failed to ensure that each resident's medication (specifically eye drops) were labeled with the resident's name and the prescriber's directions for use, for 1 of 1 residents receiving eye drops (Resident #5).

The findings include:

During medication observation conducted with Staff G on beginning at approximately 9:15 AM, she provided Resident #5 with 1 drop of Ultra eye drops in each eye. This bottle of eye drops did not contain any other labeling than the manufacturer's label. The facility did not have the box they eye drops came in (therefore there was no evidence of a label on the box/packaging). The Staff G stated she just followed the directions on the Medication Record that indicated 1 drop to each eye 2 times daily. She acknowledged it is customary to have a label on the box or the bottle and that the facility did not have this at this time.

Class III

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0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on interview and record review, it was determined the facility failed to ensure that 1 out of 5 staff members (Employee E), submitted an annual statement from a physician, indicating that the person was free from and communicable

The findings include:

Record review of Employee E's personnel record revealed her date of hire was as a registered nurse. Further review revealed Staff E's file lacked documentation from a physician indicating the employee is free from and communicable

In an interview with Administrator and Business Office Manager on at approximately 1:30 PM, they acknowledged the findings.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview, it was determined the facility failed to ensure that all staff members had completed the required in-service training's within 30 days of hire, for 2 out of 5 sampled staff records reviewed (Staff A and Staff B).

The findings include:

a) Record review of Staff A's personnel record revealed her date of hire was as a certified nurse assistant. Further review revealed Staff A's file lacked documentation indicating the employee had completed the following in-service trainings: Resident Rights, Nutritional and Safe Food Handling.

b) Record review of Staff B's personnel record revealed her date of hire was as a certified nurse assistant. Further review revealed Staff B's file lacked documentation indicating the employee had completed the following in-service training: Nutritional and Safe Food Handling

In an interview with the Administrator and Business Office Manager at approximately 1 PM, they acknowledged the findings. The Business Office Manager stated no further documentation was available for review.

Class III

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0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC
Based on record review and interview, the facility failed to ensure that 1 out of 5 staff members (Staff A) received the annual 2 hour update training on Assistance with Self-Administered Medication and Medication Management.

The Findings Include:

A record review of the Staff A's personnel file on revealed a hire date of Further review of Staff A's file found her initial 4 hour training on Assistance with Self-Administered Medication and Medication Management completed on Record review found no documentation of an annual 2 hour update training. Review of random medication observation records revealed Staff A does provide assistance to residents with their self-administered medications.

During an interview conducted on at 1 PM, the Administrator acknowledged the finding and the Business Office Manager stated no further information was available for review.

Class III

E206-ECC - Service Plans 58A-5.030(7) FAC
Based interview and record review, it was determined this facility failed to ensure that prior to 1 of 2 sampled residents reviewed (Resident #4) and before receiving services that the ECC (Extended Congregate Care) Administrator developed a preliminary services plan. This plan must include an assessment of where the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, and social needs and preferences, and an evaluation of the facility's ability to meet those needs. In addition within 14 days of receiving services the ECC Administrator must coordinate the development of a written service plan and how the facility is to meet their needs , for 1 of 2 sampled residents (Resident #4).

The findings include:

During entrance conference to the facility the Administrator stated on at approximately 9:40 AM that the facility did not have any residents receiving ECC services at this time. A letter, dated that was signed by the facility's Executive Director, indicated "at this time we have no residents on ECC".

During record review for Resident #4 a physician's telephone order was noted to prescribe "continue bag change every 7 days and as needed". Interview and record review with Staff F (LPN) conducted on at approximately 9:45 AM, revealed the facility nurses provided all care for Resident #4's Staff F stated that the Administrator determines if a resident is placed on

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ECC services. Review of this resident's record did not include any service plans or assessments related to the provision of care. Staff F stated that he had been informed by Resident #4's family that this resident has had the since he was in his 20's.

During subsequent interview with the Administrator (she is also the ECC Supervisor), conducted on at approximately 10:30 AM, she stated she was not aware that a resident with an that the facility nursing staff manages would need to be placed on ECC services. She acknowledged that the required ECC documentation had not been developed for this resident.

Class III

E208-ECC - Records 58A-5.030(9) FAC
Based on interview and record review, it was determined the facility failed to ensure service plans; nursing progress notes; and nursing assessments were on file for all residents receiving ECC (Extended Congregate Care) services, for 1 of 2 sampled residents reviewed (Resident #4).

The findings include:

During entrance conference to the facility the Administrator stated on at approximately 9:40 AM that the facility did not have any residents receiving ECC services at this time. A letter, dated that was signed by the facility's Executive Director, indicated "at this time we have no residents on ECC".

During record review for Resident #4 a physician's telephone order was noted to prescribe "continue bag change every 7 days and as needed". Interview and record review with Staff F (LPN) conducted on at approximately 9:45 AM, revealed the facility nurses provided all care for Resident #4's Staff F stated that the Administrator determines if a resident is placed on ECC services. Review of this resident's record did not include any service plans; nursing progress notes; or assessments related to the provision of care. Staff F stated that he had been informed by Resident #4's family that this resident has had the since he was in his 20's.

During subsequent interview with the Administrator (she is also the ECC Supervisor), conducted on at approximately 10:30 AM she stated she was not aware that a resident with an that the facility nursing staff manages would need to be placed on ECC services. She acknowledged that the required ECC documentation had not been developed for this resident.

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E210-ECC - Training 58A-5.0191(7) FAC
Based on interview and record review, it was determined the Assisted Living Facility who provides extended congregate care (ECC) failed to ensure that 2 out of 5 direct care staff members (Staff C and E) received at least 2 hours of of in-service training in ECC concepts and requirements.

The findings include:

During employee record reviews, Staff C's file revealed a hire date of as a certified nurse assistant and Staff E's file revealed a hire date of as the ECC registered nurse. Further review of Staff C and E's file lacked documentation of 2 hours of ECC in-service training.

On at 1:30 PM, the Administrator and Business Office Manager acknowledged that there was no documentation on file for Staff C and E that reflects 2 hours of ECC training.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brennity At Tradition (the)
10685 Sw Stoney Creek Way
Port Saint Lucie, FL 34987

Dear Administrator:

This letter reports the findings of a State Reicensure and Extended Congregate Care (ECC) survey that was conducted on . 2015 by a representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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