RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Brentwood at Fore Ranch
4511 SW 48th Avenue
Ocala, FL 34474

RE: CCR #2015008184 & 2015009376

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by a representative of this office.

Enclosed 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 surveyor). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kristie J. Merinella
Field Office Manager

KJM/amw
Enclosure

XG90

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	09/14/2015
NAME OF PROVIDER OR SUPPLIER **BRENTWOOD AT FORE RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **4511 SW 48TH AVE** **OCALA, FL 34474**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On unannounced Change of Ownership and two complaint survey's CCR #2015008184 & 9376 were conducted at Brentwood at Fore Ranch Assisted Living Facility in Ocala Florida. Discernible deficiencies were identified as a result of this survey. The facility was not in compliance at this time.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews the facility failed to post the required numbers for Florida Rights, the Agency Consumer Hotline, and the Floria Hotline for 86 of 86 residents.

Findings:

On at approximately 10:15 AM a tour of the facility was conducted to include the secured memory unit. During the tour the numbers for the Florida Rights, the Agency Consumer Hotline, and the Florida Hotline could not be found posted in the facility as required.

On at approximately 4:45 PM the Administrator was asked to show where the required numbers were posted in the facility. After he looked around he stated I guess their not posted as required.

Class III

0053 Medication - Administration

Based on interviews and record reviews the facility failed to administer medication as ordered and failed to insure licensed staff administered medication as required for 2 of 7 residents for #5 & #9.

Findings:

On an interview was conducted with resident #5. During the interview the resident statd she did not get all her medication as required for the month of 2015.

On a record review was conducted on resident #5 medication administration/observation record MAR/MOR for the month of 2015. It was observed that she is prescribed Rebif 44 MCG/0.5 ML Syringe (inject ½ ml sub-q 3 times per week) It was further observed that the medication was given at 8 PM on 8/3, 8/7, , , , , , . She did not receive the medication as required 3x a week.

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On at approximately 9:50 AM an interview was conducted with the Wellness Director RN in reference to resident #5 not getting her Rebif as prescribed. RN stated it was discovered on that LPN H (terminated) had not given the medication as ordered. It was the LPNs responsiblity to give the resident her medication at 8 PM. RN stated she was not aware that the resident was not getting the medication as required until family notified her. The RN stated that the LPN was interviewed and questioned regarding resident #5 not getting her Rebif as perscribed. LPN H did admit to not giving the Rebif as prescribed to resident #5.

On at approximately 4:28 PM an interview was conducted with unlicensed staff B (who asssists residents with self-administration of medication). She stated she checks resident #9 before giving the medication. She compares the taken with the parameter in the medication observation record to make an asssessment to determine if I need to hold the medication or not.

On at approximately 9:08 AM an interview was conducted with resident #9. During the interview the resident stated that the "Med-Tec" always takes my before giving my medication. It my is to high the "Med-Tec" holds the medication and comes back later and takes it again. Resident #9 resident was asked if she has ever run out of medicine. She stated yes, I have run out for a couple days. The longest has been a week. She stated she did not get her meds or her patch on and she didn't get her AM meds on / . She stated, I told the Administrator. She also stated, she did not get her patch on , , , or (she kept a record of these missed dosages on a personal calendar).

On a record review of resident #9 MAR/MOR was conducted for 2015. The MAR/MOR shows she refused her medication on . A review of resident # MOR/MAR shows on / the resident refused her 9 AM patch, but at 5 PM the same day it was removed. On the MAR/MOR shows resident refused Patch at 9 AM and it was removed at 9 PM same day. On the MAR shows that the resident refused 9 AM patch and it was removed at 9 PM same day.

On at approximately 3:09 PM an interview was conducted with LPN G in reference to resident #9 not getting any of her medications on or in the morning of / . LPN stated it was true that she did not give resident Reynolds her medication on because she could not find her in the facility to give her, her medication.

Class II

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0054 Medication - Records

Based on record reviews and interviews the facility failed to maintain a daily medication record for medication dosages for 13 of 31 residents (#3, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 23).

Findings:

On a record review was conducted on the medication observation records/medication administration records for residents #3, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, and #23. It was observed that the MOR/MARs for the months of and 2015 contained several missing recordings of medication dosages.

On at approximately 9:50 AM an interview was conducted with the Wellness Director RN in reference to the missing recorded documentation on the MOR/MARs for the mentioned residents. She stated that the lack of recorded documentation was due to staff not using the electronic MOR/MAR correctly.

Class III

0055 Medication - Storage and Disposal

Based on observations and interviews the facility failed to secure resident medications as required for 9 of 20 residents for residents #23, 24, 25, 26, 27, 28, 29, 30, and 31.

Findings:

On at approximately 4:30 PM it was observed that the nurses station on the memory care unit, which contained two offices, both doors open and unsecured. There were no staff present inside. The first office was observed a small black refrigerator and inside the refrigerator was observed food items and resident medication. 0.005% eye drops belonging to resident #23. 650 mg 's belonging to resident #26. BISAC-EVAC 10 mg for resident #27 & 28. and an unidentified box of PERFORMIST.

In the second section of the office in an unsecured cabinet were 8 prescription cards that contained medication for the following:

Resident #24 2 cards with 58 tabs of 1 mg.
Resident #25 1 card with 23 tabs of 7.5 mg, and 1 card with 24 tabs of 20

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mg.
Resident #29 1 card with 7 tabs of 20 mg.
Resident #30 1 card with 11 tabs of (unk mg)
Resident #31 1 card with 18 caps of 500 mg.

On at approximately 4:45 PM the unsecured medication was shown to the Administrator and he stated the doors at the nurses station should not have been left unsecured.

Medication left unsecured in the memory care unit poses serious potential harm to residents who suffer from and who may find and digest the unsecured medication.

Class II

0081 Training - Staff In-Service

Based on record reviews and interviews the facility failed to provide all the required in-service training as required for 3 of 3 staff (A, B, & C).

Findings:

On a record review was conducted on direct care staff A, B, & C. During the review it was observed that staff A who was hired did not have documentation showing she had received Activities of Daily Living and Behavior Needs (ADL) training, Emergency Preparedness and Evacuation training, or Incident Report training. Staff B who was hired and did not have documentation showing she had received ADL Behavior Needs training, Emergency Preparedness and Evacuation training, or Incident Report training. Staff C who was hired and did not have documentation showing she had received Emergency Preparedness and Evacuation training or Incident Report training.

On at approximately 11:00 AM the Human Resource person stated their was no documentation for staff A & B ADL training, but she thought for sure all them had received the Emergency Evacuation and Preparedness training and Incident Report training but she could not find the documentation.

Class III

0090 Training -

Based on record reviews and interviews the facility failed to provide

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TRAINING ( ) for 3 of 3 direct care staff (A, B, & C).

Findings:

On a record review of direct care staff A shows she was hired and she did not have documentation showing she had received training. Direct care staff B was hired and did not have documentation showing she had received training. Direct care staff C was hired and did not have documentation showing she had received training.

On at approximately 11:00 AM the Human Resource Director stated there is no documentation in the facility computer records showing that employees A, B, and C had received the training.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on interviews and record reviews the facility failed to file an adverse incident for 1 of 10 residents which broke a bone and needed a higher level of care while in the facility for resident #1.

Findings:

On an interview was conducted with resident #1. During the interview she stated she broke her ankle while in the . She had to go to rehab after surgery and was there for a couple months.

On at approximately 3:08 PM an interview was conducted with Licensed Practical Nurse F. She stated that resident #1 in her apartment on and needed a higher level of care, she went to rehab for a couple of months and has recently moved back into the facility.

On at approximately 3:29 PM an interview was conducted with the Administrator regarding him filing an adverse incident report when resident #1 and broke her ankle and needed a higher level of care. He stated he did not file an adverse incident because he felt her was out of the facilities control.

On a record review was conducted on resident #1 1823 health assessment. The assessment revels she is a risk and she needs assistance with transferring.

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