AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967857	03/08/2016
NAME OF PROVIDER OR SUPPLIER **BRENTWOOD SENIOR LIVING COMMUNITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **6280 CENTRAL AVE, STE 312** **SAINT PETERSBURG, FL 33707**	

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

0000 Initial Comments

Assisted Living Facility

On [redacted] a complaint survey CCR#2016001418 & CCR#2016001969 was done in conjunction with a revisit to / survey at Brentwood Assist Living Facility. Deficient practice was identified during the survey.

0025 Resident Care - Supervision

Based on interviews and record review, the facility failed to maintain a written record, updated as needed, of any significant changes or any illnesses that resulted in medical attention for 1 of 4 resident ' s whose records were reviewed. (Resident #3)

Resident #3 was admitted to the facility on [redacted] / [redacted]. The resident record revealed that she was assessed as being [redacted] and needing full assistance with ADL ' s, was [redacted] of bowel and [redacted] and needed hands on assistance with mobility and transfers. On [redacted] / [redacted] at [redacted] /am, nurses notes revealed that the resident was on the commode and that the Certified Nursing Assistant (CNA) went to tell the nurse about seeing [redacted] in the resident ' s stool and when they returned, the resident was on the floor. The resident complained of head pain and there was " a copious amount of frank red [redacted] in stool " . The resident was sent to the hospital.

Further review of the record revealed an order for a stool culture on [redacted] / and an order for Fiberlax was received on [redacted] / [redacted] / [redacted]. The Director of Nursing stated that the culture was ordered because the resident was reported to have loose, " bloody smelling " stools. The results were negative for [redacted].

Interview with Staff C at 12:20 P.M. revealed that on [redacted] / [redacted] when she took the resident to the [redacted], the stool was dark and that there was [redacted] on the toilet seat and in the toilet. She also stated that the resident had had loose foul smelling stools that were very dark in color for a few days before the [redacted] / [redacted] incident and that she reported it to the medication technician (Med Tech). She also stated that the nurse on duty was aware. The Med Tech could not remember who she may have reported this to, but stated that if that were the case she would have reported it to the nurse. The nurse no longer works at the facility.

Interview with the Director of Nursing (DON) at 1:00 P.M. revealed that after the [redacted] / [redacted] incident, she discovered that staff was aware of the resident having foul smelling stool and that it was noted to be dark in color. She had heard that it was reported to the nurse on duty who never assessed the resident

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or noted the concerns from staff. She terminated the nurse who was on duty at the time.

She had since heard from the hospital that the resident had a [redacted]. She confirmed that based on the report of loose bloody smelling stool and reports from caregivers, the resident ' s change in condition should have been further assessed prior to the / incident.

The facility has since initiated the use of a Care Alert Form for all staff to use to communicate issues/concerns related to changes in behaviors or medical conditions. An in service was held with all staff on .

0056 Medication - Labeling and Orders

Based on interview and record review, the facility failed to ensure that that prescriptions for residents who receive assistance with self-administration were provided as per orders within a timely manner for 1 (Resident #1) of 4 records reviewed.

Findings Include:

A record review of resident #1 physician orders dated _/ revealed resident #1 was ordered medication 10 mg give 1 tab by mouth twice a day times 7 days, than start 5 mg 1 tab by mouth twice a day times 6 months.

Per interview with the ADON on 11:58 A.M. The ADON reviewed resident #1 file with surveyor and confirmed findings. The ADON stated, she is not sure why medications were not provided to resident as per ordered. However confirmed she noticed upon a random check of medications orders for resident #1 that medication was not being provided to resident #1. The ADON stated, " On / I saw that resident #1 was ordered medication for .

A review of the (MORS) medication observation record for the months of 2015 and 2016 revealed resident #1 was not provided medications as per order. The documentation on the MORS revealed medications were not provided until / , 18 days after the medications was ordered. The ADON reviewed records with surveyor and confirmed findings.

During an interview with the facility Administrator on 4:05 P.M. The Administrator acknowledged that Resident #1 was not provided medications as per ordered. No further documentation was provided at this time.

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Brentwood Senior Living Community
6280 Central Ave, Ste 312
Saint Petersburg, FL 33707

RE: CCR #2016001969 & 2016001418

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of 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. **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 , 2016.** 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(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

PRC/clt
Enclosure: State (5000-3547) Form
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