STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967587	11/16/2016
NAME OF PROVIDER OR SUPPLIER **BRENNITY AT MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7365 ORCHESTRA LN** **MELBOURNE, FL 32940**	

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

0000 Initial Comments

A re-licensure survey visit with Extended Congregate Care (ECC) was conducted on 11/16/2016. The Brennity at Melbourne Assisted Living (License #11595) had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility failed to ensure the unlicensed staff who assisted 1 of 1 sampled residents (#5) with self-administration of medications followed the correct procedure.

Findings:

During observation of the medication pass for resident #5 on / at 11:05 AM, the medication technician placed the pill in a medicine cup with applesauce. She brought the cup to the resident and told the resident the name of the medication. The resident took the medication with a spoon.

The medication technician did not take the medication, in its previously dispensed, properly labeled container, from where it was stored and bring it to the resident and she did not, in the presence of the resident, read the label.

During an interview with the medication technician on / at 11:20 AM, she said she did not think these steps had to be done when the resident was .
During an interview regarding the findings with the regional director on / at 1:50 PM, she said "ok."
Class III

0056 Medication - Labeling and Orders

Based on record review and interview the facility did not make every reasonable effort to ensure that a prescription for 1 of 2 sampled residents (1) who received assistance with self-administration of medication was filled in a timely manner.
Findings:
Resident record review for resident #1 revealed a health assessment report form 1823 dated / that listed diagnoses of , leg injury and issues. Order dated indicated the resident needed assistance with self-administration of medication. The review revealed a healthcare provider's order dated / that indicated milligram (mg) daily. The 2016 Medication Observation Record (MOR) listed 1 mg daily and had staff initials circled for to . The back page of the MOR indicated from to that the was not given/

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awaiting delivery.
Healthcare provider's order dated 7/9/16 indicated 5 mg every morning and 90 pills (3 months) to be dispensed. Order dated 8/28/16 indicated 5 mg one twice daily.
The MOR dated listed 5 mg one twice daily at 9 am and 5 PM, had staff initials circled for 9/1 to AM. The back page of the MOR indicated from 9/2 to that the was not given; wait on pharmacy/ delivery
The MOR dated 2016 listed 5 mg twice daily at 9 am and 5 PM, and had staff initials circled for AM & PM. The back page of the MOR indicated on the was not given; awaiting delivery.
Continued record review revealed no evidence the healthcare provider was notified the resident was without the medications and what efforts were taken to ensure the medications was refilled timely.

In an interview with the administrator on / at 4 PM, who confirmed the findings.
Class III

0078 Staffing Standards - Staff

Based on interviews and record review, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and allowed them to take with prescriptive parameters and allowed the staff to make a judgment as to whether or not the medication was needed for 2 of 2 sampled residents (#1 & #5).

Findings:

1. Resident record review for resident #1 revealed a health assessment report form 1823 dated / that listed diagnoses of , leg injury and issues. Order dated indicated the resident needed assistance with self-administration of medication. Healthcare provider's order dated / healthcare provider's order indicated 25 mg one daily hold for (SBP) less than 100 or rate (HR) less than 55. An order dated indicated to increase 25 mg to twice daily and hold for SBP less than 100 or HR less than 55. The facility's vital signs flow sheet listed taken twice daily from 10/2 to . The log listed the initials and the signature of the staff who took the resident's , however there were no credentials listed. The Medication Observation Record listed 25 mg one daily hold for (SBP) less than 100 or rate (HR) less than 55. The back page of the MOR had the initials and signature of the staff who assisted with the medications, there were no credentials listed.
The administrator stated on / at 3PM after reviewing the MOR and the vital sign log that the initials and signatures were of the unlicensed staff, not the nurses.

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Review of the 2016 Medication Observation Record (MOR) for resident #5 revealed an entry dated 9/01/16 for 25 milligrams (mg) by mouth twice daily, hold for less than 100 or rate less than 60.

During observation of the medication pass for resident #5 on / at 11:05 AM, the unlicensed medication technician first checked the and pulse of resident #5. She then documented the and pulse readings on a facility form located in front of the MOR. The medication technician then placed the tablet in a medicine cup with applesauce and brought the cup to resident #5. The resident took the medication with a spoon.

Administration of the , to resident #5 required judgment based on the , and pulse readings, which could only be done by a licensed person.

During an interview with the regional director on / at 1:50 PM, regarding the findings, she said "ok."

Class III

0167 Resident Contracts

Based on resident contract review and interview, the facility did not ensure the contracts contained the required information: 1. The costs of Extended Congregate Care (ECC) services 2. A refund policy to be implemented at the time of a resident's transfer, discharge or that provided a prorated refund based on the daily rate for an unused portion of the payment beyond the termination date for 2 of 2 residents reviewed (#1 & #7).

Findings:

Review of the contracts for residents #1 and #7 revealed the costs for ECC services were not included in the contract. Further review of the contract found a section that stated " if a resident passes away or develops a medical condition that requires a higher level of care than is offered by TCG Melbourne, this Agreement shall terminate, and Resident or Responsible Party will be responsible for fifteen (15) days at the then current Monthly Fees beginning on the date Resident removes all belongings in his or her apartment. If the apartment is not vacated at the end of the 15-day period, Resident, Resident's estate, or Responsible Party will be responsible for providing TCG Melbourne a thirty (30) day written notice of termination and payment as set forth above."

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In an interview with the administrator on 11/16/16 at 3:30 PM, she stated the facility does not charge for ECC services, but confirmed that the contract did not include a statement explaining that ECC costs were included. She also confirmed that their contract, written by their corporate office, is to charge a resident for 15 days in the event of the of a resident. She explained she would bring F.S. 429.24 to the attention of their corporate offices.

Class

Z814 Backaround Screenina Clearinahouse

Based on the Background Screening (BGS) Clearinghouse Employee Roster website review and interview, the facility failed to report and update employment status on the employee roster within 10 business days for 2 of 5 sampled staff (B & D).

Findings:

On / at 4 PM, the BGS Clearinghouse website review of the employee roster revealed not updated or reported for the following staff below:

1. Staff B's date of hire on 2016
2. Staff D's date of hire on 2015

An interview on 11/ at 5 PM with the Administrator who confirmed that staff B and D was not on the Employee Roster.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Brennity At Melbourne
7365 Orchestra Ln
Melbourne, FL 32940

RE: Re-licensure w/ECC

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 Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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