STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967815	**05/16/2017**
NAME OF PROVIDER OR SUPPLIER **BRENNITY AT TRADITION (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **10685 SW STONEY CREEK WAY** **PORT SAINT LUCIE, FL 34987**	

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

0000 - Initial Comments

An unannounced relicensure survey with Extended Congregate Care was conducted on through at The Brennity at Tradition, License #11796. The facility had deficiencies at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation and staff interview, the facility failed to ensure a resident received adequate and appropriate health care consistent with established and recognized standards within the community as it relates to food service sanitation standards and control during the medication pass. The following sanitation standards were not met:
a) 2 of 4 care staff providing assistance to residents during dining failed to sanitize their hands between the assistance of each resident (Staff A and Staff I).
b) 1 of 4 staff (Staff I) failed to use disposable gloves when handling a resident's food (Resident #5).
c) 2 of 4 staff observed for medication administration/assistance (Staff G and Staff I) failed to wash/sanitize hands or handle medications in a sanitary manner.

The findings included:

1) During lunch observation on beginning at 12:05 PM, Staff A was seen escorting several of the memory care residents into the dining, either by assisting with ambulation or pushing them in their wheel chairs. Staff A then began moving around the dining several residents with set up of their meals. There was no handwashing or hand sanitizing completed by Staff A during the entire lunchtime meal as she went from assisting one resident to assisting another resident.

Also during this lunch observation, Staff I was seen using her bare, ungloved hand to pick up Resident #5 's potato chips from the resident's plate and place the chips into resident's mouth.

On at 2:30 PM, the results of these observations were discussed with the Healthcare Director and Executive Director. They acknowledged that these staff members did not perform proper hand washing/sanitizing and proper food handling while assisting residents in the memory care unit.

2) During observation of Staff G, conducted on beginning at approximately 12:20 PM, she was observed to wait in the lobby for Resident #11 to complete . Then Staff G transported Resident #11 to her apartment and proceeded to provide Resident #11 with her 3 oral medications; 1

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inhaler; and a treatment. Staff G was not observed to wash or sanitize her hands at any time during this observation.

3) During observation of Staff I, conducted on at approximately 8:45 AM, she was observed to open Resident #13's 100mg gel capsule of with scissors she obtained from a bag she had been carrying in and out of several resident's . Staff I handled this 100mg gel capsule of with her bare hands and then proceeded to squeeze the liquid contents of this gel capsule into a spoonful of applesauce. She then explained this is how Resident #13 needs to take this medication as she has trouble swallowing pills.

During subsequent interview conducted with the Administrator, on beginning at approximately 10:15 AM, she acknowledged that it was not appropriate to open with scissors and bare hands and place in applesauce.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

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 did so in accordance with procedures described in Section 429.256, F.S. and this rule. Specifically, related to the use of inhalers and , lotion provided by 2 of 4 sampled staff (Staff H and Staff I).

The findings included:

1) During observation of unlicensed Staff H, on at 11:50 AM, she was observed to provide Resident #10 with 2 puffs of her inhaler. The label on the box of the and the MOR (Medication Observation Record) for , 2017 indicated only 1 puff is to be provided four times daily for Resident #10. This observation revealed Staff H assist Resident #10 to dial the inhaler for 1 puff then assist her to dial the inhaler for a second puff. After exiting Resident #10's , Staff H was asked why she provided this resident with 2 puffs of the inhaler when only 1 puff was indicated on the label and on the MOR. Staff H denied providing 2 puffs of the inhaler.

During subsequent interview conducted with Resident #10, conducted on beginning at approximately 12:05 PM, this resident was asked how many puffs of her inhaler she had just received. She acknowledged she had received 2 puffs.

During interview conducted with the Administrator, on beginning at approximately 1:40 PM,

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she was asked if she had been informed of the incident with Staff H providing Resident #10 with 2 puffs of her inhaler instead of the 1 puff that is noted on package label and MOR. She acknowledged that she had not been informed of this incident and that she would be filing a medication error report.

2) During observation of Staff I providing assistance with the application of lotion for Resident #13, on at approximately 8:45 AM, she donned gloves and applied this lotion to both of Resident #13's hands. However, the label on the lotion was illegible (smeared); the , 2017 MOR indicated the lotion is to be applied to trunk, neck, and arms twice daily. The physician's order, dated , reflected this lotion is to be applied to upper extremities twice daily. Staff I was observed to initial the MOR for the morning application of this lotion.

3) During observation of Staff I, conducted on at approximately 8:45 AM, she was observed to open Resident #13's 100mg gel capsule of with scissors she obtained from a bag she had been carrying in and out of several resident's . Staff I handled this 100mg gel capsule of with her bare hands and then proceeded to squeeze the liquid contents of this gel capsule into a spoonful of applesauce. She then explained this is how Resident #13 needs to take this medication as she has trouble swallowing pills.

During subsequent interview conducted with the Administrator, on beginning at approximately 12:00 PM, she stated the pharmacy would not provide any documentation that could be provided in the above noted manner. She stated the current order for had been discontinued and a liquid stool softener order had been initiated for Resident #13.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, interview, and record review it was determined the facility failed to ensure that each licensed staff member administered medications in accordance with a a health care provider's order or prescription label, for 1 of 1 sampled licensed staff members (Staff G).

The findings included:

During observation of and interview with Staff G, conducted on beginning at approximately 12:20 PM, this licensed staff member provided Resident #11 with her 160/4.5 inhaler (inhale 2 puffs into lungs). The label indicated this medication is to be provided at 7:00 AM and 5:00 PM per label on box for the inhaler and per MAR (Medication Administration Record) for , 2017. Staff G was asked why she provided this medication at 12:20 PM. She could not provide an

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explanation. She was asked what she needs to do since this medication was provided outside of the time parameters. She stated she would need to monitor this resident for any reactions. She was asked if there was anything else she needed to do. She stated she should file a medication error report.

The Administrator confirmed, on at approximately 8:30 AM, that a medication error report was filed related to Staff G providing Resident #11 with an inhaled medication (,) outside of the ordered time parameters.

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview, and record review it was determined the facility failed to ensure that a revised medication label was obtained from the pharmacy and applied to the medication for 1 of 4 sampled residents observed (Resident #13).

The findings included:

During observation of unlicensed Staff I providing assistance for Resident #13's inhaler, on beginning at approximately 8:45 AM, this resident was provided 1 puff of this inhaler. Staff I was asked why the medication label indicated this inhaler is to be provided every 4 hours as needed for and the MOR (Medication Observation Record) for , 2017 indicated 1 puff is to be provided every morning. She could not provide an explanation. Staff I did acknowledged that the label and the MOR should match. Review of the health care provider's order, dated , reflected 1 puff is to be provided every morning scheduled.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on record review and staff interview, the facility failed to ensure that the individual designated for total food services and the day-to-day supervision of food service staff had completed the food and nutrition services module of the core training before assuming responsibility as Food Designee.

The findings included:

A review of personnel records for the facility's Culinary Director, who was hired and is listed as the facility's Food Designee, was completed on . The employee file contained no 2 hour Food and Nutrition Certificate to confirm completion of this required training prior to assuming the responsibilities of Food Designee. A request was made to the Executive Director (ED) and Healthcare Director (HD) to provide confirmation that the training was completed, but the documentation could not

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be provided.

During interview conducted with ED on at approximately 2:45 PM , she stated she had thought the Culinary Director had to complete the Food and Nutriont training within 12 months of being hired. The ED was provided with information on the Food Designee training requirements and acknowledged that the Culinary Director should have received the 2 hour Food and Nutrition training prior to or at the time of hire date.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and staff interview, the facility failed to file an adverse incident report and conduct a thorough investigation for an event of unknown origin resulting in injury to a resident that required transfer to unit providing more acute care (hospital) due to event, not condition of resident prior to event (Resident #5).

The findings included:

During review of 2017 progress notes for Resident #5, it is documented:
at 7:24 PM - " (purplish) noted to L[eft] wrist and R[ight] hand. No facial grimace present when touch. Will continue to monitor."
at 8:59 AM - "Observed to corner of resident's mouth; resident unable to communicate what happened; no s/s [signs/symptoms] of distress; notified POA [Power of Attorney]...POA also aware of to wrist and hand. Will continue monitoring."
at 8:24 PM - "Noted: blue-green to L[eft] inner thigh. No facial grimace present when touch. No [signs/symptoms] of distress. Unknown how and where occurred."
at 1:00 AM - "The CNAs were providing care and called the nurse into the resident's apartment. Upon examination[,] a large ecchyomotic area noted on her left inner thigh, and painful to touch. The resident would not allow staff to straighten her leg. Also noted upon examination[,] ecchyomotic area on her pelvic bone and pubic area. Also noted[,] a area on her upper lip. Called 911 and sent the resident out for evaluation. She left via stretcher at 12:29 AM..."
at 6:45 AM - "Informed the Health Care Director of the ecchyomotic area on her left inner thigh and pelvic bone area and that we sent her to ER for evaluation. The nurse also left a message on the [family member's] answering machine..."

A review was conducted of Incident/Adverse Incident Log on . There were no Incident Reports and/or Adverse Incident Reports completed for any of the events documented on , 4, 5 or 6, 2017

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for Resident #5.

When interviewed on at 2:30 PM, the Healthcare Director (HCD) stated, "I reviewed the criteria for Adverse Incident Reporting and I didn't think the incident regarding [Resident #5's] met the criteria for filing an Adverse Incident Report." The HCD stated that a thorough investigation had not been completed of this event.

It was discussed with the HCD that the suspicious /injury of unknown origin, especially requiring transfer out to a facility providing more acute care (hospital) for evaluation/treatment due to the specific incident, should have been treated as an Adverse Incident. It was pointed out on the document that was used by the HCD to determine if the incident was adverse (included in supporting documents), that "if there is insufficient information at the time of the incident to make a determination as to cause, begin the internal investigation of the incident and submit the completed 1-Day Adverse Incident Report (initial report) to the Agency. The facility should continue the internal investigation and within 15 days of the occurrence of the incident and submit the completed 15-Day Adverse Incident Report."

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on interview and record review, it was determined the facility failed to ensure each person subject to screening had not had a break in service from a position that requires a level 2 screening for more that 90 days for 1 of 4 sampled staff reviewed (Staff A).

The findings included:

During interview and record review conducted with the Business Director, on at approximately 1:00 PM, she was provided the opportunity to locate employment reference checks or any documentation that could verify employment dates for Staff A. The Business Director acknowledged she could not find any documentation that would verify employment dates for Staff A. Review of Staff A's personnel file reflected her date of hire as and her level 2 background screening was dated (almost 2 years prior). Staff A's employment application reflected a break in service from - (7 months). This was subsequent to her most recent level 2 background screening. The Business Director stated she could not provide any explanation because Staff A was hired before she assume the Business Director's position.

Unclassified