| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11967587 | 11/28/2017 |
| NAME OF PROVIDER OR SUPPLIER<br>**BRENNITY AT MELBOURNE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**7365 ORCHESTRA LN**<br>**MELBOURNE, FL 32940** | |

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

**0000 - Initial Comments**

A Change of Ownership (CHOW) survey was conducted on . The Brennity at Melbourne Assisted Living with Extended Congregate Care (ECC), License #11595 had deficiencies at the time of the visit.

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on observation, record review and interview, the administrator failed to monitor and to take into considerations the accuracy of information that was provided to the facility on the Resident Health Assessment form to determine the continued appropriateness of placement 1 of 3 sampled residents (#15) and retained the resident who was total with transfers and ambulation which exceeded the residency criteria.

Findings:

Observations on at 3 PM, revealed a hospice representative was pushing Resident #15 wheelchair (resident #15 was leaning to the side with her feet stretched out) to the area to where her . She did not know where the resident's . Staff G a caregiver was in the area and had to tell the hospice representative where to take resident #15. The hospice representative said the resident wanted to go back to her she was assisting her because she could not push herself. Staff G was asked at the time if the resident received hospice services, she said Resident #15 was not receiving hospice services.

Staff G said at the time Resident #15 required total care with bathing, dressing, ˘ ˘ and toileting, she said resident #15 did not try to assist. She said it required 3 people to transfer the resident because she did not help with transfers and she was very heavy. She said the staff were not able to place the resident in the shower because they could not transfer her into the shower and she could not sit on the shower chair that the facility had. Resident #15 would have to be bathed on the toilet and many towels would be place on the floor for the water.

Staff H said at the time Resident #15 required total care with bathing, dressing, ˘ ˘ and toileting, she said resident #15 did not try to assist. She said she could lift the resident with only 1 other staff if that staff was strong enough. She said resident #15 would move her feet sometimes to help with transfers and sometimes she would not.
Staff I was called to the help assist with the transfer of Resident #15. She said at the time Resident #15 was total care with, bathing, dressing, toileting and ˘ ˘ and would not assist with

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transfers.

On at 3:15 PM resident #15 said she wanted to sit in her recliner chair. The 3 staff present looked at each other surprised and said if they put her in the recliner chair; the next shift would not be able to get her out of the chair without a struggle. Staff G said the resident when not in bed would just sit in her wheelchair because it was easier to transfer her.

Observations on at 3 PM revealed there was one staff in the back of the wheelchair to pull the resident up the other two were on the side. They lifted the resident out of the wheelchair, struggling and placed her on the bed. The resident did not move her feet at all to assist with the transfer, her feet slid on the floor during the transfer.

Record review for resident #15 revealed a resident health assessment form 1823 that was dated . The health care provided noted the resident required total care with ambulation, bathing, dressing, toileting and transferring. The health care provider noted the resident was wheelchair bound.

On at 4 PM, the executive director and the administrator both said they had provided the resident with 3 discharge notices and she refused to leave.

Class III

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

Based on observations, record review, and interview, the facility failed to ensure the unlicensed staff who assisted a resident (#10) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #10 on at 10:55 am revealed staff F, an unlicensed caregiver, sanitized her hands and unlocked a cabinet located in the resident's . Staff F donned gloves and removed an old patch from the resident's left upper back. Staff F removed a new patch from its package and applied it to the resident's right upper back. Staff F then placed some pills into a medicine cup and handed the medicine with a cup of water to the resident, who took the medications without assistance.

Staff F did not read the prescription labels to resident #10, as required. Staff F confirmed that she did not read the prescription labels and said she did not know that she was required to read the label.

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Record review for resident #10 revealed she required assistance with self-administration of her medications.

Class III

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 1 of 2 sampled residents (#11).

Findings:

Record review for resident #11 revealed a health assessment form 1823 that was dated on . The form indicated resident #11 had a diagnosis of Advanced and he required medication administration.

Review of the 2017 MOR for resident #11 revealed an entry for Bag Balm ointment to be applied , , to his twice daily at 9 am and 5 pm.

For the 9 am application on 11/8 and , the MOR was not signed as being applied.

For the 5 pm application on 11/8, 11/9, , , , , , , , and , the MOR was not signed as being applied.

On at 4:30 pm, the administrator confirmed the findings and was unable to provide an explanation for the blanks.

Class III

**0082 - Training - / - 58A-5.0191(3) FAC**

Based on personnel record reviews and interviews, the facility failed to ensure that 1 of 6 direct care staff (#A) had completed a one-time education course on , / , , , , , ( / ) within 30 days of hire.

Findings:

Review of the personnel record for Staff #A, date of hire , did not reveal documentation of training in / as required within 30 days of hire.

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On at 4:05 PM, the administrator confirmed the training was not in the file and said she could not prove the training had been completed.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation and interview, the facility failed to maintain a sufficient supply of water for use in the event of an emergency.

Findings:

Observation of the emergency food and water storage revealed a supply of 152 gallons of water for use in the event of an emergency. There were 102 1-gallon jugs stored in boxes and 2 each of the 5-gallon jugs in the supply the Lakeside House. The dietary manager stated he had 8 more 5-gallon jugs in another area.

The facility had a census of 89 residents on the date of the survey. The requirement for 1 gallon of water per person times 3 days equals a need for a minimum of 267 gallons of water. The facility was short of the requirement by 115 gallons of water.

At 1:35 PM on , the dietary manger confirmed he did not have any more water on site and was planning to restock soon.

Class III

**0167 - Resident Contracts - 58A-5.025 FAC**

Based on record reviews and interview, the facility failed to ensure a resident contract contained all the required information for 1 of 2 resident contracts (#11).

Findings:

On at 9:45 am, the administrator identified resident #11 and said he received Extended Congregate Care (ECC) services for a feeding tube.

Review of the residency contract for resident #11 revealed it was dated on .

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The contract did not contain a list of ECC services that the resident elected to receive, as required.

On at 4:30 pm, the administrator confirmed the finding.

Class

**E205 - ECC - Health Assessment - 58A-5.030(6) FAC**

Based on record review and interview, the facility failed to ensure a new health assessment was obtained at least annually for a resident (#11) who received an Extended Congregate Care (ECC) service.

Findings:

On at 9:45 am, the administrator identified resident #11 and said he received ECC services for a feeding tube.

Record review for resident #11 revealed a health assessment form 1823, dated on that indicated he was admitted to ECC.

The record for resident #11 did not contain a new health assessment form 1823 for 2016 and 2017 to indicate a health care provider, as required, examined him.

On at 4:30 pm, the administrator confirmed the findings.

Class III

**E206 - ECC - Service Plans - 58A-5.030(7) FAC**

Based on record reviews and interview, the facility failed to ensure the service plan was reviewed and updated quarterly for a resident (#11) who received an Extended Congregate Care (ECC) service.

Findings:

On at 9:45 am, the administrator identified resident #11 and said he received ECC services for a feeding tube.

Review of the service plan for resident #11 revealed it was last updated on . There was no documented evidence to indicate the service plan was reviewed and updated quarterly, as required.

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On at 4:30 pm, the administrator confirmed the finding.

Class III

**Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC**

Based on personnel record review, Agency background screening website review, and interview, the facility failed maintain the eligibility results of employee screening in the employee's personnel file for 1 of 6 sampled staff (#B).

Findings:

Review of the personnel record for staff B, hired on , revealed a Level 2 background screening eligibility result dated for Staff B. There was no recent result available for review in the file.

Review of the Agency's website for Background screening results, revealed Staff B was eligible as of .

In an interview with the administrator on at 3:50 PM, she stated that did not know the results were not in the file. At 4:10 PM, she brought in a copy of the results that were printed on , the day of the survey.

Unclassified