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	AL11967815	**11/14/2017**
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
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0000 - Initial Comments

An unannounced Change of Ownership (CHOW) survey with Extended Congregate Care (ECC) services, and a Capacity Increase (56 to 97 beds) was conducted on 13-14, 2017 at The Brennity At Tradition (License #11796). There were deficiencies identified at the time of the survey.

Note: This survey was conducted in conjunction with Complaint investigations, CCR #2017010627 and CCR #2017013329, on the same dates. Please refer to the separate reports for the findings.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the facility failed to obtain written informed consent from the resident or resident representative relating to unlicensed staff providing assistance with self-administration with medications for 1 of 2 sampled Residents (#1).

The findings included:

Review of Resident #1's records conducted on revealed he was admitted to the facility on . Further review revealed no written informed consent (per Florida Statute 429.256) signed by the resident or resident representative advising that an assisted living facility is not required to have a licensed nurse on staff, and that the resident may be receiving assistance with self administration of medication from an unlicensed person (an individual not currently licensed to practice nursing or medicine, and has received training with respect to assisting with the self-administration of medication in an assisted living facility).

This was discussed with and acknowledged by the Administrator and Director of Nursing on 11/ at 3:00 PM.

Class III

0009 - Admissions - Admission Package - 58A-5.0181(3) FAC; 400.0078(2)

Based on record review and interview, the facility failed to provide a copy of the Resident's Bill of Rights to 1 of 2 sampled Residents (#1).

The findings included:

Review of Resident #1's records conducted on revealed he was admitted to the facility on . Further review revealed no documentation showing the resident or his representative received

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a copy of the Resident's Bill of Rights.

This was discussed with and acknowledged by the Administrator and Director of Nursing on 11/ at 3:00 PM.

Class III

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

Based on observations, interviews and record review, the facility failed to obtain the required AHCA Form 1823 (health assessment) and Interdisciplinary Care Plan for 1 of 2 sampled Residents (#1) when he began receiving hospice services.

The findings included:

Review of Resident #1's records conducted on revealed the following:

1. Resident #1 was admitted to the facility on . A health assessment dated documented diagnoses including with behaviors , history of , aphasia, , high , bowel and incontinence, non-ambulatory. He requires total assistance for ambulating, transfers, toileting, bathing, dressing, and .

2. He started receiving in-home hospice services on which represents a significant change in condition. Further record review revealed:

a. No documentation showing he received the required health assessment documented on AHCA Form 1823 which reflected his current health status, including hospice.

b. An undated [Hospice]/Assisted Living Facility Initial Collaborative Plan and the facility's personal service plan failed to identify the resident's individual needs. collaborative plan was not signed by facility staff to show consultation with the plan. No Interdisciplinary Care Plan, developed by hospice in consultation with the facility, which specifies services to be provided by hospice staff and services to be provided by assisted living facility staff, was located.

c. There was no Hospice Care Plan available for review.

Multiple requests for additional related documentation were made to Staff H, the full-time Licensed

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Practical Nurse, on . At 2:45 PM, Staff H stated there was no further information available. These concerns were discussed with and acknowledged by the Administrator and Director of Nursing on at 3:00 PM.

Class III

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

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who provide assistance with self-administration of medication maintained complete and accurate medication observation records (MOR) for 1 of 5 sampled Residents (#5).

The findings included:

Medication systems review of the facility's memory care unit conducted on and revealed the following concern related to Resident #5:

1. His 2017 MOR disclosed an entry for ophth sol 0.025% one drop daily at 9:00 AM. There was no instruction for which eye or both eyes.

2. A written Health Care Provider (HCP) order calling for , solution 0.025% one drop in both eyes daily at 9:00 AM.

3. The actual package has a label that reads, " eye sol instill one (1) drop both eyes".

This concern was discussed with Staff H, the Licensed Practical Nurse assigned to the memory care unit, on at 10:07 AM, and at 3:00 PM with the Administrator and Director of Nursing.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations, interviews and record review, the facility failed to dispose of expired resident medications for 1 of 5 sampled Residents (#5).

The findings included:

Medication systems review of the facility's memory care unit conducted on revealed the following concern related to Resident #5:

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1. A written Health Care Provider order and his . . . . . 2017 medication observation record (MOR) called for 220 (micrograms) 1 puff daily at bedtime, expires 45 days after opening. His current medication supply included a container of . . . . . , filled on . . . . . , with no "date opened" indicated on the box or container. His MOR was initialed to indicate he was still receiving this same medication 61 days after opening.

2. A written Health Care Provider order and his . . . . . 2017 medication observation record (MOR) called for Balmex (over-ther-counter skin barrier cream). Observation of the medication container revealed the medication had expired . . . . . 2014.

This concern was discussed with Staff H, the Licensed Practical Nurse assigned to the memory care unit, on at 10:07 AM, and at 3:00 PM with the Administrator and Director of Nursing.

Class III

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

Based on interviews and record review, the facility failed to ensure unlicensed staff who provide assistance with self-administration of medication followed written Health Care Provider (HCP) orders for 2 of 5 sampled Residents (#3 and #5).

The findings included:

Medication systems review of the facility's memory care unit conducted on and revealed the following concerns (photographic evidence obtained):

1. Resident #3 was admitted to the facility on . . . . . . Her AHCA Form 1823 (health assessment) dated documented she requires assistance with self-administration of medications. Review of her . . . . . 2017 medication observation record (MOR) revealed an entry that disclosed, "crush meds may crush all crushable Physician meds as indicated and mix in apple sauce". Her 2017 MOR also included entries for . . , . . . tablets, ... , . . tablets, ... , . . tablets and Avitan tablets.

In an interview conducted on at 2:17 PM, Staff H, the Licensed Practical Nurse assigned to the memory care unit, was asked and stated Medication Technicians (MT), unlicensed staff who assist residents with self-administration of medications, crush Resident #3's medications as needed.

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In interviews conducted on at 11:07 AM and 12:10 PM, two MT's stated either she crushes Resident #3's medication every time she assists Resident #3 with medications, or she sometimes crushes the medication unless she observes a do not crush order.

2. Resident #5 was admitted to the facility on . His AHCA Form 1823 (health assessment) dated documented he requires assistance with self-administration of medications. There was no written HCP order regarding crushing of medications. Observation of his medications and review of his 2017 MOR revealed the following concerns:

A. The medication prescription label disclosed, " 28 [milligrams (MG)]/10 MG Take 1 capsule by mouth daily". His 2017 MOR had a matching entry. There was no reference to "do not crush" on the label or the MOR. This medication is listed with the Institute for Safe Medication Practices (ISMP) as a medication that should not be crushed.

B. The medication prescription label disclosed, " , ER Suc Take 1 tablet by mouth every day". His 2017 MOR disclosed, " , Suc 50 MG ER *DNC* once daily". This medication is listed with the ISMP as a medication that should not be crushed. In an interview conducted on at 11:07, Staff C, a MT, was asked and stated she did not know what *DNC* meant.

C. The medication prescription label disclosed, " 60 MG Take 1 capsule every day." His 2017 MOR disclosed, " DR 60 MG capsule *D Delayed release 1 capsule every morning at 9:00 AM. This medication is listed with the ISMP as a medication that should not be crushed. The prescription label did not disclose the medication should not be crushed, and the related order on the MOR was not clear.

3. Observation of the pill crusher used for the memory care unit revealed it was excessively soiled.

These concerns were discussed with Staff H, the Licensed Practical Nurse assigned to the memory care unit, on at 10:07 AM, and at 3:00 PM with the Administrator and Director of Nursing.

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC

Based on record review and interviews, the facility failed to ensure the facility's Food Service Designee (FSD) obtained the required annual training in nutrition and food service in an assisted living facility. This has the potential to affect all 46 current residents of the facility.

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The findings included:

Review of the facility's dining and food service operations was conducted and . In an interview conducted on at 9:10 AM, the Food Service Manager was asked and stated he was the FSD and worked there for about 3 years. Review of his pertinent training records revealed no documentation showing he had received the required 2 hours of annual training in topics related to nutrition and food service in an assisted living facility, provided by either a Certified Food Manager, Licensed Dietitian, Registered Dietary Technician, or a Health Department Sanitarian.

This concern was discussed with the Facility Director and FSD on at 12:58 PM , and at 1:42 PM with the facility's Resident Supervisor. All confirmed there was no further documentation available for review at this time.

Class III

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

Based on observations, interviews and record review, the facility failed to obtain and follow Dietitian-approved modifications for menus, and does not maintain the required regular and therapeutic diets as required. This has the ability to affect any residents receiving modified diets at the facility.

The findings included:

Observations of dining services during lunch meals in the facility's memory care unit were conducted on and . Multiple residents were observed eating or receiving assistance to eat pureed meals.

Review of the facility's Dietitian-approved menus revealed the following concerns:

1. There was no documentation showing the facility received menus including modifications to textures for residents who receive special diets such as puree.

2. There was no documentation showing the facility maintained copies of regular and therapeutic diets for at least 6 months.

These concerns were discussed with the facility's Culinary Director on at 10:05 AM, and with the Administrator and Director of nursing at 3:00 PM.

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Class III

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

Based on record review and an interview, the facility failed to ensure 1 out of 2 sampled residents (Resident #11), who received Extended Congregate Care (ECC) services, had a health assessment (AHCA Form 1823) completed annually.

The findings included:

On , Resident #11's last health assessment dated was reviewed. The resident began receiving ECC services on . There were no subsequent health assessments completed for this resident.

During interview with the Administrator on 11/ , she confirmed that the resident had not had an annual health assessment completed as required for residents who receive ECC services. The facility provided no additonal documentation for review at this time.

Class III