STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969133	**12/06/2017**
NAME OF PROVIDER OR SUPPLIER **BRILLIANCE LIVING CORPORATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **699 N DIXIE FREEWAY** **NEW SMYRNA BEACH, FL 32168**	

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

0000 - Initial Comments

An unannounced Complaint Survey (CCR #2017009851) was conducted from to at Brilliance Living Corporation (License #12974). The facility had licensure deficiencies at the time of the visit.

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

Based on observation, record review, and staff interview, the facility failed to have unlicensed staff assist with self-administered medications in accordance with procedures described in Section 429.256 , F.S. for 1 of 2 sampled residents, Residents #2 and #3.

The findings include:

1. On at 9:00 a.m. , Employee C, and unlicensed staff member, was observed assistinig Resident #2 with her medications. Employee C removed all the medications from their containers, placed them in a paper medication cup and brought them to the resident's . Employee C handed the medications to Resident #2 and told her "here are your medications". Employee C did not read the label in the presence of the resident.

2. On at 9:30 a.m., Employee C was observed assisting Resident #3 with medication administration for Resident # 3. Employee C removed medications from their packages, placed them in a medication cup and brought them to the resident's . She also brought an eye drop (- 0.07%) and gel for the resident. The nurse gave the medications to the resident, put an eye drop in the resident's left eye and rubbed the gel to the resident's right shoulder. Employee C did not remove the medications in the presence of the resident and read the label.

Record review for Resident #3 revealed the 2017 Medication Observation Record (MOR) had another eye drop (Durazol) that was to be instilled in the resident's left eye at 9 a.m. and this was not observed to be given. Durazol is used to treat eye pain and caused by eye surgery.

Employee C on at 9:40 a.m. confirmed she did not remove the medication and read the label in the presence when assisting with medication administration for Residents #2 & #3. She confirmed she did not give the Durazol eye drop to Resident #3.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and staff interview, the facility failed to have an indication for use for "as needed" medications for Residents # 2 & 3, 2 of 3 sampled residents.

The findings include:

Record review for Resident #2 revealed the 2017 Medication Observation Record (MOR) had a medication 1 mg, take one tablet by mouth once a day as needed (PRN). There was no indication for use for the medication.

Employee C, an unlicensed staff member, was interviewed on at 11:00 a.m. She confirmed there was no indication for use for Resident #2's Bumetadine and she would not know when to give it or what it was given for.

Record review for Resident #3 revealed the 2017 MOR had a line for , . Instructions were to apply to daily as needed (PRN). It did not have an indication for use, or parameters for how many timesa day it could be given.

Employee A, a Licensed Practical Nurse, was interviewed on at 12:45 p.m. She confirmed the , did not have an indication for use and there was unlicensed staff who assist with medication.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and staff interview, the facility failed to ensure that over the counter(OTC) medications were labeled appropriately for 1 of 3 sampled residents, Resident #1.

The findings include:

On at 8:33 a.m., Employee A, a Licensed Practical Nurse was observed to pass medications to Resident #1. Employee A opened the medication cart and removed an over the counter bottle of Bayer , to give the resident one of them. The bottle of Bayer , did not have the name of the resident on it.

Employee A on at 8:33 a.m. confirmed the resident's name was not on the Bayer , . She stated the family brings in the , and no one labeled it correctly.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, record review and staff interview, the facility failed to maintain a safe environment free of hazards for 1 of 6 sampled residents, Residents #1.

The findings include:

On at 8:35 a.m., an observation was made in the Memory Care Unit (MCU). There was an unsupervised maintenance cart located in the hallway . On this cart was a bottle of Triple D: Universal Coil Cleaner. Resident #1 was in her close proximity to the maintenance cart . Employee A, a Licensed Practical Nurse on at 8:35 a.m. confirmed there was an unattended maintenance cart with cleaner on it. She stated that Resident #1 could freely ambulate by herself in the MCU and this cleaner could be a danger to her. Employee A stated that Employee B, a Certified Nursing Assistant should be in this Unit but she could not be located. Employee A went outside of the MCU and found Employee B and asked her to remove the maintenance cart.

Record Review of Resident #1 revealed a diagnosis of , was independent with ambulation, and possibly requires 24-hour nursing or , care.

Employee B on at 9:48 a.m. stated she did leave the MCU briefly and was in the nursing office and confirmed no one was in the MCU to watch the 2 residents in there. She stated she just gave a shower to one of the residents and was documenting it.

An Interview with the Administrator was conducted on 11/ at 9:50 a.m. She stated it is their policy that at least one staff member remain in the Memory Care unit at all times while residents are in there. She stated Employee B was assigned to this Unit and should not have left the MCU without someone else going in.

On at 10:16 a.m., Employee B stated she was never told that she could not leave residents alone in the MCU.

Employee D, a contracted vendor in Heating, and Air conditioning was interviewed on at 9:55 a.m. He stated it was his maintenance cart in the MCU. He stated he was not told anything about leaving his equipment/cleaning agents unsupervised in the MCU.

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The Administrator on at 11:05 a.m. stated that who ever let Employee D into the MCU should have have told him not to leave chemicals (coil cleaner) unsupervised.

Employee D on at 11:20 a.m. stated that the Coil Cleaner on his maintenance cart would not be safe to ingest. The label on the Coil Cleaner lists "Causes severe skin and eye damage"

Class III