STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966697	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENNITY AT VERO BEACH(THE)	**7975 17 LANE VERO BEACH, FL 32966**

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR# 2018004010, was conducted on at Brennity At Vero Beach (The), License # 10830. The facility had deficiencies at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, it was determined the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility; specifically related to following physician's orders for , for 1 of 3 sampled residents (Resident #3).

The findings include:

During interview and record review conducted with the ED (Executive Director); Healthcare Administrator; and LPN (Licensed Practical Nurse) from Mangrove Circle (Memory Care Unit), on beginning at approximately 2:45 PM, the following concerns were identified. Resident#3's EMAR (Electronic Medication Administration Record) Summaries for , 2018 through 2018 had many omissions for the application of , cream (apply 1/4 inch thick layer to affected area on every 2 hours when repositioning). The dates in , 2018 that reflected omissions are as follows: 12, 13, 14, 15, 17, 19, 20, 24, 27, 29, and 31. The dated in , 2018 that reflected omissions are as follows: 3, 4, 5, 7, 9, 10, 13, 15, 16, 21, 22, 23, 24, and 26. The dates in 2018 that reflected omissions are as follows: 2, 4, 5, 6, 9, 14, 15, 16, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, and 31. The ED acknowledged there were no notations related to these omissions on the EMAR Summaries for , 2018 through 2018. The ED also acknowledged that during the above noted time frame (, 2018 through 2018) Resident #3 had the following , :

1) right lower ( )
2) , ( )
3) right post edge of foot ( )

The ED acknowledged there was a physician/ARNP's order, dated , that reflected , ointment 1/4" layer every 2 hours to with repositioning and that the EMAR documentation does not reflect this was conducted per physician/ARNP order.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966697	05/30/2018
NAME OF PROVIDER OR SUPPLIER **BRENNITY AT VERO BEACH(THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **7975 17 LANE** **VERO BEACH, FL 32966**	

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

Based on interviews and record review, it was determined the facility failed to treat each resident with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy for 1 of 3 sampled residents (Resident #3). The facility based on interview and record review, also failed to follow their written grievance procedure for receiving and responding to resident complaints and the facility was not able to demonstrate that their procedure was implemented upon receipt of a complaint.

The findings include:

1) During interview conducted with Rehab Director and PTA (Physical , Assistant), on at approximately 12:45 PM, they were asked if they remembered any occurrences of a resident coming to , without pants. The Rehab Director and the PTA acknowledged that Resident #3 had received , without pants one time a couple of months ago. They were asked if Resident #3 was brought to , without pants on or did one of the , bring her, from her , to , without pants on. The PTA stated she was the individual that brought Resident #3 to the , her pants, but that she was covered with a blanket when she was transported. She stated this resident was out of clean clothes and that she (the PTA) thought it was important for Resident #3 not to miss a , treatment session. They were asked if they thought bringing a resident to , without pants on was a dignified manner for this resident to be treated. The PTA stated she was covered up for transport and she thought it was more important not to miss a treatment session. The Rehab Director and this PTA acknowledged Resident #3 resides in Memory Care Unit.

2) During entrance conference conducted with the ED (Executive Director) and the Healthcare Administrator, on beginning at approximately 9:10 AM, they were asked for a copy of the facility's grievance logs from - . The ED stated there were no grievance logs or forms prior to her starting in this position (approximately 2 months ago). She stated she just addresses concerns brought up at the monthly Resident Council meetings and then she writes a letter to the participants regarding follow up of any expressed concerns/grievances.

This facility's Grievance Policy was provided for review by the ED. This policy reflected when a grievance has been submitted, the ED or Regional Director of Operations will follow the grievance procedure and will document what action, i.e., contact with family, dates of contact, action plan, etc. they took in response to the grievance. Any corresponding grievance should be maintained in the ED's binder with the original copy of the grievance report.

During review of Resident #3's record and interview conducted with the ED, on beginning at approximately 3:00 PM, she was informed that on there was a notation that reflected the

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SUMMARY STATEMENT OF DEFICIENCIES
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Healthcare Administrator and ED called Resident #3's daughter and left a message to schedule a sit down meeting to better understand her concerns for her mother and if the facility can meet her expectations and Mom's needs. The ED acknowledged there was no grievance form completed or any other documentation to reflect what theses concerns are or the status of resolution of concerns. On there was a notation in Resident #3's record related to the facility not following physician's orders for checking on her mother every 2 hours. No documentation related to status of expressed concern located.

Class III