STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967587	01/30/2019
NAME OF PROVIDER OR SUPPLIER **BRENNITY AT MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **7365 ORCHESTRA LN** **MELBOURNE, FL 32940**	

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

0000 - Initial Comments

A Complaint investigation #2018016375 was conducted on . The Brennity at Melbourne license #11595 had deficiencies found at the time of the visit.

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

Based on record reviews and interviews the facility failed to ensure it provided care and services appropriate to the needs of 1 of 3 sampled residents (#3) and did not follow a healthcare provider's orders for 2 medications with parameters and assessments for .

Findings:

Resident record review for resident #3 revealed a health assessment report dated listed diagnoses pf , high . She needed assistance with bathing, grooming, toileting, ambulation and transfers .A assistance was needed with medications. The heath assessment listed 0.1 mg every 6 hours as needed PRN) for , ( ) greater than 160. 20 mg one daily PRN. A Physician's Order Sheet (POS) dated indicated 0.1 mg every 6 hours PRN for greater than 160 and 20 mg one daily PRN for , hold if was less than 100.

The Medication Observation Record (MOR) dated , and listed 20 mg one daily PRN, hold if was less than 100 and were all blank for those months.

The MOR listed 0.1 mg every 6 hours PRN for greater than 160 and 20 mg one daily PRN, hold if was less than 100 and were blank from to in AM .

There was no evidence to confirm the resident's , was taken by a licensed nurse to determine if the resident's was greater than 160 and needed to take . There was no evidence the resident was assessed for to determine if she needed to take and if her was less than 100 and there was , then the needed to be held.

In an interview on at 1:30 PM with the administrator, who said she was not able to document any additional information.

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Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interview the facility failed to ensure the unlicensed staff (A) who assisted 2 of 2 residents (#2 and #14) with self-administration of medications followed the correct procedure.

Findings:

Observation during the medication pass on at 10:20 AM noted unlicensed staff B (med tech), assisted resident #1 with self-administration of medications in the following manner:

She checked the Medication Observation Record (MOR), retrieved medications from medication cart; poured 1 pill in a cup and signed the MOR. She completed the process in same manner for 4 medications the resident was to take. She took the cup with the pills and water to resident. She told the resident "Your medications", and handed her the cup. She then told the resident "I forgot to tell you. This is omepazole, , , and cranberry".

Continued observations of the medication pass on at 10:30 AM noted staff A checked the MOR , retrieved medications from the medication cart, poured 1 pill in a cup and signed the MOR. She completed the process in same manner for all medications for resident # 2. She took the cup with the pills and water to resident and told the resident "I got your morning meds. Here you go".

In an interview on at 32 PM with the administrator who said the staff will be spoken to.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on interview and record review the facility failed to ensure 1 of 7 unlicensed staff (B) who assisted residents with self- administration of medications completed a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility.

Findings:

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The administrator identified 7 unlicensed staff who assisted residents with self-administration of medications. She provided the training certificates regarding medications for all 7 staff .
The review revealed that staff B attended 4 hours of training regarding the provision of assistance with self-administration of medication in an assisted living on and she completed 2 hour of in-service training on . There was no evidence she attended an in-service training in 2019.

In an interview on at 1:30 PM with the administrator, who said the staff needed to take a class.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observations and interview, the facility did not: 1. Develop and implement written policies and procedures to ensure the assisted living facility could effectively and immediately activate operate and maintain the alternate power source to include procedures to address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury. 2. Failed to notify in writing, unless permission for electronic communication was granted, each resident and the resident's legal representative within five (5) business days that: 1. the emergency power plan was submitted to the local emergency management agency for review and approval and 2. Upon final implementation of the plan by the assisted living facility.

Findings:

During review of the facility's emergency power plan on the administrator stated that she was unable to locate documentation that the facility notified residents and or responsible parties when the emergency power plan was submitted to the local emergency management agency for review and approval or upon final implementation of the plan by the assisted living facility. She was unable to locate policies and procedures related to the emergency power plan. She added that she had recently became the facility's administrator,

There were no policies and procedures that addressed the care of residents occupying the facility during a declared state of emergency, methods to be used to mitigate the potential for heat related injury: the use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; wellness checks by staff to monitor for signs of and heat injury; and a provision for obtaining medical intervention from emergency services

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for residents whose life safety is in jeopardy.

Class III