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	AL11967587	**04/04/2019**
NAME OF PROVIDER OR SUPPLIER **BRENNITY AT MELBOURNE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **7365 ORCHESTRA LN** **MELBOURNE, FL 32940**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

A Change of Ownership survey including Extended Congregate Care was conducted on . The Brennity at Melbourne Assisted Living Facility, License #11595 had deficiencies at the time of the survey.

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

Based on observations, record reviews, and interviews, the facility failed to follow a health care provider's medication order for 2 of 8 sampled residents (#10 and 16).

Findings:

1. Resident #10's record revealed a facility admission date of . Her current 1823 health assessment form, dated , indicated that she had a history of a , and she required assistance with self-administration of medications.

A health care provider's order, dated , instructed the facility to give 2 milligrams today only however, documentation on her Medication Observation Record (MOR) revealed the medication was signed as given on .

A facility progress note, dated at 6:16 p.m. indicated that her doctor ordered for her to receive 2 mg extra today only and the medication would be given upon its arrival from the pharmacy on the evening of . The record did not contain documentation to indicate the facility contacted the health care provider to obtain permission to give the on rather than , as was prescribed.

In addition, her MOR contained an entry for 5 mg by daily and was not signed as given on , , , , and .

On at 2:45 p.m. the resident services director confirmed the findings.

2. Observations made during a medication pass for resident #16 on at 12:43 p.m. revealed caregiver E unlocked the medication cart, removed a prescription box, entered the resident's room, and said "I'm going to give you your , ." She removed a bottle of , Ultra , from the box. The resident held each , open and the caregiver placed one drop into each , .

The entry on her , MOR, dated , indicated that she was to receive , Ultra , .

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drops, instill 4 drops in both , four times a day. The caregiver confirmed she only administered one drop in each .

Resident #16's current 1823, dated , indicated that she required assistance with self-administration of medications.

Photographic evidence obtained.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on record review and interview, the facility failed to honor resident rights and did not give 1 of 8 sampled residents (#10) consideration by notifying them in writing when the facility ownership changed pursuant to 429.12(1) Florida Statue and did not obtain consent for the use of half-bed rails for 1 of 6 sampled residents (#7) who could not remove the rails without assistance.

Findings:

1. The facility's provisional license following a CHOW was effective on .

On at 11:23 a.m. resident #10 said she was not aware the facility had a change of ownership. A request was made to review the documentation to indicate resident #10 was informed of the CHOW.

At 1:42 p.m. the executive director provided a letter that he said was mailed to resident #10 however, the letter was returned as undeliverable as addressed. The letter was sent to another facility. The director confirmed the findings and said since the letter was returned, the resident did not receive the required notification.

Photographic evidence obtained.
2. Observations on at 11 AM, revealed resident #7 was in bed with the half rails up on each side of her bed, resident 7 said the staff assisted her with the rails.

Review of the hospice record for resident #7 revealed there was an order for the half-bed rails that was dated .

Review of the resident's record and hospice record revealed there was no written consent for the use of

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the half-bed rails from the resident or her representative.

On at 2 PM the resident service director said the resident had just received the bed with the rails on and the facility had not obtained the written consent for the use of the half-bed rails from the resident or her representative.

Class III

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

Based on observations, record reviews, and interview, the facility failed to ensure the unlicensed caregiver (E) who assisted a resident (#16) with self-administered medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #16 on at 12:43 p.m. revealed caregiver E unlocked the medication cart, removed a prescription box, entered the resident's room, and said "I'm going to give you your ." She removed a bottle of Ultra from the box. The resident held each open and the caregiver placed one drop into each .

Caregiver E did not read the prescription label aloud, as required.

At 12:55 p.m. the caregiver confirmed she did not read the prescription label aloud.

Resident #16's current 1823, dated , indicated that she required assistance with self-administration of medications.

Class III

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

Based on observations, record reviews, and interview, the facility failed to centrally store a medication for a resident (#9) who received assistance with self-administration of medications.

Findings:

Observations made on at 10:40 a.m. in the secured memory care unit revealed a bottle of

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- , Solution was on a night stand next to resident #9's bed. Her room door was unlocked. She said she used the drops twice a day or as often as she remembered. The expiration date on the bottle was . The memory care director was present, confirmed the findings, and said the facility provided medication assistance to the resident.

The resident's current 1823 health assessment form, dated , indicated that she had forgetfulness and she required assistance with self-administration of medications. Her current medication list did not contain an order for the .

Photographic evidence obtained.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and interview, the facility failed to ensure that 5 of 5 sampled staff (A, B, C, D, and E) completed training as required in Statute 58A-5.0191 ( ) FAC.

Findings:

1. Review of the personnel record for staff B (caregiver, hired) did not reveal any documentation for training regarding the facility's policies and procedures for recognizing and reporting and neglect.

On at 4:30PM, the administrator confirmed the findings.
2. Personnel record review for staff A, a care giver hired revealed an online training titled and elopement essentials that was dated . Staff C the administrator hired revealed an online training titled preventing and responding to elopement that was dated .
There was no documentation for confirm they had received the in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.

3. Review of the personnel record review for staff C, the administrator, revealed she had no documentation to confirm she had received an in-service training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

On at 3:30 PM, the human resource director confirmed the findings.

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4. Nurse D was hired on . Her personnel record did not contain a statement, signed by the administrator and employee, to indicate she completed a preservice orientation of at least 2 hours, as required.

On at 4:05 p.m. the human resource director confirmed the findings.

5. Caregiver E was hired on . Her personnel record contained a 2 hour preservice orientation certificate of completion, dated . However, the certificate was not signed by the employee, as required.

At 5 p.m., the resident services director confirmed the findings and said she wrote the employee's name on the certificate.

Photographic evidence obtained.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on personnel record review and interview, the facility failed to ensure 1 of 5 direct care staff (B) received 4 hours of and Related (ADRD) continuing education annually.

Findings:

Review of the personnel record for staff B (caregiver, hired) revealed a certificate for 's training, level 1 dated and a certificate for 's training level 2 dated . Continued review did not reveal any certificates for the 4 hour annual 's training updates as required.

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

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the facility failed to ensure that 2 of 5 sampled staff (B, C) had completed the required in-service training in the facility's policies' and procedures regarding ( ) within 30 days of hire.

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Findings:

1. Review of the personnel record for staff B (caregiver, hired) did not reveal any documentation for training regarding the facility's policies and procedures regarding .

2. Personnel record review for staff C, the administrator hired revealed there was documentation in her record to confirm she had received a one hour training in the facility's policies and procedures.

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

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 2 of 4 sampled staff (A and B).

Findings:

1. Personnel record review for staff A, a caregiver hired in revealed there was certificate for both dated that did not have the number of hours of the training programs listed.
.
2. Review of the personnel record for staff B (caregiver, hired) did not reveal documentation for training regarding the facility's policies and procedures for 1)elopement, 2) emergency procedures including evacuation and chain of command, 3) nutrition and safe food handling or 4) incident reporting. A certificate dated was reviewed. The certificate had a table of various training classes, including those mentioned above, on the reverse side. None of the classes were circled, date, or initialed as having been done. There was no way to know which, if any, of the classes were completed.

Photographic evidence obtained

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

Class III

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

Based on dietary record review and interview, the facility failed to maintain a copy of the dietician's Florida license, for the dietician who reviewed and signed the menus used in the facility.

Findings:

Review of the facility menu revealed an outside, online company was used to provide menus for the facility. The menu was signed on by a registered dietician. A copy of the dietician's Florida license was not available for review.

On at 2:30PM, the dietary manager stated he checked with the company and his corporate office and confirmed he was unable to provide a copy of the license.

Class

0160 - Records - Facility - 58A-5.024(1) FAC

Based on review of county health department reports and interview, the facility failed to have evidence of an annual health department inspection report.

Findings:

Review of facility records revealed the group care county health department report was dated (due).

On at 11:30 AM, the executive director confirmed the findings.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 5 sampled staff (D) contained a copy of the employment application.

Findings:

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Nurse D was hired on . Her personnel record did not contain an employment application, as required.

On at 4 p.m. the human resource director confirmed the findings.

Class

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review, contract review and interview, the facility failed to obtain for 2 of 8 sampled residents (#7 and 10) who received assistance with the supervision of self-administered medications from unlicensed staff, a signed informed consent form that indicated whether the unlicensed staff would or would not be supervised by a nurse and did not record semi-annually for 2 of 8 sampled residents (#7 and #10) who required assistance with Activities of Daily Living and did not obtain a health care provider order for an Extended Congregate Care Services (ECC) for 1 of 8 sampled ECC residents (#7).

Findings:

On resident #7 was identified as receiving hospice services by the Resident Service Director. The resident service director stated there was only one resident who received ECC services and that was resident #10.

1. Record review for resident #7 revealed a resident health assessment form (AHCA form 1823) that was dated . The health care provider noted she required assistance with bathing, grooming, toileting, transfers and ambulation and that she required assistance with the self-administration of her medications. Further record review for resident #7 including the review of her contract revealed there was no documentation to confirm that the resident or her representative was inform that unlicensed staff assisted with the self-administration of medication and whether the unlicensed staff would or would not be overseen by a nurse. In addition there was not no record found.

Review of the hospice record revealed an interdisciplinary plan of care revision/physician order dated that was signed by the hospice nurse Admit to ECC for the order noted the resident was to have 2 liters of as needed for mild , 3 liter of as needed for moderate and 4 liters of for severe .

There was not a copy of the order that was signed by the health care provider in the file.

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On at 1 PM, the administrator confirmed there was no signed informed consent form for resident #7.

On at 3 PM, the resident service director said she could not locate any for the resident and was not aware there was an order from hospice to admit resident #7 to ECC, because she was not employed by the facility at that time.

2. Resident #10's record revealed a facility admission date of . Her current 1823, dated , indicated that she required assistance with self-administration of medications and assistance with ADLs.

Her record contained recorded only on and .

At 2:30 p.m. the administrator said she was unable to provide additional recorded .

In addition, her record nor her residency agreement contained a written informed consent for unlicensed staff to assist her with medications, as required.

On at 3:18 p.m. the administrator confirmed the finding and was unable to provide additional documentation.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on contract review and interview, the facility failed to ensure a residency contract contained all of the required information for 1 of 2 sampled residents' contracts reviewed (#7)

Findings:

Review of the contracts dated for resident #7 , revealed her contract did not contain a provision per 429.24(3)(a) that indicated that if after a contract was terminated, the facility intended to make a claim against a refund due the resident, the facility must notify the resident or responsible party in writing of the claim and must provide the said party a reasonable time period of no less than 14 calendar days to respond and a provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.

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On at 2 PM, the administrator confirmed the findings.

Class

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on facility record review and interview, the facility had a change of ownership and did not have evidence of an approved emergency environmental control plan from the local emergency management agency.

Findings:

Review of the facility's provisional license revealed there was a Change of Ownership on .

On at 11:30 AM, the administrator said the emergency environmental control plan with addendums of the new staff was submitted for approval. She said the facility had not received the approval from the local emergency management agency.

Class III

E205 - ECC - Health Assessment - 58A-5.030(5) FAC429.07 (3)(b)6., FS

Based on record review and interview, the facility failed to obtain a medical examination from a health care provider for 1 of 2 sampled residents (#7) who received Extended Congregate care service (ECC).

Findings:

Observations on at 11 AM, resident #7 was observed in bed wearing a for .
Record review for resident #7 revealed a resident health assessment form (AHCA form 1823) that was dated . The health care provider noted she required assistance with bathing, grooming, toileting, transfers and ambulation and that she required assistance with the self-administrator of her medications.

Review of the hospice record revealed an interdisciplinary plan of care revision/physician order dated that was signed by the hospice nurse Admit to ECC for the order noted the resident was to have 2 liters of as needed for mild , 3 liter of as needed for moderate and 4 liters of for severe .

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On at 3 PM, the resident service director said there was not a new health assessment for completed for resident #7 because she was not aware there was an order from hospice to admit resident #7 to ECC because she was not employed by the facility at that time.

Class III

E206 - ECC - Service Plans - 58A-5.030(6) FAC

Based on record reviews and interviews, the facility failed to develop a preliminary service plan that included an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs and within 14 days of receiving services coordinate the development of a written service plan that takes into account the resident's health assessment, the resident's unique physical, and social needs and preferences, and how the facility will meet the resident's needs for 1 of 2 sampled residents (#7) who received an Extended Congregate Care (ECC) service and failed to ensure an ECC service plan was developed and agreed upon by the resident or the resident's representative for 1 of 2 sampled residents (#10.)

Findings:

On at 10 a.m. nurse D, who was also the facility's ECC supervisor, identified resident #10 and said she received ECC for Lymphedema wraps.

The resident's ECC service plan, dated , did not contain the signature and date of the resident or her representative to indicate the plan was developed and agreed upon by the resident. The resident's record did not contain documentation elsewhere to indicate the requirement was met.

Photographic evidence obtained.

At 2:45 p.m. nurse D confirmed the findings.
2. On at 10 AM, resident #7 was identified as receiving hospice services by the Resident Service Director. The resident service director said there was only one resident who received ECC services and that was resident #10.

Observations on at 11 AM, resident #7 was observed in bed wearing a for .

Review of the hospice record revealed an interdisciplinary plan of care revision/physician order dated

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that was signed by the hospice nurse Admit to ECC for the order noted the resident was to have 2 liters of as needed for mild , 3 liter of as needed for moderate and 4 liters of for severe .

Record review for resident #7 revealed there was no preliminary service completed and nor within 14 days of receiving the ECC service did the administrator or manager coordinate the development of a written service plan.

On at 3 PM, the resident service director said she was not aware there was an order from hospice to admit resident #7 to ECC because she was not employed by the facility at that time.

Class III

E207 - ECC - Services - 58A-5.030(7) FAC

Based on record reviews and interviews, the facility failed to ensure the Extended Congregate Care (ECC) nursing progress notes for 1 of 2 sampled residents (#10) contained all of the required information, failed to ensure ECC nursing progress notes were maintained for 1 of 2 sampled residents (#7) who received an ECC service, and failed to ensure a nursing assessment was conducted at least monthly for 2 of 2 sampled residents (#7 and #10.)

Findings:

On at 10 a.m. nurse D, who was also the facility's ECC supervisor, identified resident #10 and said she received ECC for Lymphedema wraps.

Resident #10's nursing progress notes did not consistently describe the outcome of services that were rendered and the general status of the resident's health, as required.

In addition, her record did not contain documented evidence to indicate a nursing assessment was conducted in .

At 2:45 p.m. nurse D confirmed the findings and was unable to provide additional documentation.

Photographic evidence obtained.
2. On resident #7 was identified as receiving hospice services by the Resident Service Director. The resident service director said there was only one resident who received ECC services and that was

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resident #10.

Observations on at 11 AM, resident #7 was observed in bed wearing a for .

Review of the hospice record revealed an interdisciplinary plan of care revision/physician order dated that was signed by the hospice nurse Admit to ECC for the order noted the resident was to have 2 liters of as needed for mild , 3 liter of as needed for moderate and 4 liters of for severe .

Record review for resident #7 revealed there was no nursing progress notes available for each time the nursing service was provided nor was there a monthly nursing assessment of the resident conducted.

On at 3 PM, the resident service director said she was not aware there was an order from hospice to admit resident #7 to ECC because she was not employed by the facility at that time.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on personnel record reviews and interview, the facility failed to ensure 1 of 5 personnel records (D) contained An Attestation of Compliance with Background Screening Requirements.

Findings:

Nurse D was hired on . Her personnel record did not contain an attestation of compliance with background screening requirements.

On at 4:05 p.m. the human resource director confirmed the findings.

Unclassified