STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967815	05/22/2019
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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Change Of Ownership (CHOW) with Extended Congregate Care (ECC) survey was conducted on through at The Brennity At Tradition, License #11796. The facility had deficiencies at the time of the visit.

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

Based on record review and an interview, the facility failed to maintain a plan of care developed and implemented with hospice for 1 out of 2 sampled residents (Resident #12).

The findings included:

During review of Resident #12's file on , there was no plan of care developed and implemented with hospice located. The LPN (Licensed Practical Nurse) was interviewed at this time, and stated that the plan of care had not been received by hospice. She contacted hospice, requested the plan of care, and received a faxed plan for review and implementation.
The plan of care should be developed with hospice, in consultation with the facility, and should specify the services being provided by hospice and those being provided by the facility.
These findings were acknowledged by the Administrator during interview on at 12:30 PM.
The facility provided no additional documentation for review at this time.

Class III

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

Based on observation and interviews, the facility failed to failed to provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication.

The findings included:

On at 9:30 AM, during tour of the secured unit, there was an , phone observed in a private room for residents' use. The Administrator stated during interview on at 11:00 AM that this phone was not used and in working order. On at 10:00 AM, the LPN (Licensed Practical Nurse) stated that there is only one resident who uses the phone in the secured unit, and this resident uses the phone in the nurses' area. She stated that the corded phone is provided to the resident at the nurses' desk when the resident uses it. This phone did not allow residents to have

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private, unrestricted communication, and to receive unidentified calls.

Class III

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

Based on observation, interview and record review, the facility failed to ensure that all staff assist residents with self-administered medications in accordance with proper state regulatory procedures for 1 out of 2 sampled residents reviewed for medications (Resident #1).

The findings included:

While observing a medication pass between the times of 11:45 AM-1:00 PM with Staff A on , it was observed that 0.63 ML vials nebulizing solution medication was stored in Resident #1's storage closet unlocked. During this time, the Caregiver was present in the room with Resident #1 and stated on between the times of 11:45 AM and 1:00 PM, that I requested for the storage to stay unlocked because I cannot get inside of it to give her (Resident #1) the in the late afternoon. Observations of the electronic Medication Observation Record (MOR) for Resident #1 revealed that the Resident is to receive the nebulizing solution three times a day from facility staff.

During an interview with Staff A during this time (11:45 AM-1:00 PM) on regarding who assist Resident #1 it was stated I am not sure because I leave at 3:30 PM. The Caregiver than stated that I give her the treatment because waiting on the staff to come in and give it to her she will never get it. Staff D was unable to answer if the medication was given multiple times by the caregiver and the facility staff or if the facility staff is allowing the caregiver to assist with the self-administration of medication process and signing the MOR for medications that they did not give or observe.

Interview with Resident #1 on between the times of 11:45 AM and 1:00 PM confirmed that the Caregiver does assist her with the medication in the evening and afternoon.

During an interview with the Administrator on at 11:55 AM regarding the nebulizing treatments and the storage of the medication, it was stated that Resident #1's family declines the right for Resident #1 to do her own medication. The Administrator was informed of the Caregiver assisting with the medications, and that the facility staff in the evening has been signing for medications that has not been given. The findings were further discussed and acknowledged, no additional information was provided for review.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

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

Based on observation, interview, and record review, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication are filled or re-filled in a timely manner, for 1 out of 3 (Resident #5) sampled records reviewed.

The findings included:

Interview with Resident #5 and Resident #5's family on at 2:00 PM revealed that Resident #5 has been missing two of her medications for 5 days and that every month there is a problem when it is time for them to be re-filled and sent to the facility from the pharmacy. It was stated by the family of Resident #5 that I have told the Administrator, and the same thing happened every month. At 2:22 PM on , the Administrator was informed.

During an additional interview with the Administrator on at 11:55 PM, it was stated that I have multiple residents that are on over the counter medications provided by family or caregivers, and they use multiple pharmacies. It was stated that I know that it has been given sometimes when they sign off on it and when I am told it had been delivered. It was further stated that I am currently working on the whole medication system. During this time the findings were discussed and acknowledged, no further information was provided for review

Class III