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List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - E204 - 58a-5.030(5) Fac - Ecc - Admissions & Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility Change of Ownership (CHOW) with Extended Congregrate Care (ECC) survey was conducted on . . . . . and . The Brennity at Port Saint Lucie, had licensure deficiencies found at the time of the visit.

Note: The Complaint Inspections #2013003157 and #2013003185 were conducted in conjunction with the CHOW licensure survey. Please refer to the separate report.

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

Based on observation, interview, and record review, it was determined the facility did not ensure each resident received medications in a safe manner and that is considered appropriate health care consistent with established and recognized standards within the community, specifically related to handwashing techniques and medication handling techniques, for 5 of 5 sampled residents observed during medication observations (Residents #21, #22, #23, #24, and #25).

The findings include:

1) During observation of medication administration with the Memory Care Unit LPN (Licensed

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medications to Residents #21, #22, and #23. She was not observed to wash or sanitize hands prior to, during, or after all resident contacts. She was observed to apply 1 glove to the right hand during these observations.

2) During observation of the unlicensed staff member providing assistance with the self-administration of medications, on beginning at approximately 9:40 AM, she was observed to provide assistance with medications for Resident #24. She entered the resident's was observed to briefly wash and rinse her hands for 5 seconds. She dried her hands and applied gloves (to both hands). She was observed to remove and dispose of her gloves and then briefly rinse her hands with water (only) for approximately 5 seconds.

3) During observation of the unlicensed staff member providing assistance with the self-administration of medications, on beginning at approximately 9:55 AM, she was observed to provide assistance with medications for Resident #25. She entered the resident's was observed to briefly wash and rinse her hands for 5 seconds. She dried her hands and applied gloves (to both hands). She was observed to remove and dispose of her gloves and then briefly rinse her hands with water (only) for approximately 5 seconds.

4) During observation of medication administration with the Memory Care Unit LPN, on at approximately 9:08 AM, she was observed to mix this resident's medications with applesauce and obtain a plastic spoon. She then proceeded to provide spoonfuls of medication/applesauce mixture into the Resident #22's mouth. In between mouthfuls of mixture the LPN would sit the container of the medication/applesauce mixture on the floor next to the resident's wheelchair while she provided this resident with sips of water.

Review of the facility's policy related to Hand Hygiene for all Healthcare Workers (version 2013), that was provided by the Assisted Living Director, indicated that the purpose is to prevent transmission of microorganisms from patient to patient and from inanimate surface to patients by the hands of all healthcare workers. The policy indicates "hand hygiene shall be practiced before and after each patient contact (even if gloves are worn)". The section entitled Routine Handwashing Procedure reflects:
-Use warm water to wet the hands
-Apply soap (containing
-Work up good lather
-Apply vigorous contact on all surfaces of the hands
-Wash hands for at least 15 seconds
-Rinse, avoid splashing...

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During interview with the Assisted Living Director, conducted on [redacted] at approximately 11:10 AM, the above noted concerns were discussed. She acknowledged staff are to wash/sanitize hands prior to resident contact including providing assistance with medications. She acknowledged the LPN sitting the partially consumed mixture of medications and applesauce on the floor was not an acceptable practice.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, interview, and record review, it was determined the facility did not ensure medications were administered appropriately, for 8 out of 8 sampled residents receiving [redacted] and 1 of 2 residents receiving a stool softener (Residents #21, #23, #24, #26, #30, #31, #32, and #33).

The findings include:

1) During medication observation with the Memory Care LPN (Licensed Practical Nurse), conducted on [redacted] beginning at approximately 8:30 AM, she explained that it is this facility's policy that all [redacted] be provided by a nurse and not an unlicensed staff member trained to assist with self-administration of medications. She then proceeded to open the top drawer of a rolling [redacted] cart and remove 8 individual small plastic medication dispensing cups that were stacked on top of each other. These containers were labeled in black writing with the first names of 8 residents. The following residents were identified as having a container with their [redacted] medication in this stack: Residents #21, #23, #24, #26, #30, #31, #32, and #33. (Two pictures were taken of these cups in the presence of the Memory Care LPN). She was asked, why these 8 residents medications were prepared in advance of administering to each resident. She replied, "It saves time, so multiple trips do not have to be made back to the medication [redacted] obtain [redacted] throughout the medication pass". This Memory Care LPN was asked to explain the procedure for providing these [redacted] to residents. She stated the supply cart/F[redacted] cart (which she acknowledged does not contain a locking mechanism) is taken by the Nurse down the hallways to the resident [redacted], where all of the resident other medications are maintained. She explained that each residents other medications (not [redacted] are kept in a locked cabinet in the resident's individual [redacted] artment.

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She stated that she would normally have these prepared medications in the (unlocked) rolling cart and would administer as per physician's order. She stated since the discussion that this practice is not acceptable, that she will keep the individually marked medication cups in the medication [illegible] that she will come back and forth to administer. She also stated she was not aware that she could not prepare resident's medications in advance and stack one on top of another for administration.

2) During observation of medication administration conducted with the Memory Care LPN, on [illegible] beginning at approximately 9:25 AM, she was observed to obtain and provide the AM medications for Resident #23. The [illegible] 2013 MOR (Medication Observation Record) and the label of the [illegible] 100mg capsule indicated to take this medication with 6-8 ounces of water. The Memory Care LPN was observed to have this resident take a couple of sips of bottled water in order to swallow all of her medications.

During interview with the Assisted Living Director, conducted on [illegible] at approximately 11:10 AM, the above noted concerns were reviewed. She stated she was not aware medications were being pre-poured (prepared in advance) and that this is an unacceptable practice.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, interview, and record review, it was determined the facility failed to maintain a daily MOR (Medication Observation Record) for each resident who receives assistance with the self-administration of medications, specifically related to site rotation of a [illegible] patch, for 1 out of 5 residents during medication observation conducted (Resident #25).

The findings include:

During observation of the direct care staff that was providing assistance with the self-administration of medications on the Memory Care Unit, on [illegible] beginning at approximately 9:55 AM, she was observed applying an [illegible] patch 9.5mg/24 hour to right upper shoulder blade area of Resident #25. She then searched for the "old" patch in order to remove it. She could not find the "old" patch and stated sometimes this resident removes them. At this time the MOR (Medication Observation Record) was reviewed with this staff member and she was asked why a check mark is placed in the daily box that indicates site for the patch. She stated, "she did not know". She was asked how the facility tracks the site rotation of this patch for Resident #25. She stated she was not aware this needed to be done.

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During subsequent interview and record review with the Memory Care LPN (Licensed Practical Nurse),

conducted on [redacted] at approximately 10:50 AM, she acknowledged that the MOR contained an area to note the site the [redacted] patch is applied and that staff do not complete this section correctly as they place a check mark in this area. She acknowledged that the instruction on the box of [redacted] patches for Resident #25 indicated "alternating the application area with each change". She acknowledged that the MOR should be completed and the sites should be rotated for the patch so as not to cause irritation to the application sites.

Class III

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

Based on observation, interview, and record review it was determined the facility failed to dispose of expired medications within 30 days, for 2 out of 4 sampled residents whose medications had expired or been discontinued and were located in the medication [redacted] medication cart (Resident #27 & Resident #28).

The findings include:

During observation of the medication [redacted] medication cart on the Memory Care Unit, conducted with the Memory Care LPN (Licensed Practical Nurse), on [redacted] at approximately 1:05 PM, there were 2 bingo cards of [redacted] that were wrapped individually with a [redacted] count sheet that was located in the locked compartment of the current medication cart. The Memory Care Unit LPN identified these medications as expired medications. She explained that they were to be returned to the pharmacy and that they were kept in the locked [redacted] drawer until they were to be returned. The following bingo cards and [redacted] count sheets were observed:

Resident #27: [redacted] 5/500 tablets; label indicated this medication expired on [redacted]; the last dose noted as provided on the [redacted] count sheet was [redacted] The Memory Care Unit LPN acknowledged this was 12 days past the expiration date.

Resident #28: [redacted] 15mg caps; the label indicated this medication expired on [redacted] the last dose noted as provided on the [redacted] count sheet was [redacted] The Memory Care Unit LPN acknowledged this was 5 months past the expiration date.

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This Memory Care Unit LPN was asked at this time, why these expired medications were not disposed of within the 30 day required timeframe. She could not provide an explanation.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on interview and record review it was determined the facility failed to obtain a physician's order prior to the discontinuation of a physician prescribed medication, for 1 out of 13 sampled residents reviewed related to medications (Resident #29).

The findings include:

During interview and record review conducted with the Assisted Living Director, on ..... at approximately 1:30 PM, the 2013 MOR (Medication Observation Record) for Resident #29 was reviewed. This MOR reflected the last dose of 40mg to be provided daily at 5:00 PM was provided on ..... The Assisted Living Director was provided the opportunity to locate a physician's order discontinuing the use of this medication. She was unable to locate this discontinuation order. The Assisted Living Director located an interdisciplinary progress note, dated ..... at 3:50 PM, that reflected "Resident has not been getting ..... as pharmacy felt they did not have a valid order. Fax original signed 1823 which listed to pharmacy". She explained this must be why Resident #29 had not been given the ..... She was asked to locate any documentation to reflect a follow up with pharmacy or physician or a clarification order related to this medication. She was unable to locate this documentation.

Class III

0086-Training - ADRD 58A-5.0191(9) FAC
Based on record review and an interview, the facility failed to ensure that 1 out of 3 sampled staff (Staff B) who have regular contact with or provide direct care to residents with ADRD and Related in this facility that maintained a secured area had obtained 4 hours of initial training Level 1) within 3 months of employment.

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The findings include:

The personnel file for Staff B was reviewed for training in ADRD and did not contain documentation of 4 hours of training in ADRD dated within the required timeframe. The following training was documented and available for review:

Staff B-Date of Hire
Level I and Level II completed prior to hire on
One hour of training completed after hire (not Level I or II)

During interview with the Administrator at approximately 11:30 AM on she acknowledged the staff member did not have documentation of Level I (4 hours) completed within 3 months of hire and did not have documentation of continuing education on an annual basis (4 hours in ADRD) since

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC
Based on record review and interviews, the facility failed to ensure the person designated by the administrator as responsible for total food services and the day to day supervision of food service staff had made this designation in writing and/or had training with adequate documentation of credentials; and, failed to ensure therapeutic diets were served as ordered, for 3 of 12 sampled residents (Residents #1, #2 and #4).

The findings include:

a) On at 10 AM, the administrator was asked to provide documentation of the required annual training (2 hours in nutrition in an ALF) for the person in charge of food services. She and the Executive Director identified this person during interview at this time as Staff E, "Executive Chef". During interview with Staff E on at 10:30 AM, he acknowledged he was in charge of overall food service for the ALF but was unable to show the required training aforementioned conducted by a qualified trainer (Certified Food Manager, Licensed Dietician, Registered Dietary Technician or Health Department Sanitarian).

At approximately 2 PM on a consultant was interviewed and stated he was a "Certified Food Manager" and had completed the required training for the Administrator, not for the person identified

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as in charge of overall food service. There was no written designation of Staff E's position found in facility records. A certificate for the Administrator dated within the previous year was reviewed with the consultant's signature, hours of training and subject of training documented but did not have documentation of any of the above listed credentials. During interview with the Administrator at 2:30 PM on she stated she was the person in charge of food service and would obtain the credentials noted above from the trainer.

b) On at 12 PM, Resident #2 and #4 were observed eating lunch, both with whole chicken quesadillas on their plates (not cut in pieces). A server was asked at this time if they were on a special diet and she said "yes" and showed the facility's list of residents' diets, indicating these residents' "current diet order" was "mechanical soft". When asked how staff ensure the residents receive this type of diet, she stated, "we cut the food up". She then walked over to Resident #4 and cut her quesadilla into bite size pieces. Review of the diet order dated for Resident #2 documented she was on a "mechanical soft" diet. Review of the health assessment (Form 1823) dated and a diet slip signed by a speech language pathologist dated indicated Resident #4 was to receive a "mechanical soft diet, cut up into bite size pieces".

These findings were discussed with the Administrator at approximately 2:30 PM on

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations, record review and interviews, the facility failed to ensure planned menus (at least one week in advance) were posted or easily available to residents; failed to document substitutions at the time of or before the meal (on approved menu) was served; and, failed to document 1 out of 12 resident's (Resident #1) refusal to comply with a therapeutic diet order and notify the resident's health care provider of such refusal and obtain a signed statement from the resident or resident's representative refusing the diet.

The findings include:

a) During tour of the facility and main dining area on from 9 AM to 1 PM, a week long planned and approved menu was not located. A list of items available for lunch only was left on each table for residents to choose from. A limited list of entrees only was observed posted in the main dining , indicating "manicotti" was the entree for lunch on this day. Additionally, "Week 2" of the cycle menu approved by the dietician was posted in the secured unit on this date (Week 4 was the

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correct menu). These findings were discussed with the executive chef at 10:05 AM on .

b) On . at 10:05 AM, the Chef acknowledged during interview that the hot dog, manicotti and chicken quesadillas with rice and green beans served for lunch on were not listed on the Week 4 cycle menu approved by the Dietician. The approved menu indicated the residents were to receive ravioli, zucchini, bread and assorted fruits and desserts. There was no documentation of the substitutions available for review at this time. The chef acknowledged there was no documentation of the substituted lunch items.

c) On . at 12:43 PM, Resident #1 was interviewed after observation of her lunch, which included grilled cheese and a fruit cup as well as a regular chocolate chip cookie for dessert. Another resident at the table stated, "all she eats is grilled cheese for lunch and dinner every day". Resident #1 responded, "I can eat what I want". The server and line cook were interviewed at 12:50 PM and acknowledged the resident was automatically served the aforementioned, as this is "what she wants". Review of the resident's record and the facility's "diet order list" showed the resident was on a low low fat, no added salt diet. A diet order dated signed by the resident services director and a LPN (licensed practical nurse) documented the same. During interview with the Administrator on at 12 PM, she confirmed there was no documentation of the resident's (or her representative) refusal to adhere to the diet order or notification to the health care provider of her refusals.

d) During observation of the menu posted on the memory care unit, on at approximately 12:00 PM, this menu noted it was the week 2 cycle menu and the following items were noted to be served:

baked potato soup - 6 oz

Grilled Monte Cristo sandwich (3 oz on 2)

sliced tomatoes (4 oz)

assorted fruit and desserts (1 serving)

choice of milk (8 oz)

water (8 oz)

crackers x2

During observation of the 2 dining on the Memory Care Unit (the independent and the assisted dining on , beginning at approximately 12:05 PM, residents were noted to have

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received a glass of water; a glass of milk; and a tan colored bean soup. After the residents consumed their soup, they were provided with a 1/2 chicken quesadilla; salsa; yellow rice; mixed vegetables; and mixed green salad.

During interview with the Assisted Living Director and the Memory Care Unit LPN, conducted on at approximately 12:45 PM, they acknowledged the residents were served an entirely different menu than what was posted on this unit. The Assisted Living Director stated she would check into it.

During interview and record review with the Culinary Director, conducted on at approximately 10:05 AM, revealed he had obtained copies of the menu from another property. He stated we used the week 4 of the menu that we had for lunch on He stated he did not know where the menu that was posted on the Memory Care Unit had come from, but that it was the wrong menu that was posted on that unit.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on interview and record review it was determined this facility failed to ensure that each resident receiving hospice services has an interdisciplinary care plan that was developed by facility staff and hospice, for 2 of 2 sample residents receiving hospice services (Resident #26 and Resident #30).

The findings include:

1) During review of Resident #26's medical record an integrated plan of care with hospice could not be located. During interview and record review with the Memory Care Unit LPN (Licensed Practical Nurse) and the Assisted Living Director, conducted on at approximately 12:40 PM, they both acknowledged the facility did not have an integrated plan of care with hospice that delineates hospice staff and facility staff responsibilities for the provision of care and services for Resident #26.

During interview with the hospice RN (Registered Nurse), conducted on beginning at approximately 9:45 AM, she was asked to locate an integrated plan of care for Resident #26. She provided for review a document that reflects a meeting of the hospice care team related to this resident's care. She was asked about documentation that delineates hospice staff and facility staff responsibilities for the provision of care and services for Resident #26. She acknowledged there is not one for this resident.

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2) During record review and interview conducted with the hospice RN, on [redacted] beginning at approximately 9:45 AM, Resident #30's chart was reviewed for an integrated care plan between the facility and hospice. The hospice RN stated that she did not have aforementioned documentation and that she is not aware of one that the facility developed. She acknowledged that she had not participated in the development of an integrated care plan for hospice with facility staff.

During subsequent interview with the Memory Care Unit LPN, conducted on [redacted] beginning at approximately 2:25 PM, she was asked to locate an integrated plan of care between hospice and the facility that describes what care and services hospice is to provide and what care and services the facility staff is to provide for Resident #30. She stated she was not aware this type of documentation was required.

Class III

E204-ECC - Admissions & Continued Residency 58A-5.030(5) FAC
Based on interview and record review, it was determined the facility failed to assess 1 out of 2 sampled residents for continued residency that are receiving hospice services, as the facility did not develop an interdisciplinary plan of care and implemented this plan of care in consultation with hospice for a resident with multiple unstageable [redacted] (Resident #26).

The findings include:

The Memory Care Unit LPN (Licensed Practical Nurse) stated during interview and record review, conducted on [redacted] at 9:25 AM, that Resident #26 has a couple of [redacted] and she proceeded to gesture to hip and bottom area. She stated that hospice is providing treatment for these areas. The interdisciplinary progress note, dated [redacted] reflected "resident's bandage was soiled and needed to be changed on the left hip. Used [redacted] solution to clean that was provided as well as the ointment. Covered with non-stick bandage and secured with surgical paper tape". (This note was signed by another facility LPN).

During entrance conference conducted with the Assisted Living Director, at 8:30 AM on [redacted] with the AHCA Team Coordinator, she was asked to identify all residents that have [redacted] in this facility. She informed the Team Coordinator that there were no residents with [redacted] at this time. However, during exit conference conducted with the Assisted Living Director on [redacted] beginning at approximately 4:00 PM, she was informed Resident #26 had multiple unstageable pressure

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that hospice is treating and that one of the facility LPNs provided treatment for on She stated she was not aware of any

During record review and interview, conducted with the hospice RN (Registered Nurse), on beginning at 9:45 AM, she was asked to provide information related to Resident #26's and and integrated plan of care for this resident. She acknowledged there was not an integrated plan of care developed with facility staff. She stated the left hip is unstageable; has eschar (is a or piece of tissue that is off from the surface of the skin); is foul smelling; and measures approximately 3cm X 4cm. She stated the right hip is a is a area; and only preventative measures are being taken at this time. She stated the upper back area is unstageable and measures approximately 2.5cm X 3cm. During review of Resident #26's medical record, the hospice RN acknowledged the last note related to this resident's was dated She stated they are in the process of going computerized and it takes too long to print the notes on site. She stated she will have the hospice office fax more current information to the facility and place it on the chart for review.

Review of hospice certification, with start of care noted as indicated life expectancy of less than 6 months if follows usual course. diagnosis was noted as

The hospice "general note", dated (that had to be faxed from the hospice office on and put in the chart), reflected an interdisciplinary case conference among hospice staff (only) took place. This documentation indicated dressings to left hip and back with large amount of (containing, discharging, or causing production of pus) drainage. Foul smelling. Wounds irrigated and dressing done as ordered. No signs/symptoms of distress during dressing change. Family had refused treatment previously stating that is not what patient would have wanted. Patient continues with poor appetite and increased

During interview with the Memory Care Unit LPN, conducted on at approximately 10:00 AM, she stated that she was not aware of the size, location, or severity of Resident #26's wounds until yesterday when she had the opportunity to observe them with the hospice RN.

The hospice RN (Registered Nurse) comprehensive visit, dated (that had to be faxed from hospice office on and put in the chart), was reviewed with the hospice RN on beginning at approximately 11:00 AM. This RN stated that Resident #26 was just placed on "crisis care" this morning and that constitutes 24 hour hospice presence with this resident. The RN

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

comprehensive visit, noted above, was reviewed related to the management of this resident. This RN had previously stated that 2 of this resident's wounds were "unstageable". The left hip was noted as follows: moderate-large drainage (saturates dressing); drainage is (yellow/tan) to (thick/green/foul); non-viable tissue present; and care provided to include Magsorb packing material. The right hip was noted as follows: discolored (brown) area; and dressing of Optifoam gentle was applied. The upper back was noted as follows: measuring 3.25 X 4 (does not indicate type of measurement); moderate and (yellow/tan) drainage; non-viable tissue noted; and dressing noted to include packing with Magsorb AG and Optifoam dressing.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Brennity At Port St Lucie (The)
10685 SW Stoney Creek Way
Port Saint Lucie, FL 34987

Re: Change of Ownership (CHOW)

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2013 by a representative from this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **. 2013** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

for Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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