RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Brentwood at Fore Ranch
4511 SW 48th Avenue
Ocala, FL 34474

RE: CCR #2014008918 & 2014010364

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 by a representative of this office.

Enclosed 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 ***2014*** 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 surveyor. Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kristen J. Mennella
Field Office Manager

KJM/amw
Enclosure

Alachua Field Office
14101 N W Hwy 441, Suite 800
Alachua, FL 32615-5669
Phone:(386) 462-6201; Fax:(386) 418-5300
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin 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 - E205 - 58a-5.030(6) Fac - Ecc - Health Assessment S-S= D
St - A - E206 - 58a-5.030(7) Fac - Ecc - Service Plans S-S= D
St - A - E210 - 58a-5.0191(7) Fac - Ecc - Training S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Extended Congregate Care Monitoring Survey, and Complaint Surveys CCR #2014010364, and CCR #2014008918 were conducted at Brentwood at Fore Ranch Senior Living Community on 27 - 28, 2014 in Ocala, Florida. Licensure deficiencies were identified as a result of the survey. The facility was not in compliance with 58A-5, FAC and Chapter 429, Part I, FS.

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, interview, and record review the facility failed to ensure medications were not mixed, and control policy and procedures were followed for medication assistance for 2 of 2 sampled residents, Resident #5 and #23.

Findings:

1) An observation conducted on at 9:09 AM of Staff G, Licensed Practical Nurse (LPN) showed the LPN had been working at the computer and looking at residents ' charts. The LPN then went to the medication cart to prepare medications Resident #5. Three medication cups were used to hold the various medications and each medication cup was set on the medication cart. The medication cart was observed to have stain marks, and small black flecks of debris on the top of the cart. The LPN put one medication cup on top of the other containing the resident ' s pills and took the medications the resident's The medications were provided to the resident, and the resident took the medications.

An observation conducted on at 9:23 AM of Staff G, LPN showed the LPN did not wash her hands, and did not apply gloves. The LPN took the eye drops from the box for Resident #5, instructed the resident to lean back, pulled down at the bottom of the resident ' s right eye and instilled one drop of medicine into the resident's right eye, and then repeated the same action for the resident's left eye. The LPN returned the eye drop bottle back into the container. The LPN did not wash her hands, and exited the resident's The LPN put the eye drop container back into the medication cart.

2) An observation conducted on at 9:29 AM of Staff G, LPN showed the LPN did not wash her hands. The LPN prepared the medications for Resident #23 which included two creams in their boxes. The LPN took the medications and a glass of water to the resident ' s

An observation conducted on at 9:42 AM showed the LPN did not wash her hands and put on gloves. The LPN removed Cream, (a medications used for reducing itching, redness, and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	

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

associated with many skin conditions) from the box, applied the cream to her left gloved hand and rubbed the cream unto the resident's arms using her left and right hands. The LPN took the tube of cream with her gloved right hand and returned it to the container. At 9:43 AM the LPN did not remove the gloves, and applied cream, (a medication used to treat fungal to the resident's legs using both gloved hands, and returned the tube to the container using her gloved hands. The nurse removed the gloves, and held them in her left hand. The nurse threw out the used water glass into the resident's waste basket under his sink; continued to carry the used gloves out of the resident ' s disposed of the used gloves into the medication cart ' s waste basket, and returned the boxes containing the creams to the medication cart. The LPN did not wash her hands.

An interview was conducted on at 9:46 AM with Staff G, LPN and she stated the medication cups that were placed on top of the medication cart should not have been put inside of each other with Resident #5 ' s pills in them. When this surveyor asked the LPN about washing her hands prior to the medication pass, the LPN stated that she didn't wash her hands because she wasn ' t going to be touching the pills with her hands. The LPN verified she did not use gloves or wash her hands prior to or after instilling eye drops into Resident #5 ' s eyes. The LPN stated she did not wash her hands prior to putting gloves on before applying the cream to Resident #23's arms, and did not remove the gloves, wash her hands, or apply clean gloves to apply the cream to Resident #23's legs. The LPN confirmed the two creams would be mixed together and there could be more cream applied then ordered to the resident's legs, and she did not know if that was safe or not to do. She verified she did not wash her hands before or after removing her gloves.

Record review of the Control-Hand Washing-Community/Staff Policy and Procedures showed all personnel shall wash their hands to prevent the spread of and to other residents, personnel and visitors. Appropriate ten to 15 second hand washing must be performed under the following conditions: Before preparing or handling of medications, and after contact with Eye Drop Administration: Wash your hands thoroughly with soap and water. Ensure to wash your hands in between applications. Skin Medication Administration: Wash your hands thoroughly with soap and water

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview the facility failed to ensure medications was secure.

Findings:

An observation conducted on at 9:29 AM of Staff G, Licensed Practical Nurse (LPN) showed the LPN unlocked the medication cart to start preparing medications for a resident. The LPN opened the second draw, then walked away from the medication cart 12 feet into the nurses' station. The cart was left unlocked, with the draw open, and unattended.

An interview was conducted on at 9:46 AM with Staff G, LPN and she stated I shouldn't have walked away from the medication cart while it was unlocked.

Class III

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	

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

Based on interview, and record review the facility failed to ensure physician's orders were being written for (a medications used to prevent , and clots in veins and , that was being given as ordered, and labs were being completed as ordered by the physician to monitor the effectiveness of for 2 of 3 sampled residents, Residents #18 and #20.

Findings:

1) Record review of the medical record for Resident #18 showed the Resident has a diagnosis of (the most common type of irregular rhythm which increases the risk of and failure).

Record review of the physician ' s orders for Resident #18 showed dated 4 mg Friday, Saturday, and Sunday. Repeat INR (International ratio, used to monitor the effectiveness of on Monday.

Record review of the Medication Observation Record) MOR for Resident #18 showed 3 mg was administered on Friday, and Sunday . The order was for 4 mg to be administered. was not administered on Saturday .

Record review of the result of the INR for Monday, showed a lab could not be located in the resident ' s medical record.

An interview was conducted on at 4:12 PM with Staff G, Licensed Practical Nurse (LPN) and she stated she was not able to find lab results for the resident on for an INR that was ordered for , she stated she called the lab and they don ' t have a record of an INR being done, or requested to be done on .

Record review of the MOR showed the resident did not receive on and was given 3 mg on . The resident did not receive on or .

An interview was conducted on at 4:18 PM with Staff G, LPN and a request was made to view the order for 3 mg that was given on . The LPN stated she couldn ' t find an order for 3 mg to be given on .

Record review of the lab results for the INR dated showed an order was written to start 4 mg by mouth every day.

Record review of the lab results for the INR dated showed the INR was 4.9, (the result is high, and above the therapeutic range).

Record review of the MOR dated showed 4 mg was administered at 5:49 PM even though the results were above the therapeutic range.

An interview was conducted on at 4:24 PM with Stagg G, LPN and she stated by the time I saw the lab, and I text the Advanced Registered Nurse Practitioner (ARNP); the had already been administered. When this surveyor showed the LPN the lab results were faxed to the facility on at 1:22 PM, and the was not administered until 5:49 PM. The LPN stated, "I was probably out to lunch". The LPN further stated she is not at the desk all the time, I became busy, and when I saw it I text the ARNP, and let her know the had been given already. She said to hold the for today, and tomorrow; repeat an INR on

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	

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

When this surveyor asked what system is in place to prevent from being administered on days when labs are due until the results are known, the LPN shrugged her shoulders and did not respond to the question. A request was made by this surveyor to view the order received from the ARNP. The LPN stated she wrote the information in the nurses' notes, and she felt that was good enough. The Director of Nursing (DON) was present during the interview and asked the LPN why this was not an order. The LPN did not respond. The DON stated you signed that you wrote the information in the nurses ' note, " Where is the doctor supposed to sign stating the order was given". The LPN stated, "I guess they wouldn't".

An interview was conducted on at 5:22 PM with the DON and he stated there is no system in place to track INRs. The DON further verified that the was not administered as ordered, an order was not written for 3 mg to be given on , and INR labs were not done as ordered by the physician for Resident #18.

An interview was conducted on at 4:21 PM via telephone with the ARNP and she stated she was not aware that Resident #18 only received 3 mg of on and , and no on . She further stated she was not aware the resident didn't receive on and , and that the ordered INR for had not been completed. The ARNP stated she did not give an order for 3 mg to be administered on . The ARNP was aware that the resident's INR on was 4.9 and that 4 mg had already been given by the time she was notified. I asked the nurse how this could have been happened. Don't they know they should not give until they know the results of the INR, and call it to me or the doctor? They have no system in place there. I have told them that can't be administered on days when INRs have been ordered until they call the results in to me. I just don't understand what they are doing. This resident's INRs have been all over the place. This is why. I am not aware of what they are doing, they are not telling me. Something has to be done about this. This is very scary. This resident could definitely be harmed by this. I need to rely on them to do their job, and they are not doing it. This just cannot happen, this is very serious.

Review of the Nurses' Notes for the period of through showed there was no entry as to why the INR was not completed on .

2) Record review of the medical record for Resident #20 showed the resident has a diagnosis of .

Record review of physician's orders dated Continue current dosage. Repeat INR in one week.

Record review of the result of the INR for Monday, showed a lab could not be located in the resident's medical record.

An interview was conducted on at 3:37 PM with Staff H, LPN/Clinical Coordinator and she stated the INR was not redrawn on as ordered by the physician on . The LPN called the Lab and stated to this surveyor that the lab verified an INR was not done on .

Review of the Nurses' Notes for the period of through showed there was no entry as to why the INR was not completed on as ordered.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	10/16/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

E205-ECC - Health Assessment 58A-5.030(6) FAC

Based on interview and record review the facility failed to ensure annual health care assessments were completed for 1 of 2 sampled residents, Resident #2 receiving Extended Congregate Care, (ECC).

Findings:

Record review of Resident #2's medical record showed Resident #2 was admitted to ECC on for assistance with continuous positive airway pressure, (used to treat sleep -pauses in breathing) equipment. The record further showed an annual assessment was not completed.

An interview was conducted on at 3:02 PM with Staff G, LPN and she stated verification that an annual assessment had not been completed for Resident #2.

Class III

E206-ECC - Service Plans 58A-5.030(7) FAC

Based on interview and record review the facility failed to ensure service plans for residents receiving Extended Congregate Care were being updated quarterly for 1 of 2 sampled residents, Resident #2.

Findings:

Record review of Resident #2's medical record showed Resident #2 was admitted to ECC on for assistance with continuous positive airway pressure, (used to treat sleep -pauses in breathing) equipment. The record further showed the service plan was last updated on

An interview was conducted on at 2:28 PM with the DON and he stated verification that the quarterly service plan was not up to date for Resident #2.

Class III

E210-ECC - Training 58A-5.0191(7) FAC

Based on interview and record review the facility failed to ensure Extended Congregate Care (ECC) Training was completed by 1 of 3 sampled staff, Staff G.

Findings:

Record review of Staff G's employment file showed Staff G was hired on , and proof of Extended Congregate Care Training was not located in the file.

An interview was conducted on at 5:14 PM with the DON, and he stated verification that the employee file for Staff G, LPN did not contain proof of ECC training having been completed.

An interview was conducted on at 5:16 PM with Staff G, LPN and she stated did not have ECC training.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	**10/16/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Brentwood At Fore Ranch	**4511 Sw 48th Ave Ocala, FL 34474**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on interview and record review the facility failed to ensure eligible level II background screens were completed for 1 of 3 sampled staff, Staff B.

Findings:

Record review of the employee file for Staff B, Certified Nursing Assistant (CNA) showed Staff B was hired on . Review of the Level II Background Screen dated showed Status: Agency Review Required.

An interview was conducted on at 5:22 PM with the DON and he stated that he was not aware of the status of agency review required for the Level II background screen for Staff B.

Unclassified