STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	09/28/2015
NAME OF PROVIDER OR SUPPLIER RESIDENCES OF BRANDON MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1819 PROVIDENCE RIDGE BLVD. BRANDON, FL 33511	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A Complaint Investigation, CCR# 2015007104, was conducted on .

. Residences of Brandon Memory Care, Assisted living Facility, had a deficiency found at the time of the visit.

0081 Training - Staff In-Service

Based on interview and record review, the facility failed to ensure that employees received in-service training concerning Recognizing and Reporting Resident , Neglect, and (training) within 30 days of employment for 1(Staff I) of 3 employee records reviewed.

Findings Include:

According to the employee's record, Staff I, a licensed practical nurse, began employment at the facility on . A review of her record shows a certificate for training conducted on . It is required that staff that providing direct care to residents must receive training within 30 days of employment.

A follow-up phone interview with Staff A at 1:51 P.M. on / / confirmed that the facility did not provide the required training within 30 days of employment.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Residences Of Brandon Memory Care
1819 Providence Ridge Blvd.
Brandon, FL 33511

RE: CCR #2015007104

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

FD/

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
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PRC/clt
Enclosure: State (5000-3547) Form