STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	**10/25/2017**
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

On , an off-hours complaint investigation, (CCR# 2017009184), was completed at , Residences of Brandon Memory Care, Assisted Living Facility. Deficient practice was identified at the time of the visit.

(License # 9739)

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on observation, record review, and interview, the facility did not complete the required preliminary adverse incident report within one business day and did not complete the required full adverse incident report within 15 days for three (Resident #3, #4, and #5) of three residents reviewed.

Findings included:

During the facility tour on at 4:20 PM, the surveyor observed Resident #4 in a common dining area. Resident #4 was observed to have her right arm in a sling. The surveyor observed Resident #5 at this time as well. Resident #5 was observed to be reclined in a recliner in a common area with his eyes closed. Resident #5 was observed to have to the left side of the resident's face and neck. Resident #5 was also observed to have a near his left eye.

A review of nursing notes for Resident #4 revealed that on at 11:45 PM, a facility nurse found the resident on the floor of her on her right side. The nurse noted that Resident #4 was from her right eye and was complaining of right arm pain. Resident #4 was emergently transferred to a local hospital for treatment. A review of the hospital notes for Resident #4 revealed that Resident #4 was admitted to the local hospital from to for treatment of a right (upper arm bone) and a nasal bone .

A review of the nursing notes for Resident #5 revealed that on and , Resident #5 was transferred to a local acute care hospital for treatment of incidents occurring on and . A nursing note from documented that Resident #5 observed on the floor near his bed with

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on his face and a to his head. Resident #5 was emergently transferred to a local hospital. Resident #5 returned to the facility at 3:00 AM with five staples repairing a laceration to Resident #5's right forehead. On at 7:00 AM, Resident #5 was observed by the nurse laying on the floor in front of a recliner with the left side of his face down. The nurse observed to Resident #5's left eyebrow and noted that Resident #5 was complaining of pain. Resident #5 was again emergently transferred to a local hospital due to the incident.

A review of the nursing notes for Resident #3 revealed that on , Resident #3 was observed by the nurse to have a laceration to her right leg. The nurse documented in her note that Resident #3 had a very deep with skin hanging from the . The nursing notes documented that Resident #3 was transferred to a local hospital for treatment. A review of the hospital notes for Resident #3 revealed that on Resident #3 presented with a 10cm laceration to the right vertical ankle with exposed. Resident #3 required 16 to repair the laceration.

A record review for Residents #3, #4, and #5 revealed that there were no adverse incident reports completed by the facility for the above incidents.

On at 8:58 PM, the Director of Nursing (DON) confirmed that the facility did not complete any adverse incident reporting for the above incidents for Residents #3, #4, and #5. The DON stated that the facility policy was to report incidents to the facility's regional director and the regional director would tell them if an adverse incident report needed to be completed.

Class III