STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968282	**01/16/2018**
NAME OF PROVIDER OR SUPPLIER **BRENTWOOD AT FORE RANCH**	STREET ADDRESS, CITY, STATE, ZIP CODE **4511 SW 48TH AVE** **OCALA, FL 34474**	

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

0000 - Initial Comments

On , an unannounced complaint investigation (CCR#2017013756) was conducted at Brentwood at Fore Ranch Assisted Living Facility (License #12234). Deficient practice was identified at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to maintain a written record of any change in condition that required medical attention for 1 of 3 residents reviewed (Resident #1).

Findings:

On at 12:55 p.m., an interview was conducted with the son of Resident #1. The son stated on during the evening hours, the son was having a phone conversation with his father when his father began slurring his words. The son stated he was unable to make contact with the facility which lead him to call emergency personnel to the facility to assess his father.

On at 11:00 a.m., a record review was conducted for Resident #1. No documentation found in chart noting change in condition, presence, or nursing assessment.. A progress note, dated by the nurse practioner indicated the complaint for the visit was "Nurse reports patient with slurred speech on the phone with the family last night. called and reportedly by the time they came, that resolved."

In an interview with Staff B, LPN of the assisted living facility on at 11:15 a.m., Staff B confirmed no documentation was present in the chart collaborating the nurse practioner's statement concerning the visit on . Staff B confirmed symptoms should be documented in resident's chart. Review of staff schedule indicated nurse on duty at the time of the event on was Staff I.

In an interview with Staff H, LPN of the memory care, on at 11:30 a.m., Staff H stated that she was not at the facility on the night in on , but her expectations would be if resident experienced those reported symptoms and was notified, there should be documentation in the resident's chart concerning the event.

In an interview with Staff I on at 12:56 p.m., Staff I stated she began working at the facility . She stated she was on orientation under a former employee on that date and does not recall the incident.

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In an interview with Staff J on [redacted] at 3:20 p.m., Staff J confirmed that [redacted] arrived at the facility on [redacted] to assess the Resident #1. Staff J stated that Resident #1 was not removed from the facility. Staff J stated that she had informed Staff I that [redacted] was in the building but she did not remember the nurse actually seeing the resident.

Class III