STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	**08/09/2018**
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 (2018007610 & 2018009209) survey was conducted in conjunction with a Change of Ownership (CHOW) survey on , at , Residences of Brandon Memory Care (License #9739), an assisted living facility located in Brandon, Florida. Deficient practice was cited related to the complaint survey. Additional deficiencies were cited related to the Change of Ownership survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the Facility failed to provide a safe and decent living environment, free of and to treat 24 residents of the Facility's Unit with consideration and respect.

Findings Included:

A Facility tour, conducted in the Facility's / Unit on between 06:20am through 07:00am, revealed twenty-four residents up and dressed in the dining on their way to the dining . There was no food or fluids in front of any residents. There was no type of entertainment in place for these residents with while they sat in the dining a minimum of one to two hours. The residents seated at the dining tables had clothing protectors on. Resident #1 was observed lying diagonal in a Geri-Chair with the top half of resident's body leaning toward the left and the bottom half of resident's body tilted to the right of the chair. Resident #1's head was not supported and the resident was sleeping.
Resident #2 was observed sitting in a locked high-backed wheelchair and Resident #2's mouth appeared to be crusted over with food or some other substance. Resident #2 was awake and was unable to unlock the wheelchair or move away from table.
Resident #3 was sitting in a locked high-backed wheelchair and was sleeping with their head hanging forward and not supported. Resident #4 was sitting in a locked high-backed wheelchair and awake but unable to unlock the chair or move away from the table. Resident #5 was sitting in a locked wheelchair between the wall and the table. Resident #5 was slumped over sleeping with thier head lying on the table. Resident #5's shirt was not pulled down around their abdomen and the resident's back and left abdomen were exposed.
Resident #7 was sitting at the dining table awake. Resident #7's mouth was crusted over with food or some other substance.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES OF BRANDON MEMORY CARE	**1819 PROVIDENCE RIDGE BLVD. BRANDON, FL 33511**

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

During an interview with Staff I, conducted on . . . . . at 06:40am, Staff I stated that staff begin to get residents up about 04:00am and breakfast is served between 07:30am to 07:45am.

During an observation with Staff E, conducted on . . . . . at 06:55am, Staff E was observed strongly guiding Resident #27 into a dining chair.

A record review of Staff E's employee file, conducted on at 12:02pm, revealed that staff E had a complaint dated . . . . . that stated, "rough care of residents performed by an aide working in D hall. Student felt that patient was a two-person assist but saw aid aggressively transfer patient from wheelchair to bed. Another student stated that the same aid was roughly treating residents during lunch" signed by the Clinical Instructor.

During an interview with a visiting Hospice Aide, conducted on at 07:06am, the Hospice Aide stated, "When I get here at 05:30am there are already quite a few residents up and sitting at the table."

During an interview with Staff E, conducted on . . . . . at 10:38am, Staff E stated that staff begin getting residents up and into the dining 04:00am.

An observation of Resident #3, conducted on . . . . . at 01:05pm, revealed that the Facility did not consider Resident #3's dignity and respect for privacy; and, did not follow safe practice with control measures with the performance of incontinence care. Staff L double gloved before performing incontinence care with Resident #3. While performing incontinence care, Staff F was leaning over Resident #3. Staff F had a lanyard with a Walkie-Talkie and keys hanging around Staff F's neck. The Walkie-Talkie and keys kept bumping Resident #3, the soiled incontinence , , and the soiled incontinence brief. Staff K, a Licensed Practical Nurse, present during the incontinence care, did not state anything to Staff F about the contamination of the items that remained around Staff F's neck. The window blinds were observed wide open during the incontinence care. There was a vehicle parked only a few feet away from Resident #3's window and a man was observed walking away from the van toward the door across the parking area. Staff K stated, "We should have closed the blinds." Staff L removed the outer gloves on their hands and disposed of soiled items outside of Resident #3's . Then Staff L removed the inner pair of gloves and proceeded up the hallway toward the dining . . Neither Staff F nor L washed hands. Staff K did not inform either Staff F or Staff L to wash hands.

During an interview with Staff D, conducted on at 04:44pm, Staff D stated that staff get residents up, dressed, and put them at the table for breakfast with their bibs on.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	**08/09/2018**
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)

A review of the Facility's posted "getup list" (See Photographic Evidence7), conducted on , revealed that the Facility's practice/expectation is for twenty-one residents with diagnoses of 's and/or to be up before 06:00am every day.

During an interview with the Director of Nursing and the Administrator on at 05:02pm, the Administrator stated that residents are awakened about 04:00am and seated at the dining tables with bibs on. The Administrator stated, "We have a get up list and I know that it is early in the morning and before breakfast. We have two staff on each side and one nurse for night shift. We are concerned with so we get them up early."

During an observation and interview with the Administrator and Corporate Nurse for Resident #3, conducted on at 05:00pm, Staff E and L assisted Resident #3 to a standing position and began to pull the resident's pants down with the window blinds open. Surveyor stopped the staff. The Administrator acknowledged and confirmed that the windows in the regular windows, which can be seen through from both inside and outside. Staff E went over and closed the blinds and both Staff E and L proceeded with care. After care performance, Staff L removed their outer gloves and walked outside of Resident #3's dispose of soiled items. Staff L then removed inner gloves and walked toward the dining area. Neither Staff E nor Staff L washed hands after Resident #3's care. The Administrator acknowledged and confirmed that staff should wash hands before and after care.

Class III