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)

0000 - Initial Comments

Assisted Living Facility

A Change of Ownership survey with Limited Nursing Services and Extended Congregate Care in conjunction with a Complaint Survey (CCR#: 2018007610 and 2018009209) was conducted at , Residences of Brandon Memory Care Assisted Living Facility on . , Residences of Brandon Memory Care Assisted Living Facility had deficient practice identified at the time of survey .

(License#: 9739)

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview, the Facility failed to determine the appropriateness of continued residency for one Resident (#3) of one resident discharged from Hospice services.

Findings Included:

A tour of the Facility's / Unit, conducted on between 06:20am through 07:00am, revealed Resident #3 was sitting in a locked high-backed wheelchair and sleeping. Resident #3's head was hanging forward and not supported. Resident #3 had a clothing protector/bib on for the breakfast meal.

An observation of Resident #3, conducted on at 01:05pm, revealed that the Facility did not provide the care and service that Resident #3 required. Resident #3 had an undated dressing covering a to the resident's right hip. The dressing appeared old, worn, and full of brownish liquid. When Staff F and L rolled Resident #3 to the right side and back to the left, the brownish liquid from the dressing leaked onto the incontinence , . Staff F stated, "Oh look, it's leaking again." Staff K, a Licensed Practical Nurse leaned over to look. Staff K did not attempt to change the 's dressing.

A review of Resident #3's record, conducted on , revealed that Resident #3 was discharged from Hospice services on . There were no dressing changes documented by the Facility on Resident #3's Medication Observation Records for , 2018 and , 2018. Resident #3's Agency for Health Care Administration Health Assessment Form 1823 (See Photographic Evidence1), dated stated that Resident #3, admitted to Hospice Services, had , muscle , was at risk for , and had an un-stage-able to the right hip. Resident #3 required total care for all Activities of Daily Living. Resident #3 was not admitted to the Facility's Extended Congregate Care

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Services on the day of survey (See Photographic Evidence4). A new order written by the Advance Registered Nurse Practioner, dated , was for Hospice to evaluate and treat Resident #3's right hip . Documentation found in Resident #3's electronic record, dated at 02:32pm, revealed that Resident #3 had ", on right hip, slight pain when touched with some and an odor." On at 06:10pm: Resident #1 was "discharged from Hospice services for non-recertification. New Hospice Order -trimethoprin (for right hip for 10-days)." On at 06:54pm: " pending delivery was ordered through Hospice it was discontinued by Hospice Pharmacy reordered and fax from (Pharmacy)." On at 11:42am: "Started first dose for right hip [and] Care Nurse stated is deep and un-stage-able."

During an observation and interview with the Administrator and Corporate Nurse for Resident #3, conducted on at 05:00pm, the same soiled dressing remained covering the to Resident #3's, right hip. The Corporate Nurse acknowledged and confirmed that the dressing needed to be changed. The Administrator pulled back the dressing from the and exposed a soiled/soaked dressing with brownish liquid and what appeared to be packing for the inside of the on the dressing.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the Facility failed to ensure that within 30-days of employment all newly hired staff had a written statement from a Health Care Provider documenting that they were free of signs and symptoms of communicable for one Staff (B) of three sampled staff records.

Findings Included:

A record review for Staff B, conducted on at 01:00pm, revealed that Staff B did not have a statement from a Health Care Provider that Staff B was free from communicable . Staff B's date of hire was .

During an interview with the Business Office Manager, conducted on at 02:18pm, the Business Office Manager confirmed that Staff B's employee record did not include a statement by a Health Care Provider that Staff B was free from communicable .

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RESIDENCES OF BRANDON MEMORY CARE	**1819 PROVIDENCE RIDGE BLVD. BRANDON, FL 33511**

SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview, the Facility failed to ensure that staff who provide direct care to residents received the required in-service trainings, within 30-days of employment for three Staff (A, B, and C) of three sampled staff records reviewed.

Findings Included:

An employee record review for Staff A, conducted on . . . . . , revealed that Staff A had one hour of Activities of Daily Living Training instead of the three required hours. Staff A did not have the following training documented in the employee's record: Emergency Preparedness and Evacuation Training, Incident Reporting Training, Recognizing and Reporting , , , and , Training, and Nutritional and Safe Food Handling. Staff A was hired on . . . . . .

An employee record review for Staff B, conducted on . . . . . , revealed that Staff B had one hour of Activities of Daily Living Training instead of the three required hours. Staff B was hired on . . . . .

An employee record review for Staff C, conducted on , revealed that Staff C had one hour of Activities of Daily Living Training instead of the three required hours. Staff C was hired on . . . . . .

During an interview with the Business Office Manager, conducted on . . . . . at 02:18pm, the Business Office Manager acknowledged and confirmed that Staffs A, B, and C were missing the aforementioned trainings from their employee records. No other documents or certificates were provided during the survey.
Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on record review and interview, the Facility failed to ensure that staff who provide direct care to residents received the one-time required , and , ... (/) Training within 30-days of employment for one Staff (A) of three sampled staff records reviewed.

Findings Included:

An employee record review for Staff A, conducted on , revealed that Staff A did not have a

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RESIDENCES OF BRANDON MEMORY CARE	**1819 PROVIDENCE RIDGE BLVD. BRANDON, FL 33511**

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one-time / Training certificate in the employee's record. Staff A was hired on .

During an interview with the Business Office Manager, conducted on at 02:18pm, the Business Office Manager acknowledged and confirmed that Staff A was missing the one-time required / Training certificate from the employee's record. No other documentation or certificates provided.
Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview, the Facility to ensure that staff who provide direct care to residents received the required ( ) Training within 30-days of employment for one Staff (A) of three sampled staff records reviewed.

Finings Included:

A record review for Staff A, conducted on at 12:30pm, revealed that Staff A did not have a documentation that Staff A completed the required Training in the employee's record. Staff A was hired on .

During an interview with the Business Office Manager, conducted on at 02:18pm, the Business Office Manager acknowledged and confirmed that Staffs A was missing the required Training from the employee's record. No other documents or certificates provided.
Class III

0151 - Physical Plant - Existing Facilities - 58A-5.023(2) FAC

Based on record review, observation, and interview, the Facility failed to ensure that a multiple occupancy were used for no more than two assisted living residents. One was actively occupied was used for four Residents (#4, #8, #25, and #26).

Findings included:

A review of the Facility's census, conducted on , revealed that residents' (E-5) was occupied by four Residents #4, #8, #25, and #26 on the day of survey.

An observation of -5, conducted on , revealed that Residents #4, #8, #25, and #26 actively occupied and used -5. There were four beds with linens and resident personal belongings in and around each of the four beds in -5. Residents #4 and #8 were admitted to the

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Facility's Extended Congregate Care Services on the day of survey.

During an interview with the Administrator and the Corporate Nurse, conducted on at 06:36pm, the Administrator confirmed that the Facility used -5 for four residents. The Administrator stated that they were not aware of rules that limited the Facility to two residents per .

Class III

E204 - ECC - Admissions & Continued Residency - 429.26(10); 429.07(3)b ; 58A-5.030(4)

Based on observation, record review, and interview, the Facility failed to determine appropriateness of residency; and, failed to provide care and services required for one Resident (#1) of two sampled residents admitted to Extended Congregate Care Services (ECCSs).

Findings Included:

A tour of the Facility's / Unit, conducted on between 06:20am through 07:00am, revealed Resident #1 lying diagonally in a Geri-Chair in front of the dining table. Resident #1's head was not supported and the resident was sleeping. There were no supportive or positioning devices in or around Resident #1's Geri-Chair. Resident #1 had a clothing protector/ on for the breakfast meal.

During an interview with Staff E, conducted on at 07:07am, Staff E stated that Resident #1 was unable to bear weight during transfers. Staff E stated that, "we carry her and [Resident #1] does not stand at all."

An interview with the Hospice Aide, conducted on at 07:52am, revealed that Resident #1 was bedridden. The Hospice Aide stated that Resident #1stayed in the Geri-Chair or bed at all times.

An observation of Resident #1, conducted on at 12:50pm, revealed that the Facility did not provide the care and services that Resident #1 required. Staff E and L transferred Resident #1 unsafely from the Geri-Chair to the bed for a resident who did not bear any weight or assist with the transfer. Staff E was to the right and Staff L was to the left of Resident #1. Both Staff E and L lifted Resident #1 by the shoulders/arms. Resident #1's legs contracted and did not straighten to bear any weight. Resident #1 was breathing heavily and appeared short of breath after the transfer. There was a dressing covering a to Resident #1 left hip dated that appeared old and worn. Staff K, a Licensed Practical Nurse was present at the time. Staff K did not attempt to change the 's dressing. Staff L had

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RESIDENCES OF BRANDON MEMORY CARE	1819 PROVIDENCE RIDGE BLVD. BRANDON, FL 33511

SUMMARY STATEMENT OF DEFICIENCIES
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double gloves covering hands. After changing Resident #1's incontinence brief, Staff L removed the outer gloves, disposed of the soiled items, and then removed the inner gloves. Staff L did not wash hands before moving on to assist Resident #3 with a transfer and incontinence care. Staff K did not inform Staff L to wash hands.

A review of Resident #1's record, conducted on , revealed that Resident #1 was admitted to the Facility's ECCSs for Total Care with all Activities of Daily Living on (See Photographic Evidence4). Resident #1 was admitted to Hospice services on (See Photographic Evidence2). There were no dressing changes documented by the Facility on Resident #1's Medication Observation Records for , 2018 and , 2018. Resident #1 had on ongoing un-stage-able to the left hip and , since . A new order, written by the Advanced Registered Nurse Practitioner, for Hospice to treat the wounds on . Resident #1's ECCSs Plan stated that Hospice and the Assisted Living Facility staff "to provide level of care needed to meet the needs of resident" documented on . Documentation in Resident #1's ECCSs Notes noted only documentation regarding "total care with Activities of Daily Living. There was no documentation regarding Resident #1's wounds. Resident #1's Hospice Interdisciplinary Care Plan dated made no mention regarding the wounds, , risk, and risk. Resident #1's Agency for Health Care Health Assessment Form 1823 dated stated that Resident #1 was:

- At risk for , and
- Unable to propel self in Geri-Chair
- Required Primo-boots to feet around-the-clock
- Required total care with all Activities of Daily Living
- Unable to bear weight
- Had a to the left hip and .

During an interview with Staff H, conducted on at 04:14pm, Staff H stated that Resident #1 was in a Geri-Chair because Resident #1 slides out of a regular wheelchair and staff turn Resident #1 every two hours because Resident #1 was contracted. Staff H stated that pillows were used for support and positioning.

During an observation and interview with the Administrator and Corporate Nurse for Resident #1, conducted on at 04:00pm, Resident #1 was lying in a Geri-Chair in the television area. Resident #1's gown and blanket was up around the chest area exposing Resident #1's abdomen and soaked incontinence brief. There were several other residents both male and female in the area. There was no pillow between Resident #1's contracted knees. The Administrator placed the blanket to cover Resident #1 and Staff E and L wheeled the Geri-Chair to resident's . Staff E and L performed a transfer and incontinence care. The Administrator and Corporate Nurse acknowledged and confirmed

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that Resident #1 was unable to bear weight; and, that the left hip dressing had an older dressing dated . The Administrator stated that Hospice changes Resident #1's, dressings and that Facility staff changes it as needed. After assisting Resident #1, Staff L removed an outer pair of gloves from hands. Staff L disposed of soiled items and then removed an inner pair of gloves from hands. Staff L proceeded to go toward Resident #3 to assist with care. Neither the Administrator nor Corporate Nurse informed Staff L to wash hands.

Class III