STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	R 10/08/2018

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 Revisit to an 08/09/18 Complaint Survey (CCR#: 2018009209 and 2018007610) was conducted in conjunction with a Revisit to an 08/09/18 Change of Ownership Survey and in conjunction with a Complaint Survey (CCR#: 2018013068) 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)

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

Based on observations and record reviews, the Facility failed to provide oversight and supervision to meet the residents' total care and services needs for , , feeding, and safe transferring of all residents identified as lower functioning and residing on the Unit.

Findings Included:

A review of an staff in-service, conducted on , revealed that the Facility did not follow the Facility's Policy and Procedures to not rush residents and to observe residents swallow, while assisting residents during meals.

Observations conducted on from 04:00pm through 07:00pm during the evening meal, revealed the staff on the lower functioning Unit observed rushed and in a hurry to provide care and feed residents. The Facility had twelve residents admitted to Hospice and Extended Congregate Care services who required total care with all Activities of Daily Living and were assesed as high risks. Residents were observed at the dining table waiting to be fed with food sitting in front of them. There were not enough staff present to feed these residents in a timely fashion before their meal got . Staff feeding residents were observed to continuously stop and provide care needs to other residents that away from the dining tables. The staff were unable to take time to wash the residents' or faces before and after the meal. Several residents were observed eating with their . There was no provision of care for residents until well after the evening meal was over. After the evening meal, staff escorted residents to the television area to sit in their wheelchairs or on sofas and recliners. Some of those residents were then observed sleeping with their heads and bodies unsupported.

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A record review for Resident #1, conducted on , revealed that Resident #1 required total care with all Activities of Daily Living, which included transfers. Resident #1's Personalized Service Plan updated stated that the resident was a two-person transfer. This Service Plan did not state that Resident #1 required a sling transfer and greater than two-persons for transfer assistance.
An observation of Staff D, F, and G providing total care and total transfer assistance at 04:10pm, revealed that the Facility staff did not provide care and services Resident #1 required for safe transfer, and , and proper care. When the staff washed feces off Resident #1's and , the staff left feces on the resident. There was smeared feces on Resident #1's to the . The Director of Nursing was present and did not halt the care staff to have the replaced or instruct the care staff to wash the feces left on the resident. Staff D, F, and G were observed to transfer Resident #1 unsafely from the Geri-chair to the bed. The staff placed a bed sheet under Resident #1 and left the bed sheet loose under the resident during the transfer.

A record review for Resident #3, conducted on , revealed that Resident #3 required total two-person care assist with all Activities of Daily Living and was assessed as a high risk. Resident #3 sustained a from an unknown origin on . Further record review revealed that the resident sustained an unreported just two days prior to the discovery. Resident #3 sustained from a in . Resident #3 had additional between these two .
Resident #3's Personalized Service Plan dated did not state the provision of care and services required to meet Resident #3's precaution needs. There were no specific interventions documented that were implemented with each for prevention measures for Resident #3.

A record review for Resident #4, conducted on , revealed that Resident #4 had on and . Resident #4 sustained a right , during the and the Facility transferred the resident to the local hospital's Emergency Department. Resident #4's Personalized Service Plan dated did not state the provision of care and services required to meet Resident #4 precaution needs. There were no specific interventions documented that were implemented with each for prevention measures for Resident #4.

An observation of Resident #9, conducted on at 06:05pm, revealed that Staff D and Staff E transferred Resident #9 unsafely from the wheelchair to a reclining chair. The Director of Nursing, present at the time of the observation told both staff twice to use a gait belt. Staff D obtained the gait belt and proceeded to transfer Resident
#9 by placing the gait belt around Resident #9's waist and then left five to six inches of space between the gait belt and the resident. Resident #9's wheelchair was at a 180-dagree angle from the recliner. When the staff got Resident #9 to a standing position, the resident's were twisted and the resident

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yelled out in , . Staff were able to maneuver Resident #9 in to the recliner after much force. Resident #9's were both edematous (filled with fluid). The staff did raise the of the recliner. However, a review of Resident #9's Personalized Service Plan conducted on revealed that the resident must be laid down in bed after every meal.

A review of the Facility's Prevention Gait Belt Use Policy and Procedure (P and P), conducted on , revealed that the staff did not follow the Facility's P and P for gait belt use. The P and P stated to "place the gait belt around the waist of the residents leaving enough space to slide your under and to make sure that the wheelchair is locked at a 90 degree angle."

Class III

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

Based on observation, interview, and record review, the Facility failed to treat residents with dignity and respect in regards to not providing privacy during personal care, not keeping residents free from and not providing safe transfer assistance.

Findings Included:

Observations of the evening meal on the lower functioning Unit, conducted on from 04:00pm through 07:00pm, revealed that staff brought residents to the dining tables up to an hour and half before the meal began. The staff parked and locked the residents' wheelchairs in place. Multiple residents appeared unable to unlock their wheelchairs or move away from the dining tables.

Observations of Resident #1 and #2, conducted on , revealed that the Facility failed to provide privacy during care, which included a three-person transfer of the resident from the Geri-chair to the bed and also included care. At 04:10pm, Staff D, Staff F, and Staff G provided total care with Resident #1's window open. Staff D, Staff F, and Staff G transferred Resident #1 from the Geri-chair to the bed in a manner that appeared to put the resident at risk of a . The staff used a bed sheet during the transfer of Resident #1 and the sheet was loose and not pulled tight during the transfer, which placed the staff and the resident at risk for injury. At 04:44pm, the same Staff then proceeded to provide Resident #2 with total care, which included the resident's transfer from wheelchair to the bed, and care with the window open. The Director of Nursing was present at the time of the care provision and did not halt care, shut the window , or remind staff to shut the window .

During an observation of Resident #13, conducted on at 05:10pm, Staff D was observed

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pulling on Resident #13's arm while attempting to get the resident to stand. Staff G attempted to talk the resident into standing but Staff D kept pulling at the resident's arm and told Staff G to go away. Staff D yelled across the room for Staff F to come and help. Both Staff D and Staff F pulled Resident #13's arms in order to get the resident to a standing position. The staff forced the resident out of the chair and into the dining room.

During an observation of Resident #9, conducted on at 06:05pm, Staff D and Staff E were observed attempting to transfer Resident #9 from the wheelchair in to a reclining chair. After several attempts to get the resident into a standing position by pulling on the resident's arms, the Director of Nursing stated that "maybe you should use a gait belt." Both staff kept pulling on the resident's arms and the resident became resistive and . The Director of Nursing stated again, "you should use a gait belt." The staff halted the transfer and Staff D went to find a gait belt. The staff then placed the gait belt too loosely leaving five to six inches of space between the gait belt and Resident #9. Resident #9's wheelchair was at a 180-degree angle from the reclining chair. During the transfer, Resident #9's twisted and the resident yelled out in . Resident #9's were edematous (filled with fluid).

During an observation of Resident #1, conducted on at 06:10pm, Resident #1 was observed in the common area lying in a Geri-chair with the blanket pulled out to the side not covering their body. Resident #1's , , and brief were exposed. The Director of Nursing then pulled the blanket over the resident's body. There were multiple other staff present in and around the area and none made any attempts to cover Resident #'s1 exposed body.

During an interview with the Director of Nursing, conducted on at 04:45pm, the Director of Nursing stated that the staff should close the window blinds during resident care.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observations, interviews and record review, the Facility failed to employ sufficient staff to meet the scheduled and unscheduled needs required for residents on the facility's lower functioning Unit. This resulted in violations in residents' rights and safety for all residents admitted to the Unit.

Findings Included:

Observations of the evening meal on the lower functioning Unit, conducted on beginning at 04:00pm, revealed that there was not enough staff present in order to feed the residents

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who required total feeding assistance. Some residents at the dining table were sitting with food uncovered in front of them and had to wait while staff fed the residents beside them. Staff began bringing residents to the dining room beginning at 04:00pm and placed them at the dining table with their wheel chairs locked in place. Some of these residents continued to wait at the dining table with their wheelchairs locked in place until after the meal was over (approximately 07:00pm). Staff had to stop feeding residents on several occasions to attend to resident care needs or to redirect ambulatory residents to the dining room.

At the first feeding table, there was only one staff for four residents who required feeding. The staff proceeded to feed the two residents on the right while ignoring the two residents on the left. At one point (05:10pm), there was one table with three residents with food uncovered in front of them with no staff to feed these three residents

Record reviews of Hospice and Extended Congregate Care (ECC) residents, conducted on , revealed that there were twelve residents admitted to Hospice and ECC services who resided on the lower functioning Unit. These residents required two-person total care for all Activities of Daily Living, which included feeding, , transfers, and high risk residents.

The higher functioning Unit had one resident on Hospice and ECC services and housed residents who were more independent or required supervision. The Facility staffed the lower and higher functioning units equally with the same amount of staff on each side and on each shift.

During an interview with the Divisional Director of Operations, conducted on at 07:55pm, the Division Director of Operations acknowledged and confirmed the requirement to immediately, increase staff above the minimum required and current Facility levels to accommodate the needs of their lower functioning Unit's residents required total care needs. The Facility will be required to submit a corrective action plan to the Agency within the time specified in the notification as to how the residents' care needs will be achieved with the provision of additional staff.

Class III

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

Based on observation, interview, and record review, the Facility failed to submit an Adverse Incident Report to the Agency for Health Care Administration for an event over which led to the transfer of two Residents (#3 and #4) with bones to an Acute Care Facility.

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Findings Included:

A record review for Resident #3, conducted on , revealed that Resident #3 was sent to the hospital on and determined to have a broken left of unknown origin. Upon investigation, Resident #3 had a two days prior. Resident #3's Agency for Health Care Administration Form 1823 (1823) dated and Hospice Interdisciplinary Care Plan did not specify services offered or arranged for inability to bare and total two-person assistance with all Activities of Daily Living. Resident #3 had on (with no injury) and (with a injury). Resident #3 had a in , which resulted in . Resident #3's Personized Service Plan did not list specific interventions or prevention measures put in place to reduce occurrences after each . The Facility did not submit an Adverse Incident Report for Resident #3's and left .

A record review for Resident #4, conducted on , revealed that Resident #4 had an unwitnessed on , which lead to Resident #4's transfer to the Hospital's Emergency Department and a right , . Resident #4 did not have on non-skid socks at the time of the . Resident #4's 1823, dated , did not list specify that Resident #4 was at risk for . According to this older 1823, Resident #4 required assistance with bathing, , and grooming. Resident #4 had another documented on . Resident #4's Personalized Service Plan did not list specific interventions or prevention measures put in place to reduce occurrences after each . The Facility did not submit an Adverse Incident Report for Resident #4's right , .

Observations of resident transfers with Resident #1 and #9, conducted on , revealed that Facility Staff did not perform safe transfers of Residents #1 and #9. The Facility did not have enough Staff on duty to provide care and services required for the Lower Functioning Unit, which included twelve residents who required total care of two or three Staff assistance and were risks. The Facility did not have a program implemented for the high number of residents who were risks.

An interview with the Director of Nursing, conducted on at 00:00pm, the Director of Nursing stated that the Facility did not have a program or plan in place for the high number of residents at risk for residing at the Facility. The Director of Nursing stated that the risk statuses were listed on each residents Personalized Service Plans.

Class III