STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965363	R 12/12/2018

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 a 08/09/18 Complaint Survey (CCR#: 2018009209 and 007610) was conducted at Residences of Brandon Memory Care Assisted Living Facility on 12/12/18. Residences of Brandon Memory Care Assisted Living Facility had a deficiency at the time of the survey.

(License#: 9739)

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

Based on observation, interview, and record review, the Facility failed to provide the required level of supervision, care, and oversight to meet the needs of one newly admitted Resident (#1) of one sampled resident who did not meet Admission Criteria for residency.

Findings Included:

A review of the Admission and Discharge Log, conducted on , revealed Resident #1 was newly admitted from another Assisted Living Facility (ALF).

A review of Resident #1's record, conducted on , revealed that Resident #1 had documentation of a -to- health assessment (See Photographic Evidence1) dated . Resident #1's assessment indicated that the resident required 24-hour nursing or , care and stated "unknown" if the resident had , and posed a danger to self or others. Further review of the record indicated Resident #1's Responsible Party was given a 24-hour notice (See Photographic Evidence2) dated of medically necessary discharge for Resident #1 displaying , inappropriate behaviors with other residents and staff of the former ALF. Resident #1's Responsible Party provided this notice of discharge to the current Facility, which detailed some of the resident's , inappropriate behaviors. Resident #1's Care Plan (See Photographic Evidence3) did not state any intervention or prevention measures for staff to take to prevent or deter , inappropriate behaviors. Resident #1's assessment documentation stated that the resident required assistance with all Activities of Daily Living. There was only one entry in Resident #1's Daily Record Log (DRL) dated that made no mention of the resident's history or that the Facility staff were educated on appropriate measures to take and the entry noted the admission assessment which included the resident's .

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

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

An observation of Resident #1, conducted on at 11:30am revealed that the resident had wet -soaked pants on. During a later observation at 04:05pm, Resident #1 wore the same soaked pants that continued wet.

During an interview with the Administrator and the Marketing Director, conducted at 11:37am, both confirmed knowledge of Resident #1's history of , inappropriate behaviors toward staff at the prior facility but denied knowledge of behaviors toward other residents. Both stated that the Facility's staff had been informed of Resident
#1's history and knew to monitor the resident.

During an interview with Staff A, conducted on at 01:55pm, Staff A denied knowledge of Resident #1's history or behaviors to monitor. Staff A was assigned to Resident #1 most days. A later interview with Staff A at 04:15pm, Staff A acknowledged that the staff did not make a nurse or supervisor aware that Resident #1 refusing or difficult with care.

During an interview with Staff B, conducted on at 02:05pm, Staff B denied knowledge of Resident #1's history or behaviors to monitor.

During an interview with the Director of Nursing, conducted on at 05:05pm, the Director of Nursing acknowledged and confirmed that Resident #1's health assessment and Care Plan were not consistent and agreed that the Resident was inappropriate for the Facility. The Director of Nursing stated that she "was left out of the loop of [the resident's] admission.

Class III