

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI

**3201 ROUSE ROAD
ORLANDO, FL 32817**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a re-licensure survey was conducted at Bridge Assisted Living at Life Care Center of Orlando on . The facility had uncorrected deficiencies at the time of the survey.	{A 000}		
{A 010} SS=D	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the	{A 010}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 010}	Continued From page 1 resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: - Move, turn, or reposition without total physical assistance; - Transfer to a chair or wheelchair without total physical assistance; or - Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial	{A 010}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 010}	Continued From page 2 examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a _____, _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	{A 010}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 010}	Continued From page 3 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interview, the facility failed to ensure an interdisciplinary care	{A 010}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 010}	Continued From page 4 plan was developed and implemented for 1 of 1 sampled resident who received hospice services (#16). Findings: Review of resident #16's record revealed the resident was admitted to hospice services on The record contained a hospice interdisciplinary care plan that was also dated however, it was not completed. At 1 p.m. on the administrator confirmed the finding and was unable to provide additional documentation. Class III	{A 010}			
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident 's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident 's	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 025}	Continued From page 5 representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by:	{A 025}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 025}	Continued From page 6 DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to ensure a health care provider's medication order was followed for 1 of 4 sampled residents (#3). Findings: Review of resident #3's current 1823 that was dated _____ revealed the resident had a diagnosis of _____ (_____) _____ (_____) and _____ and he required assistance with self-administration of medications. The 1823 contained a health care provider order for _____ 0.4 mg by _____ daily after supper. Review of the resident's _____ Medication Observation Record (MOR) revealed the _____ was being given at 8 a.m. and not after supper. At 12:15 p.m. on _____ the director of nursing (DON) confirmed the findings. Class III	{A 025}			
{A 078} SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have	{A 078}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 078}	Continued From page 7 been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to	{A 078}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 078}	Continued From page 8 provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on personnel record reviews and interview, the facility failed to ensure 2 of 6 sampled staff (A & B) submitted a written statement from a health care provider documenting freedom from communicable _____ within 30 days after beginning employment and failed to ensure the personnel record for 1 of 6 sampled staff (G) contained documented evidence of a negative () exam on an annual basis. Findings: 1. Review of staff A's personnel record revealed a hire date of _____. Review of staff B's personnel record revealed a hire date of _____. Neither staff's record contained a written	{A 078}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI

**3201 ROUSE ROAD
ORLANDO, FL 32817**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 078}	Continued From page 9 statement from a health care provider documenting freedom from communicable, as required. 2. Review of staff G's personnel record revealed a hire date of The record contained a negative exam that was dated but did not contain a negative exam for 2021, as required. At 12:45 p.m. on the human resource director confirmed the findings and was unable to provide additional documentation. Class III	{A 078}		
{A 081} SS=D	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 081}	Continued From page 10 completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of	{A 081}			

If continuation sheet 12 of 17

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI

**3201 ROUSE ROAD
ORLANDO, FL 32817**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 081}	Continued From page 12 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on personnel record reviews and interview, the facility failed to ensure that 6 of 6 sampled direct care staff received the required in-service training as described in 59A-36.011(. . .) FAC (A, B, C, E, F, G.) Findings: Review of personnel records revealed the following: 1. Staff A was hired on Staff A's record did not contain documentation to indicate a 2-hour preservice orientation, reporting adverse incidents, facility emergency procedures including chain of command, activities of daily living (ADLs) with behavioral changes, resident elopement and control trainings were received. 2. Staff B was hired on Staff B's record did not contain documentation to indicate a 2-hour preservice orientation, reporting	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI

**3201 ROUSE ROAD
ORLANDO, FL 32817**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 081}	Continued From page 13 adverse incidents, facility emergency procedures, ADLs with behavioral changes, resident elopement, control and nutrition trainings were received. 3. Staff C was hired on Staff C's record did not contain documentation to indicate a 2-hour preservice orientation was received. 4. Staff E was hired on Staff E's record did not contain documentation to indicate a 2-hour preservice orientation, reporting adverse incidents, facility emergency procedures, resident elopement and control trainings were received. The record contained an ADL certificate of training that was dated however, the duration was for only 0.5 hours. 5. Staff F was hired on Staff F's record did not contain documentation to indicate a 2-hour preservice orientation, reporting adverse incidents, facility emergency procedures, resident elopement, resident control and nutrition trainings were received. The record contained an ADL certificate of training that was dated however, the duration was for only 0.5 hours. 6. Staff G was hired on Staff G's record did not contain documentation to indicate resident rights, ADLs, reporting adverse incidents, facility emergency procedures and control trainings were received. The record contained a nutrition certificate of training that was dated however the duration was	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 081}	Continued From page 14 for only 0.5 hours. The staff records did not contain documentation to indicate any of the staff were a certified nursing assistant, home health aide or nurse and no documentation to indicate they received CORE training to exempt them from some of the requirements. At 12:45 p.m. on _____ the human resource director confirmed the findings and was unable to provide additional documentation. Class III	{A 081}			
{A 082} SS=D	59A-36.011(4) FAC Training - / (4) _____. Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and _____, including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on personnel record reviews and interview the facility failed to ensure 1 of 4 sampled staff completed a one-time education course on and _____ within 30 days of employment (D).	{A 082}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/19/2021
---	--	--	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI **3201 ROUSE ROAD**
ORLANDO, FL 32817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 082}	Continued From page 15 Findings: Review of staff D's personnel file, who was the administrator, revealed a hire date of . The record contained an and certificate of training that was dated however, the administrator signed the certificate herself as the trainer. At 12 p.m. on the administrator confirmed she gave herself the training and said she did not know what else to do. Class III	{A 082}		
{A 090} SS=D	59A-36.011(11) FAC Training - ----- (11) ----- TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding ----- (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 5 of 5 direct care staff received at least one hour of training in the facility's policy and procedures regarding Do Not	{A 090}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2021
NAME OF PROVIDER OR SUPPLIER BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF OI			STREET ADDRESS, CITY, STATE, ZIP CODE 3201 ROUSE ROAD ORLANDO, FL 32817		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{A 090}	Continued From page 16 Orders (.....) that included information in Rule 59A-36.009, F.A.C. (A, B, E, F, G.) Findings: Review of personnel records revealed the following: Staff A was hired on Staff B was hired on Staff E was hired on Staff F was hired on Staff G was hired on None of the records contained documentation to indicate the staff received at least one hour of training in the facility's policy and procedures regarding At 12:45 p.m. on the human resource director confirmed the findings and was unable to provide additional documentation. Class III	{A 090}			