Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967652	A. BUILDING: _____ B. WING _____	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES	11202 DEWHURST DRIVE RIVERVIEW, FL 33578

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A 000	Initial Comments A complaint investigation (#2025019212 & #2026000118) in conjunction with a generator monitoring visit was conducted at The Bridges on . The facility had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent	A 008		

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A 008	Continued From page 1 part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information	A 008		

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A 008	Continued From page 2	A 008		

about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance.

59A-36.006
(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,
3. Any nursing or , , services required by the individual,
4. Any special diet required by the individual,
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,
6. Whether the individual has signs or symptoms of , Resistant

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A 008	Continued From page 3 , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by	A 008		

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A 008	Continued From page 4 the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , , to be administered in the case of or , , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 008		

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A 008	Continued From page 5 failed to maintain resident records with an updated and completed copy of the Resident Health Assessment form, AHCA Form 1823 for three Residents (Resident #1, Resident #2, and Resident #10) of five sampled residents. Findings included: A record review for Resident #1, who was admitted on , revealed Resident #1's AHCA Form 1823 was signed and dated on and did not include the physician telephone number under the medical certification at the bottom of page three. A record review for Resident #2, who was admitted on , revealed Resident #2's AHCA Form 1823 was signed and dated on and did not include the facility information on page one. A record review for Resident #10, who was admitted on , revealed Resident #10's AHCA Form 1823 was signed and dated on and did not include the facility information on page one. During an interview on at 2:35 p.m. the Administrator agreed the 1823 form was missing information for Resident #1, Resident #2 and Resident #10. Photographic evidence obtained. Class III	A 008		
A 032 SS=H	59A-36.007(7) FAC Resident Care - Elopement Standards	A 032		

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A 032	Continued From page 6 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 7 resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide care and services appropriate to the needs of residents accepted for admission, to include awareness of general health and safety for two (Resident #1 and Resident #4) of two sample residents with elopement risk. The facility's lack of identifying elopement risk, implementing elopement risk precautions such as resident worn identification that included their name and the facility's name, address, and telephone number, and ensuring direct care staff participation in elopement response drills, placed the residents at	A 032		

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A 032	Continued From page 8 significant risk of serious injury or harm. Findings included: A review of a facility's self-reported adverse incident dated revealed Resident #13 eloped after last seen in the facility lobby at 11:49 p.m. Law enforcement notified the Administrator at 12:06 a.m. that Resident #13 had been found across the street and was assisted to the facility. During an interview on at 11:12 a.m. Staff B revealed Resident #1 eloped approximately one to two months prior. Staff B said Staff C went to get Resident #1 by the bridge down the road from the facility and Resident #1's spouse (Resident #3) was out of the facility for rehabilitation. Additionally, Staff B said Resident #13 eloped and was brought by an employee and no longer resided in the facility. During an interview on at 12:59 p.m. Staff C said Staff C was not on duty in , but was driving by and saw Resident #1 walking on the road. Staff C said Resident #1 was observed at approximately 9:30 a.m. on highway 301, just before the interstate, approximately 1.6 miles away from the facility. Staff C said when Resident #1 was found walking, Resident #1 was sweaty and . Staff C had Resident #1 get in the car to go to the facility. Staff C was unsure of the faility's elopement protocols and was unable to say what the procedures were if a resident went missing from the facility. An observation on at 10:07 a.m. revealed Resident #1 was sitting with Resident #3	A 032		

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A 032	Continued From page 9 in the assisted living facility common area on the second floor. During an interview on at 10:07 a.m. Resident #3 said while out at the hospital in Resident #1 (spouse) was moved to the Memory care unit. In an attempted record review of the facility's self-reported incidents for Resident #1, there was no adverse incident report for Resident #1. A record review of the Agency for Healthcare Administration Resident health assessment (1823) for Resident #1 dated revealed no elopement risk, a diagnosis of and no elopement precautions. During an interview on at 2:00 p.m. the Resident Care Director revealed Resident #1 was an elopement risk if the spouse (Resident #3) was not present and Resident #1 needed an updated 1823 for elopement risk. Additionally, the Resident Care Director said residents with elopement risk did not have armbands. Furthermore, the Resident Care Director said hire date was in late , of 2025 and had not yet participated in any elopement drills. An observation conducted on at 3:42 p.m. revealed Resident #4 was in the locked memory care unit ambulating around the unit and appeared pleasantly . During an interview on at 3:42 p.m. Staff C said Resident #4 was supposed to stay in the locked memory care unit but there were no beds available. Additionally, Staff C said Resident	A 032		

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A	Continued From page 10	A 032		

#4 was in the locked unit for and when in the unit. Staff C said Resident #4 would go to the previous room on the assisted living side at approximately 8:00 p.m. each night and the staff would check on Resident #4 every two hours.

A record review of the undated facility elopement policy revealed the following:
"The Policy as defined for our facility of elopement is that a resident has left the property and did not inform staff of where he or she was going, and 8 hours has passed without anyone seeing the resident. Unless the resident has been defined by management as a high-risk resident, law enforcement would be called if this criterion is met." A High Risk resident is defined as: "One who has no ability to communicate where he or she lives, or one who has been determined by their physician to need a higher level of monitoring."

A review of the facility elopement drills dated , and revealed Staff E (caregiver/Medication Technician hired on), Staff F (caregiver/Medication Technician hired on) and Staff G (caregiver/Medication Technician hired on) had not participated in elopement drills.

During an interview on at 5:15 p.m. the Administrator said there was not a plan for Resident #4 but the facility would work on something.

During an interview on from 11:00 a.m. to 2:00 p.m. the Chief Executive Officer (CEO) said Resident #1 was only a problem when the

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A 032	Continued From page 11 spouse (Resident #3) was not in the facility. The CEO said Resident #1 left a walking group and the group returned but the count was off by one when Resident #1 eloped. Additionally, the CEO said Resident #1 had to have a one on one caregiver when the spouse (Resident #3) was out of the facility after the incident, but Resident #1 would be an elopement risk if the spouse were to leave the facility. Additionally, the CEO said the facility would update the care plan and 1823 assessment to reflect the elopement risk for Resident #1. The CEO said the facility had nothing in place for elopement risks except for "observation and , " and would implement monthly elopement drills and have cameras added to the exit doors. Photographic evidence obtained. Class II	A 032		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following	A 152		

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A 152	Continued From page 12 furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, clean and decent living environment that was free of hazards for all residents. Findings included: During a tour of the facility conducted on at 9:45 a.m. to 10:00 a.m., the following was found: - Two opened boxes stacked on top of each other with what appeared to be trash in the top box in front of double doors leading to the common area in memory care unit.	A 152		

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A 152	Continued From page 13 - The common bathroom in memory care unit had what appeared to be dust build up on ceiling vent, a lose toilet paper holder with exposed screws, and three circular yellow staining's observed on the ceiling tiles. - Five opened boxes stacked on top of each other in front of the Director of Resident Care's door. During an interview on at 5:26 p.m., the Executive Director agreed the boxes and memory care unit bathroom create hazards and did not provide a safe, clean and decent living environment for residents. (Photographic evidence obtained) Class III	A 152		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could	A 165		

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THE BRIDGES	11202 DEWHURST DRIVE RIVERVIEW, FL 33578

(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 165	Continued From page 14 exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967652	A. BUILDING: _____ B. WING _____	01/26/2026

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THE BRIDGES	11202 DEWHURST DRIVE RIVERVIEW, FL 33578

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A 165	Continued From page 15 (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to file an Adverse Incident Report (AIRS) to the Agency for Healthcare Administration (AHCA)	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 165	Continued From page 16 within one business day for one resident (Resident #10) out of five sampled residents. Findings included: A review of Resident #10's record, conducted on , revealed Resident #10 was sent to the hospital on and was diagnosed with a of the left . There was no evidence found that the facility submitted an Adverse Incident Report to the Agency for Health Care Administration. During an interview on at 10:25 a.m. the Health and Wellness Director agreed no AIRS was submitted to AHCA after Resident #7's of bones on . Class III	A 165		