STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911906	**07/02/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Clare Bridge Of Sarasota	**8450 McIntosh Road Sarasota, FL 34238**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - N278 - 58a-5.031(3) Fac - Lns - Records S-S= D

Specific Tag Findings:
These are the results of a Biennial and Limited Nursing Service (LNS) survey conducted on [redacted] through [redacted] at Clarebridge of Sarasota an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review and interview, the facility failed to complete an updated 1823 Health Assessment after a significant change in status to ensure the appropriateness of continued residency for 1 (Resident #17) of 2 sampled residents.

The findings include:

Observation of Resident #17 on [redacted] at 9:30 a.m., revealed the resident in a wheelchair in the common area near the couch. She was [redacted] and used her feet to ambulate herself while in her wheelchair. Interview with Staff "A" during this observation revealed the resident is receiving Hospice services for a [redacted] diagnosis of [redacted] and has been since "About [redacted] 2013." In addition to the decline in functional status, he confirmed the resident is receiving [redacted] care to her right hip by Hospice.

The 1823 Health Assessment dated [redacted] documents the resident as independent in eating, dressing, toileting and transferring. In addition, the resident requires assistance with [redacted] There is no indication on this assessment of Hospice involvement nor the provision of [redacted] care.

Interview with Staff B on [redacted] at 9:50 a.m., revealed the resident is no longer independent in eating, dressing, toileting and requires assistance with wheelchair mobility. She confirmed the resident had a significant change in status in [redacted] 2012 and though Hospice has been involved, confirmed the physician did not complete a revised 1823 Health Assessment to reflect the functional decline and physical changes of the resident.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview, the facility failed to ensure advanced directives were properly executed for 1 (Resident #17) of 2 sampled residents.

The findings include:

Observation of Resident #17 on [redacted] at 9:30 a.m., revealed the resident in a wheelchair in the common area near the couch. She was [redacted] and used her feet to ambulate herself while in her wheelchair. Interview with Staff "A" during this observation revealed the resident is receiving Hospice services for a [redacted] diagnosis of

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and has been since "About 2013."

Review of the financial file of the resident on revealed a copy of a general durable power of attorney dated appointing the resident's 3 daughters (#1, #2, #3), in succession, for decision making as it relates to financial affairs on behalf of the resident.

In addition, the file contained a designation of a health care surrogate (date illegible) appointing daughter #3 as the resident's surrogate for health care decisions.

The dated documents daughter #1's signature consenting to the order. However, daughter #1, was not the health care surrogate.

Interview with acting Executive Director and Regional Nurse Consultant on at 1:30 p.m., revealed they were unaware daughter #1 was not the healthcare surrogate and would call Hospice, the physician and resident's family to complete an accurate as the one currently in Resident #17's record was invalid.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation, interview, and record review, the facility failed to ensure the accurate administration of medication by facility nursing staff for 1 (Resident #13) of 5 residents observed during medication administration.

The findings include:

Resident #13 had a physician's order for 75 mcg to be given 30 minutes before breakfast." On at approximately 10:15 a.m., during the morning medication administration, Resident #13 received the along with her other morning medications.

A review of the 2013 physician's orders revealed the was to be given one half hour before breakfast and the MOR (Medication Observation Record) indicated it was to be given at 7:00 a.m.

The LPN (Licensed Practical Nurse), "Staff A", initialed on the MOR dated that the 75 mcg was given at 7:00 a.m. according to the time indicated on the MOR. He failed to circle the medication listed on the MOR to indicate it was not given at 7:00 a.m. and failed to document the medication was actually given at 10:15 a.m.

During this observation, Staff A stated Resident #13 is a late riser and usually does not eat her breakfast until late morning, between 10:30 a.m. and 11:00 a.m.

During an interview with Resident #13 on at 11:45 a.m., she indicated that she likes to sleep in and not be "Rushed" in the morning. "I like my breakfast after I am situated for the day."

On at approximately 9:50 a.m., LPN "Staff A" removed the from the pack and placed in a medication cup to be given to Resident #13. In an interview with "Staff A" to clarify why the was not given at 7:00 a.m. as indicated on the MOR or not documented the medication was given at a different

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time, he stated, "Well what am I supposed to do?"

During an interview with LPN, "Staff B" it was revealed she was unaware Resident #13 was not receiving her at 7:00 a.m. and she notified the physician.

Class III

N278-LNS - Records 58A-5.031(3) FAC
Based on observation, record review and staff interview, the facility failed to ensure physician's orders were in place for a for 1 (Resident #7) of 2 residents and monthly assessments were being conducted for 2 (Resident #7 and #12) of 2 residents receiving Limited Nursing Services (LNS).

The findings include:

1. Observation of Resident #7 on at 9:10 a.m., revealed the resident seated in the main dining She stated "I'm doing fine. They changed my to a leg bag, they do it every morning." She stated staff will come and empty her bag at night or during the day if she needs it emptied; however, the nurse will empty it at night before she leaves and it's up to the nurses in the facility to change it which she could not remember if it was once every month or two months. She could not remember why she had the

Record review on revealed that the resident was admitted to the facility on Review of the 1823 Health Assessment documents the resident requires assistance with all ADLs (Activities of Daily Living).

The physician's order dated documents "Change once a month." However, there were no orders specifying the type, size or when to perform care of the

Interview with the Staff Nurse "B" on at 9:51 a.m., confirmed there were no specific orders for when to clean the tubing or the type and size of the She stated the POA (Power of Attorney) has elected to have home health come in and change the however, there were no physician's orders available from the Home Health Agency (HHA) for review as well.

Review of the nursing progress notes between through current support nursing changes the leg bag to night bag as well as emptying the however, the care of the (cleansing the tubing) is not documented nor is it ordered. In addition, there was no monthly assessment.

2. Observation of Resident #12 on at 9:14 a.m., revealed the resident in her in bed. was running at 2 liters via concentrator through a nasal cannula continuously. The resident was however, she appeared in no distress. tanks were properly stored in a bin by her door which was upright and secure. The resident confirmed nurses apply the tubing to her nose.

Record review for Resident #12 revealed a move in date of The 1823 Health assessment documents the resident requires assistance with all ADLs. Nursing services ordered by the physician includes at 2 liters continuous for the date of Nursing progress notes confirm daily documentation of nursing monitoring the use of the by the resident to include her status. There were no monthly assessments conducted since 2013.

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3. Interview with the Regional Director of Health Services on [redacted] at 10:28 a.m., revealed the previous Health and Wellness Director never shared with her the residents who were on LNS therefore monthly assessments were not completed. She confirmed there was no specific physician's order for the care and treatment of the [redacted] for Resident #7.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

Administrator
Clare Bridge Of Sarasota
8450 McIntosh Road
Sarasota, FL 34238

Dear Administrator:

This letter reports the findings of a Biennial and Limited Nursing Service (LNS) survey that was conducted on . 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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