| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964515 | 08/19/2013 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| Clare Bridge Of Ormond Beach | 240 Interchange Blvd Ormond Beach, FL 32174 | |
| SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) | | |

**List of Tags Cited:**
St - A - 0000 - - Initial Comments
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

**Specific Tag Findings:**

0000-Initial Comments

A relicensure survey was conducted on 2013.
Clare Bridge of Ormond Beach had licensure deficiencies found at the time of the visit.

**0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC**
Based on observation, record review, and staff interview, the facility failed to provide adequate toileting for 1 of 15 sampled residents, Resident #15.

The findings include:

On from 11:50 a.m. until 12:30 pm, ( lunch time) , Resident #15 was observed in the dining By 1:45 pm , everyone had left the dining for one couple at another table and Resident #15. Resident #15 was sleeping in his chair. His lap was observed to be wet. There was a strong -like smell in the proximity of the resident as well as other areas of the dining

On at 1:55 pm, Resident #15 was still observed sitting in his chair with his eyes closed and head down and his lap was still wet. Employee A was interviewed on at 1:57 p.m. She stated the resident should be in activities right now. She did not know why he was still in the dining On at 2 pm, Employee H was observed walking with Resident #15 down the hallway to his She stated that someone asked her to bring this resident to his be changed. She stated that this resident was not assigned to her. The resident's pants were observed to be wet as well as the lower part of his shirt. As the resident was escorted into his Employee H, there was a strong like odor throughout the whole Employee H prompted the resident to go into the sit down on the toilet. She explained that she would help him pull his pants down and assist him with his brief. Employee H stated that his brief was very wet and had overflowed onto his clothing. Employee H stated that she had been taking care of this resident for a few months and his had this pungent smell.

The resident's health assessment dated revealed the resident had a diagnosis of and needed supervision with toileting. The Health Wellness Director (HWD) was interviewed on at 2:34 pm. She stated that the facility's last assessment for Resident #15 revealed the resident did not use products and sometimes inappropriately but was continent. She had went down to the resident's confirmed the smell in the She stated she did not remember the smell being that bad. She did not know specifically what inappropriately at times" meant. She stated that the resident care assistants (RCA) used the neighborhood book for guidance about what care a resident needed. At 2:47 p.m , the HWD stated she did not see a plan of care for the staff to toilet the resident at certain times of the day. She did state that the residents should be toileted before and after meals and anytime it was apparent that he needed it.

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Employee I , the caregiver assigned to Resident #15 on this shift was interviewed on at 2:50 p.m. She stated that Resident #15 can participate in his toileting, but you have to cue him for each individual task from where to walk to, sit down, pull down pants and actually urinate. If he was not physically brought to the cued, he would be totally . She stated she was aware that the resident was wet and needed assistance when he was in the dining . When she was getting ready to bring him to be toileted, she had to attend to another resident first. When she returned to the dining , another caregiver had already taken care of him.

Class III

**0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS**
Based on observation, record review, and staff interview, the facility to ensure adequate healthcare per community standards for 1 of 15 sampled residents, Resident #1 by not washing hands after a sugar check and not sanitizing the glucometer before storing it in central storage. The facility also failed to honor resident privacy for 1 of 15 sampled residents, Resident #3 by not knocking on a resident door before entering.

The findings include:

1. On at 11:15 a.m. Employee A had a sugar test and possible administration to do for Resident #1. She stated Resident #1 was not feeling too good and was having since yesterday. He was in his Employee A brought the sugar testing device (glucometer) into the resident's She set the glucometer on the resident's bed. Employee A with gloves on her hand, retrieved a drop of from the resident and placed it on the test strip that was inserted into the glucometer. She announced the resident's sugar was 205 and went to the medication cart. Employee A removed her gloves and tossed them in the trash on the cart and put the glucometer back into the container (belonging to Resident #1) and placed the container back into the medication cart. The medication cart contained medications for other residents in the facility. The nurse did not wash her hands. She looked up the sliding scale for a sugar of 205 and it revealed the resident was to get to 2 units of . The nurse drew up the 2 units, put on gloves and went back into the resident's injected the into the resident's arm.

Employee #A was questioned on at 11:29 a.m. regarding handwashing during medication administration and of glucometers. She admitted she did not wash her hands after the sugar testing and injections and removing her gloves. She stated she even had hand sanitizer on the cart and did not use it. She also stated she did not the glucometer after use. They do have the wipes but she did not use it. She did admit she laid the glucometer on the resident's bed without a barrier and the machine could have contracted germs. The device was then placed into the centrally-stored medication cart where other resident medications were stored.

The facility's Policy on How to Clean and Maintain a Glucose Glucometer, revealed after each use following the manufacturer's directions using a cloth/wipe with an EPA-registered detergent/ germicide. Their policy and procedure on Handwashing revealed Associates should wash their hands immediately or as soon as practicable after the removal of gloves and/ or other personal protective equipment.

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2. On at 11:30am, an interview was conducted with Resident #3. The interview took place in the residents the door closed. During the interview, the Resident Assistant (Employee G) entered the opening the door with her master key without knocking or announcing herself. Employee G walked past Resident #3 and stated she was there to take away his meal tray from breakfast. When she left the the resident was asked if the staff usually entered his knocking, he stated they do not always knock on the door or let him know they are coming into the

An interview was conducted with Employee G on at 11:45 am. When asked what was the policy regarding entering a resident's she stated they were supposed to knock first and wait for response.

Class III

**0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC**
Based on observation and staff interviews, the facility failed to maintain a safe and clean living environment for 42 of 42 residents that lived in the facility.

The findings include:

Upon entrance to the facility on at 9:05 am, there was a strong odor of detected in the lobby area. During the tour at 9:30 am odors were detected on 3 of the 4 hallways, as well as, the main dining There was carpeting throughout the facility including the resident There were strong odors found in 108, 113, 123, 124, 129, and 132. A very strong presence of odor was found in the main dining.

During the lunch observation in the main dining at 12:05pm, an intensely strong odor of he was detected in the back half of the dining with the most offensive odors found outside the kitchen door leading into the dining There were 8 tables with 24 residents seated in the back of the dining Employees were seated at 3 of the 8 tables feeding or assisting residents during the meal. The residents seated in the back area of the dining and unable to be interviewed. An interview with Resident Assistant (Employee G) was conducted on at 12:15pm and revealed the odor had been a problem since she started working at the facility in 2012. When asked what if anything had been done, she stated the carpets had been cleaned, but did not helped.

On at 2:05 pm, the Wellness Director (WD) was asked to accompany the surveyor to the back of the dining When asked about the strong smell of she stated it had been an ongoing problem. She confirmed the odor was very strong and offensive and was most intense by the kitchen door leading into the dining She further stated that the carpets had been cleaned, however the smell seemed to intensify after the cleaning. The WD stated she believed the odor had most likely penetrated into the concrete beneath the carpeting and needed to be replaced.

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An interview with the administrator on at 2:45 pm revealed that the odor in the facility was an ongoing problem even though carpets had been cleaned , the odor still persisted. He further added that the facility was slated for renovation next year including replacing the flooring.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Clare Bridge Of Ormond Beach
240 Interchange Blvd
Ormond Beach, FL 32174

Dear Administrator:

This letter reports the findings of a state biennial licensure 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 **2013** 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.myflo tions/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

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

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