STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964559	**03/13/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Clare Bridge Of Venice	**1200 Avenida Del Circo Venice, FL 34285**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D

Specific Tag Findings:
These are the results of an unannounced Complaint Survey, CCR# 2014001437 which was conducted on through at Clare Bridge of Venice, an Assisted Living Facility (ALF).

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to contact the resident's family and the physician of a change in condition for 1 (Resident #5) of 3 residents reviewed.

The findings include:

On review of Resident #5's medical records revealed she was admitted to the facility and discharged to the hospital on due to facial lacerations, purple to left eye and left upper lip and to both areas. Resident #5's medical records noted she had multiple behavioral issues including laying and crawling on the floor. The nursing progress notes had multiple entries about to legs and arms, red and upper back which are pealing which are noted on the Skin Observation Form dated . The progress notes also note to her hands, feet, and lower legs related the resident crawling on the floor which the husband and the physician were notified.

The nursing progress note dated at 7:30 p.m., state the dressing to her feet and legs are intact, resident's socks remained on, and the resident had no complaint of pain at this time.

The next nursing progress note is dated at 3:00 p.m. The nurse wrote the resident has purple and to left eye and left upper lip. The left upper lip also had lacerations. Report from the 11-7 shift state the resident had bitten her own lip. The resident is able to open her eye with no discharge and/or pain is noted. Spouse in to visit his wife at lunch. Increase noted but the resident is still able to open her left eye with no complaints. Due to spouse request sending Resident #5 to the emergency department for evaluation and a call was made to the primary physician. Prior to arrival the physician ordered for an ice pack to be applied to the left eye as tolerated, monitor and call back if any complication.

The next nursing progress note is dated at 11:55 p.m. It states: phone call to hospital and was told Resident #5 was admitted with a diagnosis of high troponin levels, and facial .

A nursing progress dated and written as a 'late entry' by Staff E said when she did her first round Resident #5 was found on the floor and was wet with Two cleaned the resident and put her back to bed. She then wrote the resident had bitten her lower lip/jaw on the inside, left eye is and purple and thinks was from recent , right hand is , fingers and legs. The are from being constantly on the floor. The resident has no complaints and slept the rest of the night. This progress note was not time as

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to when it was written.

Further review of the records noted a nursing progress note dated that the husband had reported his wife had hit her head on the door 6 days prior to the injuries noted on The only noted in the nursing progress note was 9 days prior on when the staff heard Resident #5 in her

On at 10:00 a.m., interview Staff A, the nurse who wrote the nursing progress note dated at 3:00 p.m., stated when she arrived to work the morning of her staff told her about Resident #5's left eye and left upper lip being and purple. After she checked on Resident #5 she confirmed the injuries the staff had told her. Resident #5 had to her left eye and left upper lip which also had a laceration. Both areas were purple. It concerned her because when she had reported off to the 3-11 shift the day prior on Resident #5's left eye and lip was not and was not purple with She had asked Staff E the Med Tech in charge on the 11-7 shift what had happen and was told the injuries had occurred on the 3-11 shift and she (Staff E) had found Resident #5 was like that when she had arrived at work. She further stated Staff E had not called the physician or the husband to inform them of the injuries that night and she did not tell her of the injuries during the morning report.

Staff A then stated she did not call the husband or the physician but told the home health nurse when she came in about the incident so she can address the laceration to the upper left lip and the to the left eye and thought they would call the physician for orders. The husband arrived at the facility around lunch time and was upset he was not notified of his wife injuries. The left eye appeared more and the husband insisted Resident #5 be sent to the hospital for an evaluation. The facility staff called 911 for transport and the physician's office, who ordered an ice pack to the left eye as tolerated and to monitor the left eye for any complications. 911 arrived an took Resident #5 to the hospital. She again stated she had not called the husband prior to his arrival and did not do an incident report about the injuries except for her nursing progress notes.

On at 11:00 a.m. during an interview with Staff B, the nurse who worked the 3-11 shift on she stated that she had seen Resident #5 that night and the resident did not have any to her left eye, left upper lip and there was no purple She had not contacted the physician or the husband because Resident #5 was not injured on her shift. She also stated that when Staff E came to work on the 11-7 shift she asked her about the injuries and was told by Staff E when she made her first round Resident #5 was not injured. When Staff E did her second round she noted then Resident #5 was at the foot of her bed with the injuries noted. Staff B also stated the only time she was asked about the incident was on around 1:00 p.m. when they called her on the telephone about the injuries to Resident #5. They asked her if she knew anything about Resident #5's injuries and she told them, "no." They told her Resident #5's left eye had a large which was purple and the left eye is almost shut. She also stated she was never asked to give a written statement about the incident and was never interviewed again about the incident.

Review of the adverse incident log noted there were no Day 1 or Day 15 investigations completed for Resident #5's left eye and upper lip injuries. Review of the grievance log where all grievances are note, investigated and the results of the investigations revealed all the pages were blank and no investigations were done related to

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residents and/or families grievances.

On ... at around 12:30 p.m., interview with the Administrator confirmed Resident #5 was injured on the 11-7 shift on ... to her left eye and left lip which had a laceration. The area was ... and ... with a purple color. He was not informed of the injury until the husband started to complain about his wife injuries and was asking the staff why he was not informed about the injuries and why he had to find out when he came to visit his wife for lunch. Resident #5 was sent to the hospital where she was admitted. He had talked with the nursing staff involved in the incident and believed it occurred on the 11-7 shift. He had written a corporate incident report which had minimal information about the incident, it just states when the injury occurred and who was involved. He further stated he did not do a Day 1 or Day 15 adverse incident investigation and has no written investigation paper work of who he had interviewed related to the injuries and/or any written statements from the staff with possible information into Resident #5's injuries. He further stated Resident #5's husband was upset an asked what had happened and why he was not notified of the injuries. He also confirmed the grievance log book had no grievances entries and/or investigations since the opening of the facility including Resident #5's husband grievance about not being notified about his wife's injuries and what had happen to his wife to cause the injuries.

On ... at around 1:30 p.m., during an interview, Resident #5's husband, stated he was not aware of his wife injuries until he arrived at the facility on ... around noon to be with his wife for lunch. He found his wife at the dining ... with her left eye ... shut with ... dripping into her food. He had asked the staff what had happed but no one could give him an answer. He insisted the staff call 911 to take his wife to the hospital for an evaluation and treatment of her left eye because it looked bad. She was admitted to the hospital on ... On ... he came to the facility to remove his wife belongings and again asked the staff what had happen and no one would give him an answer of what happen to cause the injuries to his wife. As of this time no one from the facility has called him about what had happen to his wife and why he was not notified and/or the physician about his wife's injuries that night or earlier that morning.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Clare Bridge Of Venice
1200 Avenida Del Circo
Venice, FL 34285

Re: CCR #2014001437

Dear Administrator:

This letter reports the findings of a complaint survey that was completed on . 2014 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 19, 2014 to verify that the necessary corrections are in place to correct the deficiency 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 surveyors. 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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