STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965405	05/01/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
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= G
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:
These are the results of an unannounced Complaint Survey, CCR# 2014001879 and 2014002655 which was conducted on through at Clare Bridge an Assisted Living Facility (ALF) in Cape Coral, FL.

The following is a description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on resident records reviewed and facility staff interview, the facility failed to provide care and services to meet 3 (Residents #1, #2, and #8) of 3 resident needs to eliminate . Residents #1, #2, and #8 had several and some with injuries. The facility did not provide them with updated approaches and needs to prevent them from continuing to and have injuries.

The findings include:

1. Record Review for Resident #1:
Personal Service assessment dated and signed by Resident reveals:
Escort and Mobility:
Do you need help going to and from the dining /or community activities, Yes.
Have you in the past twelve months? Yes, history of Left hip
Do you use a mobility aid? Yes, wheelchair
Do you use a bedside mobility device? No.
Comments: Needs to be taken to meals, reminders now has low bed, mat and seat belt.
Skin Care Comments: to and hands, dry patchy skin, takes
Personal service plan dated
Escort and Mobility: Provide physical assistance to and from the dining /or community activities as needed. Memory is one of the reasons for the escort assistance. Physical is one of the reasons for the escort assistance. Be alert for risk for falling. Resident is on the Management Program which includes: Educate resident on the use of emergency call system, Familiarize resident to environment and routine of the community as needed, minimize environmental clutter, Encourage resident to use handrails n , Encourage resident to lock wheelchair if applicable, Prompt resident to use night light, Encourage resident for the appropriate use of assistive devices, Be alert to placing resident's personal items within reach; be alert to appropriateness of resident's foot wear. Resident uses a specialty mattress (e.g. scoop).
History of with hip prior to move in poor safety awareness updated Physician order dated states Resident requires wheelchair with anti-tippers to decrease risk of in wheelchair.

The progress note states that resident continues to get out of wheelchair. Resident #1 remains an ongoing risk of falling. Resident doesn't understand or retain staff attempts to keep him safe He looks weak, is quite thin keep him safe. I strongly advise a SNF placement for Resident #1 even a memory care unit such as that found at Gulf Coast Village.

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Skin Assessments: Drawing of a body that is not dated is in the record. It represents Resident #1 with the right eye large amount of black and blue discoloration. The drawing depicted the left eye with a small amount of black and blue discoloration. The drawing showed both arms with multiple areas of black and blue discolorations from the elbows to the fingers and knuckles. [illegible] to the right [illegible]. The drawing showed a surgery scar to left hip. On [illegible] to both arms, elbows to fingers, right eye large amount, [illegible] left eye small amount [illegible] right [illegible], has hip surgery scar. On [illegible] right elbow 3.0x2.5x01 [illegible] base bloody. On [illegible] right elbow 2.0x0.3x0.1, bloody, [illegible] healed. Left elbow [illegible] 3.0 x 0.3. x0 bloody, [illegible] 1.5X0.2x 0.1, [illegible] healed.

Resident log: [illegible] 5:30 p.m. Resident #1 was found lying on the floors all curled up asleep. Resident said he was getting up from the chair, was sleepy was on the floor. No injury noted upon assessment [illegible] P 63, R 20. Resident assisted to chair and transported to his [illegible] assisted to bed. Chris Anderson, RN Sister, POA and ARNP notified at 7:15 p.m. on [illegible] observed Resident #1 on floor in game [illegible]. He denies hitting head. Table cloth on floor. Vital signs [illegible], P70, T98 Called to Resident #1's daughter inform her. Called Dr. on record. Called Dr. on 1823 who stated he was not resident's physician. No current physician to call at this time. On [illegible] 10:00 a.m. it was reported at 1:35 a.m., that Resident #1 was found on the floor on his knees next to his bed. Staff assessed him, reported no [illegible] and assisted him back to bed. Staff notified POA. On [illegible] 7:10 a.m., Resident #1 was found on his knees next to his bed. He had gross hematuria [illegible] in his [illegible]. His [illegible], a [illegible] was stopped. On [illegible] at 11:45 a.m. Resident #1 was on the floor in front of the dining [illegible]. He was assisted to lunch. On [illegible] 2:00 p.m. Resident #1 was observed on the floor next to the dining [illegible]. On [illegible] 2:00 p.m., Resident #1 is mobile with his wheel chair. He gets up despite his alarms and he needs watching at all times. On [illegible] 1:20 p.m., Resident #1 is found on the floor in the Country Kitchen; 911 is called and he is taken to the ER due to possible head injury. He is positive for a [illegible] and returns to the skilled nursing facility. On [illegible] 3:30 p.m. Resident #1 is found on the floor next to his wheelchair. On [illegible] 11:45 a.m. Resident #1 was found on the floor in front of his wheelchair in hallway. On [illegible] Resident #1 is found nude in the dining [illegible]. On [illegible] 10:50 a.m. Resident #1 is found on the floor in front of his wheelchair in the Hollywood [illegible]. On [illegible] 9:15 a.m. Resident #1 was found sitting in the middle on the floor. On [illegible] 1:30 p.m. Resident #1 was found on the floor in front of his wheel chair. On [illegible] 11:00 a.m. Resident #1 was found on the floor in B hallway sitting against the wall. On [illegible] 7:20 p.m. Resident #1's knees got week walking down the hall holding his wife's hand and he slid to the floor. On [illegible] Resident #1 stood up in the dining [illegible], tried to sit down, the chair moved and he was lowered to the floor. On [illegible] 1:10 p.m. Resident #1 was found sitting on the floor in hallway; his wife said he lost his balance. The wheelchair was in the dining [illegible] the alarm sounding. On [illegible] 4:30 p.m. Resident #1 was in the hall walking. Staff observed him [illegible] back against the wall and slide to the floor. His alarm and cord was found neatly folded in the dining [illegible]. On [illegible] 6:40 p.m. he was found on the floor in front of the wheel chair. His alarm still attached. On [illegible] 7:10 a.m. the alarm was heard sounding in C hall. He was found lying on the floor. On [illegible] 4:00 p.m. Resident #1 was observed to slide out of his wheelchair in Hollywood [illegible]. On [illegible] 12:30 p.m. Resident #1 was found slipping out of his wheel chair. He was [illegible], not easily aroused. The Power of Attorney is present and said she would be looking for a skilled nursing facility. On [illegible] 1:00 p.m. Resident #1 is in the front lobby on the floor, sleeping on his side. On [illegible] 9:50 a.m. Resident #1 is outside Hollywood [illegible] the floor, with a moist [illegible]. On [illegible] 1:35 p.m. Resident #1 is found on the floor in [illegible] with [illegible], 911 called. On [illegible] 5:30 a.m. It was reported by 3rd shift that Resident #1 was found on the floor by his bed during the night. On [illegible] 9:45 a.m. Resident #1 is witnessed falling to the floor hitting his head in the dining [illegible] Activity staff. 911 was called. He returned to the ALF [illegible] with a [illegible] left knee. On [illegible] 9::20 a.m. Resident #1 was witnessed to stand up from his wheel chair, [illegible] to the floor and hit his head. 911 took him to the ER. A 45 day notice was mailed, referencing a conversation with the POA on [illegible] that Resident #1 needed a skilled nursing facility. On [illegible] 11:00 a.m. Resident #1

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was found on the floor in front of his wheelchair in the lobby on . . . 2:00 p.m. Resident #1 was witnessed to stand up and . . . l hitting the left side of his head on the handrail. Staff was unable to reach him in time. 911 was called. On . . . . 3:35 a.m. it was reported by third shift that Resident #1 was found on the floor at 3:35 a.m. and 911 was called. Vital signs were P 98, ... and T read LO.

On . . . . at 9:10 a.m. Staff B stated that they encourage the residents to sit down. They put mats by the bed and they try to put them in the middle of the bed. This is how the try to prevent . . . . and to Staff B's knowledge the . . . l Management Protocol. On . . . . . at 9:15 a.m. Staff C stated they try to keep them seated. They do bed checks more often. If their legs are hanging of the bed they put them back on the bed. Sometimes they put the mattresses on the floor with the doctor's order.

During an Interview on . . . . at 1:21 p.m. the Executive Director (ED) stated that they had alarms on his bed and wheel chair. Resident #1 would just remove them. She stated that she was unaware that she could discharge a resident prior than 45 days if it was unsafe for the resident or others. She stated that they were trying other interventions to keep Resident #1 from falling. She did state there was no documentation of this.

2. Observation at 12:00 p.m. on . . . . . shows Resident #2 sitting in the dining . . . . . She stood up out of her wheelchair. The chair alarm sounded and staff responded immediately by assisting her to sit back down in the wheelchair. She stood up in her wheelchair several times during the course of lunch. The alarm sounded off each time. Her husband helped her sit back down in her wheelchair. Observation at 1:30 p.m. on . . . . showed her bed is located on the floor.

A review of Resident #2's record showed she was admitted to the facility on . . . . . A review of the "Resident Log" form in her record showed she has had several . . . since her admission. The incident reports also show . . . . The following is a count of . . . . Resident #2 has had by date since admission:
. . . . . Resident #2 was found on the floor with no injuries.
. . . witnessed Resident #2 . . . with head injury.
1/6 Resident #2 found on floor with no injuries
1/7 witnessed Resident #2 . . . with no injuries
. . . l witnessed Resident #2 . . . l with no injuries
. . . Resident #2 observed on floor and head . . . . . called and sent to hospital and returned from hospital on . . . . . .
Resident #2 observed on floor with no injuries.
3/1 Resident #2 observed on floor at 2:35 p.m. with no injuries. At 7:50 p.m. Resident #2 was observed by other residents she slid off her wheelchair and landed on the floor with no injuries.
3/4 Resident #2 . . . l was observed with no injuries.
3/5 Resident #2 observed sitting on floor with no injuries.
3/6 Resident #2 observed on floor mat with no injuries.
. . . . Resident #2 found on floor and she said she hit her head and went to hospital.
. . . Resident #2 found on floor mat with redness to her left hand.
. . . . at 10:50 a.m. observed Resident #2 with . . . . l hand with no complaints of pain. Called ARNP. At 2:00 p.m. no return call from ARNP. Pass info to 2nd shift. At 3:34 p.m. Resident #2 complained of . . . pain to left side and staff awaiting call back from ARNP. On . . . . at 4:15 p.m. Resident #2 has tenderness to left . . . cage and left hand still . . . . . ARNP called and left message. At 4:30 p.m. x-rays ordered. On . . . l x-rays show . . . . . to left ribs 4-8, fluid in the lower lung.

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Resident #2 found observed sitting on the floor. She stated she hit her head. 911 called and transported to hospital emergency . She was brought back to facility with no new orders.
4/2 - observed Resident #2 sitting on floor with no injury.
l unwitnessed with no injuries.
Resident #2 was found on the floor with no injury.

Resident #2 has had a total of 19 documented since admission. Further review of Resident #2's chart shows she has a PSP (Personal Service Plan) dated It shows an area of concern titled "Escort & Mobility." It shows Resident #2 is to have a low bed, bed and chair alarm. It also shows to provide assistance to and from dining and activities, encourage Resident #2 to use her wheelchair, be alert to risk for falling, educate Resident #2 to use the emergency call system and several other reminders. This plan was printed on Resident #2 has had 19 since this plan was developed and has not been updated with new intervention and/or approaches to prevent further This plan is identified in the chart as the "Current PSP (personal service plan) do not thin."

An interview was conducted with the Administrator on at 11:20 a.m. She stated this PSP was developed for Resident #2 when she was admitted to the facility. She is not aware if there were changes on this plan. She stated there is a Care Profile for each resident in the spa for the staff to review to know what type of care they need to provide for each resident they are assigned to. The Administrator also stated the health and wellness director provides information to the other nurses and concerning resident and the type of care needed for them to prevent further This is on the Care Profile and 24 hour report.

The Ancillary Service Manager was also involved with this interview. She stated Resident #2 has been having physical to help with her transfers; a wheelchair was order to fit her better. She had bad positioning in an older chair. This fitted chair would help with her sitting up better. They also obtained a doctor's order for pain medication whenever she needs it to help her if she is in pain. This might prevent her from trying to get out of the wheelchair. She also had a Trach and were ordered and given. They are also going to order bolsters to put in her wheelchair on her sides to keep her sitting up straight and not leaning to one side.

The surveyor then looked for the Care Profiles. There were two Care Profiles for Resident #2. One was located in the administrative assistance's office and the other was located in the spa Hall B where Resident #2 lives. Both Care Profiles were reviewed. They both did not mention Resident #2 is a risk for or has had The Care Profile located in the spa showed it was updated on There was no information for the staff to provide for Resident #2 to decrease or eliminate her There was no information Resident #2 is a risk.

An interview was conducted with Staff C on at 12:15 p.m. She stated they are to keep Resident #2 sitting straight in her wheelchair. If she keeps leaning then they are to put her in bed because she might be tired. She was not aware Resident #2 had physical and does not know if there is anything they need to do for Resident #2 concerning exercise or She know she is on low bed and has the alarms. At approximately 1:00 p.m. the Administrator returned and stated there is no mention of Resident #2's in the 24 hour reports for the nurses and .

An interview was conducted with Resident #2's responsible party at 12:40 p.m. on She stated she thinks Resident #2 broke her ribs by the repositioning her. She could not remember when the repositioned her. A review of the incident reports show the assisted her on when she l and reported she hit

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her head. The incident report dated showed there was redness to her left hand. Resident #2's "Resident Log" form dated showed she complained of pain in her hand and ribs.

At 2:00 p.m. on , the Administrator and health and wellness director were both asked if they knew how Resident #2 broke five ribs. They both did not know and this was not investigated.

3. Record review for Resident # 8, admitted revealed a Health History: above the stomach, Resident Log 9:30 a.m. Called to apt by RCA resident observed on floor laying prone arms underneath head. Resident #8 complains of upper chest pain. from Left elbow. At 9:35 called to transport. Daughter notified. At 9:45 a.m. here to transport resident to Cape Coral Hospital Hospital physician notified. Resident returned from via Daughter's car. Resident #8 has a laceration to right elbow with aid. Resident admitted to hospice.
Resident observed sitting on the floor in his doorway of his of bowel movement. Resident alert and denies pain. States he wheeled himself back to his tried to get up from the wheelchair to go to the He from the wheelchair. No signs or symptoms of new or open areas. POA, Dr. and Hospice all notified. On 9:15 a.m. Resident #8 was observed on floor in Hollywood on No complaints of pain. Freely moves all extremities. , P 70, R 20, and Temp 97.7. 9:30 POA notified. On Hospice delivered alarm for wheelchair. On 6:00 a.m. Night shift reports resident at 1:15 a.m. with no signs and symptoms of injury noted. Also, made Health Wellness Director aware. On Call to POA who states due to increase in she will be talking with Hope Hospice for a lower bed. Dr. also aware with no new orders noted. On 11:30 a.m. per hospice consult new hospital bed with 2 safety mats ordered along sided chair alarm @ 10:30. POA notified of above. Physician Orders. On 8:30 a.m. Hospice Consult. On 11:00 a.m. Hospital bed, low to floor two floor mats for safety chair alarm. Personal Service Plan dated
Escort and Mobility. Provide staff attention and/or verbal prompts to and from the dining or community activities as needed. Memory is none of the reasons for the escort assistance. Be alert for falling. Resident uses a walker as a mobility aid. Resident is on the Management Program:

1. Educate resident on the use of emergency call system
2. Familiarize resident to routine of the community, as needed
3. Minimize environmental clutter
4. Encourage resident to use handrails in
5. Encourage resident to lock wheelchair if applicable
6. Prompt resident to use night light
7. Encourage resident to use appropriate assistive device

Be alert to placing resident's personal items within reach; be alert to appropriateness of resident's footwear.

Service plan was updated on No new interventions were added.

Hospice notes dated Mobility/safety: Mobility Assessment: Endurance poor, wheelchair bound, needs assist; transfers, ss/injury; generalized Safety: Safe in residence.

Report for through Resident #8 3 times during this period. New low hospital bed, floor mats and chair alarm. Invoice for chair alarm Invoice for pickup of 2 mats dated

Class II

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0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on resident and staff interviews, the facility failed to provide residents who require assistance with Activities of Daily Living (ADLs), including washing their face and brushing their [illegible] prior to going to bed at night.

The findings include:

Interviews were conducted with Residents #6 and #7 at 2:00 p.m. on [illegible]. They both were wearing make-up (lip sick). Resident #7 was also wearing blush. They both stated that the staff does not do anything for them. They don't make sure their make-up is washed off their faces before they go to bed. The staff does not help them brush their [illegible].

A review of Resident #6's health assessment dated [illegible] shows she requires assistance with [illegible].

A review of Resident #7's health assessment dated [illegible] shows she requires assistance with her [illegible].

Interviews were conducted with Staff B and C on [illegible] at 9:10 a.m. They both stated when they wake residents in the morning they have make-up on their faces. They are not washed. Staff C stated the residents also have food on their faces and [illegible].

Another interview was conducted with Staff E at 9:30 a.m. on [illegible]. She stated she will get some residents up from bed in the morning and they still have make-up on their faces and food in their [illegible].

Staff C and E both stated they have notified administrative staff about this in the past.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on three of three resident records reviewed, family and staff interviews, the facility neglected to ensure 3 (Residents #1, #2, and #8) of 3 residents were in a safe environment free from repeated [illegible] and injuries from these [illegible].

The findings include:

1. Observation at 12:00 p.m. on [illegible] shows Resident #2 sitting in the dining [illegible]. She stood up out of her wheelchair. The chair alarm sounded and staff responded immediately by assisting her to sit back down in the wheelchair. She stood up from her wheelchair several times during the course of lunch. The alarm sounded off each time. Her husband helped her sit back down in her wheelchair.

Observation at 1:30 p.m. on [illegible] showed her bed is located on the floor.

A review of Resident #2's record showed she was admitted to the facility on [illegible].

A review of the Resident Log form in her record showed she has had several [illegible] since her admission. The incident reports also show [illegible]. The following is a count of [illegible] Resident #2 has had by date since admission:
[illegible] Resident #2 was found on the floor with no injuries.
[illegible] witnessed Resident #2 [illegible] with head injury.

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1/6 Resident #2 found on floor with no injuries
1/7 witnessed Resident #2 with no injuries
witnessed Resident #2 with no injuries
Resident #2 observed on floor and head called and sent to hospital and returned from hospital on
Resident #2 observed on floor with no injuries.
3/1 Resident #2 observed on floor at 2:35 p.m. with no injuries. At 7:50 p.m. Resident #2 was observed by other residents she slid off her wheelchair and landed on the floor with no injuries.
3/4 Resident #2 was observed with no injuries.
3/5 Resident #2 observed sitting on floor with no injuries.
3/6 Resident #2 observed on floor mat with no injuries.
Resident #2 found on floor and she said she hit her head and went to hospital.
Resident #2 found on floor mat with redness to her left hand.
at 10:50 a.m. observed Resident #2 with hand with no complaints of pain.

Called ARNP at 2:00 p.m. no return call from ARNP. Pass info to 2nd shift. At 3:34 p.m. Resident #2 complained of pain to left side and staff awaiting call back from ARNP. On at 4:15 p.m. Resident #2 has tenderness to left cage and left hand still ARNP called and left message. At 4:30 p.m. x-rays ordered. On x-rays show to left ribs 4-8, fluid in the lower lung. On Resident #2 found observed sitting on the floor. She stated she hit her head. 911 called and transported to hospital emergency She was brought back to facility with no new orders. On 4/2 - observed Resident #2 sitting on floor with no injury. On unwitnessed with no injuries. On Resident #2 was found on the floor with no injury.

Resident #2 has had a total of 19 documented since admission. Further review of Resident #2's chart shows she has a PSP (Personal Service Plan) dated It shows an area of concern titled "Escort & Mobility." It shows Resident #2 is to have a low bed, bed and chair alarm. It also shows to provide assistance to and from dining and activities, encourage Resident #2 to use her wheelchair, be alert to risk for falling, educate Resident #2 to use the emergency call system and several other reminders. This plan was printed on Resident #2 has had 19 since this plan was developed and has not been updated with new intervention and/or approaches to prevent further

An interview was conducted with the Administrator on at 11:20 a.m. She stated this PSP was developed for Resident #2 when she was admitted to the facility. She is not aware if there were changes on this plan. She stated there is a "Care Profile" for each resident in the spa for the staff to review to know what type of care they need to provide for each resident they are assigned to. The surveyor then looked for the Care Profiles. There were two Care Profiles for Resident #2. They both did not mention Resident #2 is a risk for or has had The Care Profile located in the spa showed it was updated on There was no information for the staff to provide for Resident #2 to decrease or eliminate her There was no information Resident #2 is a risk.

An interview was conducted with Staff C on at 12:15 p.m. She stated they are to keep Resident #2 sitting straight in her wheelchair. If she keeps leaning then they are to put her in bed because she might be tired. She was not aware Resident #2 had physical and does not know if there is anything they need to do for Resident #2 concerning exercise or She know she is on low bed and has the alarms.

An interview was conducted with Resident #2's responsible party at 12:40 p.m. on She stated she thinks Resident #2 broke her ribs by the repositioning her. She could not remember when the repositioned

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her. A review of the incident reports show the assisted her on when she and reported she hit her head. The incident report dated showed there was redness to her left hand. Resident #2's "Resident Log" form dated showed she complained of pain in her hand and ribs.

At 2:00 p.m. on the Administrator and health and wellness director were both asked if they knew how Resident #2 broke five ribs. They both did not know and this was not investigated.

The facility did not ensure Resident #2's environment was safe for her to live in since the Care Profile and PSP were not updated to show Resident #2 continues to have with injuries. This resulted in the staff not providing her with appropriate care and she continued to have injuries with her .

2. Record Review for Resident #1's Personal Service assessment dated and signed by Resident reveals: Escort and Mobility: Do you need help going to and from the dining /or community activities, Yes.
Have you in the past twelve months? Yes, history of Left hip .
Do you use a mobility aid? Yes, wheelchair
Do you use a bedside mobility device? No.
Comments Needs to be taken to meals, reminders now has low bed, mat and seat belt.
Skin Care Comments: to and hands, dry patchy skin, takes .
Personal service plan dated . Escort and Mobility: Provide physical assistance to and from the dining /or community activities as needed. Memory is one of the reasons for the escort assistance.
Physical is one of the reasons for the escort assistance.
Be alert for risk for falling.
Resident is on the Management Program which includes: Educate resident on the use of emergency call system, Familiarize resident to environment and routine of the community as needed, minimize environmental clutter, Encourage resident to use handrails n . Encourage resident to lock wheelchair if applicable, Prompt resident to use night light, encourage resident for the appropriate use of assistive devices, be alert to placing resident's personal items within reach; be alert to appropriateness of resident's foot wear. Resident uses a specialty mattress (e.g. scoop).
History of with hip prior to move in poor safety awareness updated . Physician order dated states Resident requires wheelchair with anti-tippers to decrease risk of in wheelchair.

On /14 progress note states that resident continues to get out of wheelchair. Resident #1 remains at ongoing risk of falling. Resident doesn't understand or retain staff attempts to keep him safe He looks weak, is quite thin keep him safe. I strongly advise a SNF placement for Resident #1 even a memory care unit such as that found at Gulf Coast Village.

Skin Assessments: Drawing of a body that is not dated is in the record. It represents Resident #1 with the right eye large amount of black and blue discoloration. The drawing depicted the left eye with a small amount of black and blue discoloration. The drawing showed both arms with multiple areas of black and blue discolorations from the elbows to the fingers and knuckles. to the right . The drawing showed a surgery scar to left hip. On to both arms, elbows to fingers, right eye large amount, left eye small amount , right , has hip surgery scar. On right elbow 3.0x2.5x01 base bloody. On right elbow 2.0x0.3x0.1, bloody, healed. Left elbow 3.0 x 0.3. x0 bloody, 1.5X0.2x 0.1, healed.

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	AL11965405	05/01/2014
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Clare Bridge Of Cape Coral	911 Santa Barbara Blvd Cape Coral, FL 33991	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

Resident log: 5:30 p.m. Resident #1 was found lying on the floors all curled up asleep. Resident said he was getting up from the chair, was sleepy was on the floor. No injury noted upon assessment P 63, R 20. Resident assisted to chair and transported to his assisted to bed. Chris Anderson, RN Sister, POA and ARNP notified 7:15 p.m. On observed resident #1 on floor in game He denies hitting head. Table cloth on floor. Vital signs P70, T98 Called to Resident #1's daughter inform her. Called Dr. on record. Called Dr. on 1823 Dr. who stated he was not resident's physician. No current physician to call at this time. On 10:00 a.m. It was reported at 1:35 am that Resident #1 was found on the floor on his knees next to his bed. Staff assessed him, reported no , and assisted him back to bed. Staff notified POA. On 7: 10 a.m. Resident #1 was found on his knees next to his bed. He had gross hematuria in his His , a was stopped. On at 11:45 a.m. Resident #1 was on the floor in front of the dining He was assisted to lunch. On 2:00 p.m. Resident #1 was observed on the floor next to the dining On 2/08//14 2:00 P.M. Resident #1 is mobile with his wheel chair. He gets up despite his alarms and he needs watching at all times. On 1:20 P.M. Resident #1 is found on the floor in the Country Kitchen; 911 is called and he is taken to the ER due to possible head injury. He is positive for a and returns to the skilled nursing facility. On 3:30 p.m. Resident #1 is found on the floor next to his wheelchair. On 11:45 a.m. Resident #1 was found on the floor in front of his wheelchair in hallway. On Resident #1 is found nude in the dining On 10:50 a.m. Resident #1 is found on the floor in front of his wheelchair in the Hollywood On 9:15 a.m. Resident #1 was found sitting in the middle on the floor. On 1:30 p.m. Resident #1 was found on the floor in front of his wheel chair. On 11:00 a.m. Resident #1 was found on the floor in B hallway sitting against the wall. On 7:20 p.m. Resident #1's knees got week walking down the hall holding his wife's hand and he slid to the floor. On Resident #1 Stood up in the dining tried to sit down, the chair moved and he was lowered to the floor. On 1:10 p.m. Resident #1 was found sitting on the floor in hallway; his wife said he lost his balance. The wheelchair was in the dining the alarm sounding. On 4:30 p.m. Resident #1 was in the hall walking. Staff observed him back against the wall and slide to the floor. His alarm and cord was found neatly folded in the dining On 6:40 p.m. He was found on the floor in front of the wheel chair. His alarm still attached. On 7:10 a.m. the alarm was heard sounding in C hall. He was found lying on the floor. On 4:00 p.m. Resident #1 was observed to slide out of his wheelchair in Hollywood On 12:30 p.m. Resident #1 was found slipping out of his wheel chair. He was , not easily aroused. The Power of Attorney is present and said she would be looking for a skilled nursing facility. On 1:00 p.m. Resident #1 is in the front lobby on the floor, sleeping on his side. On 9:50 a.m. Resident #1 is outside Hollywood the floor, with a moist On 1:35 p.m. Resident #1 is found on the floor in with 911 called. On 5:30 a.m. it was reported by 3rd shift that Resident #1 was found on the floor by his bed during the night. On 9:45 a.m. Resident #1 is witnessed falling to the floor hitting his head in the dining Activity staff. 911 was called. He returned to the ALF with a left knee. On 9:20 a.m. Resident #1 was witnessed to stand up from his wheel chair, to the floor and hit his head. 911 took him to the ER. A 45 day notice was mailed, referencing a conversation with the POA on that Resident #1 needed a skilled nursing facility. On 11:00 a.m. Resident #1 was found on the floor in front of his wheelchair in the lobby. On 2:00 p.m. Resident #1 was witnessed to stand up and hitting the left side of his head on the handrail. Staff was unable to reach him in time. 911 was called. On 3:35 a.m. it was reported by third shift that Resident #1 was found on the floor at 3:35 a.m. and 911 was called. Vital signs were P 98, , and T read LO.

On at 9:10 a.m. Staff B stated that they encourage the residents to sit down. They put mats by the bed and they try to put them in the middle of the bed. This is how the try to prevent and to Staff B's knowledge the Management Protocol. On at 9:15 a.m. Staff C stated they try to keep them seated. They do bed checks more often. If their legs are hanging of the bed they put them back on the bed. Sometimes they put

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the mattresses on the floor with the doctor's order.

Interview on at 1:21 p.m. with the Executive Director (ED) stated that they had alarms on his bed and wheel chair. Resident #1 would just remove them. She stated that she was unaware that she could discharge a resident prior than 45 days if it was unsafe for the resident or others. She stated that they were trying other interventions to keep Resident #1 from falling. She did state there was no documentation of this.

3. Record review closed record Resident #8 admitted on Health History: above the stomach, Resident Log on 9:30 a.m. called to apt by RCA resident observed on floor laying prone arms underneath head. Resident #8 complains of upper chest pain. from Left elbow. At 9:35 called to transport. Daughter notified. At 9:45 a.m. here to transport resident to Cape Coral Hospital physician notified. On Resident returned from via Daughter's car. Resident #8 has a laceration to right elbow with aid. On Resident admitted to hospice. On Resident observed sitting on the floor in his doorway of his of bowel movement. Resident alert and denies pain. States he wheeled himself back to his tried to get up from the wheelchair to go to the He from the wheelchair. No signs or symptoms of new or open areas. POA, Dr. and Hospice all notified. On 9:15 a.m. Resident #8 was observed on floor in Hollywood on No complaints of pain. Freely moves all extremities. P 70, R 20, and Temp 97.7. 9:30 POA notified. On Hospice delivered alarm for wheelchair. On 6:00 a.m. Night shift reports resident at 1:15 a.m. with no signs and symptoms of injury noted. Also, made Health Wellness Director aware. On Call to POA who states due to increase in she will be talking with Hope Hospice for a lower bed. Dr. also aware with no new orders noted. On 11:30 a.m. Per hospice consult new hospital bed with 2 safety mats ordered along sided chair alarm @ 10:30. POA notified of above. Physician Orders. On 8:30 a.m. Hospice Consult. On 11:00 a.m. Hospital bed, low to floor two floor mats for safety chair alarm. Personal Service Plan dated Escort and Mobility. Provide staff attention and/or verbal prompts to and from the dining or community activities as needed. Memory is none of the reasons for the escort assistance. Be alert for falling. Resident uses a walker as a mobility aid. Resident is on the Management Program:

1. Educate resident on the use of emergency call system
2. Familiarize resident to routine of the community, as needed
3. Minimize environmental clutter
4. Encourage resident to use handrails in
5. Encourage resident to lock wheelchair if applicable
6. Prompt resident to use night light
7. Encourage resident to use appropriate assistive device

Be alert to placing resident's personal items within reach; be alert to appropriateness of resident's footwear.

Service plan was updated on No new interventions were added.

Hospice notes dated Mobility/safety: Mobility Assessment: Endurance poor, wheelchair bound, needs assist; transfers, ss/injury; generalized Safety: Safe in residence.

Report for through Resident #8 3 times during this period. New low hospital bed, floor mats

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and chair alarm. Invoice for chair alarm . . . . . Invoice for pickup of 2 mats dated . . .

Class II

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on resident record reviews, observation, and staff interviews, the facility failed to ensure 1 (Resident #3) of 3 residents was served her prescribed diet.

The findings include:

A review of Resident #3's record shows she is on hospice care. Her health assessment dated . . shows an order for regular, mechanical soft diet. The monthly physician orders sheets for . . and . . . shows an order for mechanical soft diet. The physician signed these monthly orders.

Observation on . . . . . at 12:00 p.m. showed Resident #3 sitting in the dining . . . for her lunch. She was served applesauce for her salad. At 12:20 p.m., she was then served broccoli, bread stuffing, and pork loin. The pork was cut in bite size pieces and the broccoli was also in large pieces.

An interview was conducted with the activity staff on . . . . at 12:20 p.m. She was assisting Resident #3 with her lunch. She stated she is not aware of Resident #3's diet. Staff A stated Resident #3 is on a mechanical soft diet and the broccoli is soft. The meat is cut up and that should be mechanical.

An interview was conducted with Health Wellness Director on . . . . . at 12:30 p.m. She stated they do not have any residents on a mechanical soft diet. She described mechanical soft diet as the meat should be ground. She reviewed Resident #3's chart and confirmed she is on a mechanical diet and she was not served her prescribed diet.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Clare Bridge of Cape Coral
911 Santa Barbara Blvd
Cape Coral, FL 33991

Dear Administrator:

This letter reports the findings of a complaint inspection survey completed on , 2014, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
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= G
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Directed Corrective Actions:

1. The facility, in consultation with medical and physical professionals, will review the facility Prevention policies and procedures and revise as necessary. These policies and procedures will be reviewed and revised as needed no later than , 2014.

2. The facility will evaluate all residents in the facility for continued residency as well as for risk and medication interactions. These evaluations will be completed by a Registered Nurse or the Resident's primary physician and will be completed no later than , 2014.

3. The facility will develop an individualized plan to reduce the risk of falling for each resident identified as a risk. These plans will be developed by a Registered Nurse and will be completed no later than , 2014. Each individualized plan to reduce the risk of falling for each resident who is a Hospice resident will be shared/coordinated with the resident's hospice provider.

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

4. All staff will be in-serviced on the facilities Prevention policies and procedures no later than 2014.

5. All staff will be in-serviced on each resident's plan to reduce the risk of by no later than 29, 2014.

6. The facility administrative staff will monitor the implementation of the facility's Prevention policies and procedures, as well as monitor the implementation of each individual resident's plan to prevent This monitoring will take place on all shifts and will continue for at least 90 days.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Mr. Harold D. Williams, Field Office Manager at (239) 335 1315.

Sincerely,

Harold D. Williams
Field Office Manager
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