STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964856	05/08/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Clare Bridge Of Tequesta	211 Village Blvd Tequesta, FL 33469	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint survey, CCR#2014004497, was conducted on at Clare Bridge of Tequesta. The facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on interview and record review, the facility failed to provide care and services relating to a resident receiving medications timely, for an acute condition; and failing to notify the family that a delay in receiving medications occurred, for 1 of 3 residents (Resident #1).

The findings include:

Resident #1 was admitted to the facility on with diagnosis of and of the right eye. He was receiving Hospice services beginning He was and relied on the staff to anticipate his needs. He required total assistance with care and services. His most current Health Assessment Form, (AHCA Form 1823) dated documented under Status, "nonverbal, except for uncomprehensible mutterings, all needs are anticipated/met by caregivers." The 1823 form documented under Nursing Requirements, "medication management." He was coded for needing medication administration.

On at 11:00 AM, the Wellness Director was summoned to the resident's confirm a report the resident was bitten by ants in his Bites were found on his lower back on the right side, right thigh, and his right ankle. A Hospice Registered Nurse, who was present in the facility at the time assessed the resident's skin and obtained orders from the Hospice Physician to include: 25 mg po 4 times a day x 48 hrs" and "Decadron 4 mg po today and 5/3 at dinner time." The pharmacy was made aware and the medications arrived in the facility at approximately 9:30 PM on The resident did not receive the first dose of until 8:00 AM on and the Decadron until 5:00 PM on The dose of Decadron on was supposed to be the second dose administered, however due to the avoidable delay, was only the first received.

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The Licensed Practical Nurse (LPN) on duty for the 3-11 shift on and assigned to administer the medications to the resident, was made aware by the Med Tech at 9:30 PM on , the medications arrived in the facility to administer. An interview was conducted with the LPN on at 12:49 PM. She expressed she was aware the medications arrived and were available to administer. She stated it did not come to her mind he needed them as soon as possible, and she failed to return to the medication cart where the medications were. She stated she was assisting another resident at the time and did not follow through on Resident #1's medications. She stated she administered his routine 5:00 PM medications that he normally receives, and at the time, she observed the new orders for the and the Decadron on his MOR, but failed to follow through to administer the two medications on , when they were available. She validated this was an error and the resident did not receive what he needed timely, nor was it proper following of physician's orders. She expressed she checked on the resident at the beginning of her shift and the end of her shift, for a total of two times.

An interview with the med tech was conducted on at 3:30 PM. The med tech validated the medications arrived at 9:30 PM on and the LPN was present in the , when the med tech put the medications in the cart. The med tech stated she informed the nurse verbally, as well.

Review of a nursing progress note dated at 11:00 AM, the following was documented: "Upon examination, the following sites had clusters of red bite-appearing areas: 1. Right lower lateral region, 2. Right lateral thigh, and 3. Right anterior ankle extending to top of right foot."

The next progress note found in the medical record regarding the condition of the resident's skin involving the three bite areas, was found dated 7-3. There was no evidence any of the areas of skin affected were being assessed from at 11:00 AM though on 7-3 shift.

An interview was conducted with the Wellness Director, a Licensed Practical Nurse (LPN), on at 10:00 AM. The LPN validated the progress notes were not maintained ongoing to monitor the skin issues. The LPN agreed the skin condition should have been documented at a minimum of daily, until healed. An interview with the Administrator, a Registered Nurse (RN), was conducted on at 5:00 PM who agreed there was a lack of documentation in the progress notes, and did not support the facility maintaining nursing progress notes for an acute skin condition.

An interview was conducted with the responsible family member of Resident #1, on at 4:40 PM. The family member expressed she was not informed the resident did not receive the medications on , as he needed. When asked if she was made aware by the facility, she stated, "No. No one at the facility told me. I had no idea."

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An interview was conducted with the Hospice RN on . . . . . at 11:11 AM, she revealed the following. She expressed the details of the assessment she did on Resident #1, regarding the ant bites, and obtained medication orders to ensure the resident did not have a systemic reaction. She stated the reaction remained local, minor, the resident did not show any response, and showed no signs of distress. Remedies on the part of Hospice and the staff were immediately put in place to prevent any further issues. The resident was supplied on with all new equipment and supplies. The resident ' s wife was present and was aware, as well as made aware on the medications the Hospice physician ordered. She stated the areas were small, cleaned, and did not require any sort of cream or ointment. The medications were only for internal prevention. She stated the areas scabbed right away and healed. The surveyor observed a few small marks on the resident ' s foot that were dry, scabbed, and healed. All other areas of the skin were clear with no signs.

The issue was discussed with the Wellness Director and the Administrator on . . . . . at 5:00 PM, who both validated the resident experienced an unnecessary delay in receiving his medications for the treatment of ant bites, which was avoidable. Both validated disciplinary action was underway for the 3-11 nurse on Both stated they were made aware of the situation on . . . . . Review of the staffing schedules revealed the facility allowed the nurse to work on and pass medications, while an investigation was in progress. Both expressed in hindsight this was an error on their part. Both validated the resident's family was not informed about the delay in receiving the medications, which was also avoidable.

Class III

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0054-Medication - Records 58A-5.0185(5) FAC

Based on interview and record review, the facility failed to properly maintain an accurate Medication Observation Record (MOR), for 2 of 3 residents (Resident #1, Resident #2). As evidenced by Resident #1's medications were not properly transcribed, and Resident #2's medication was not documented as received.

The findings include:

1. Resident #1 was admitted to the facility on with diagnosis of and of the right eye. He was and required medication administration.

On staff discovered the resident sustained ant bites on three areas of his body. The physician was made aware an at 11:00 AM, and ordered 25 mg po 4 times a day x 48 hrs" and "Decadron 4 mg po today and 5/3 at dinnertime." The resident did not receive the first dose of until 8:00 AM on and the Decadron until 5:00 PM on . (See A0025).

The 7-3 shift nurse, who transcribed the physician orders to the MOR, documented the orders drawing an arrow for the medication to begin at 8:00 AM. She transcribed the Decadron to begin on at 5 pm. An interview was conducted with the 7-3 nurse on at 1:15 PM. She indicated she was aware the medications were ordered right away and would be delivered on and the resident needed the medications promptly to prevent a systemic reaction to the bites. She was unable to explain why she planned for the to begin on , instead of to meet his needs.

An interview with the Wellness Director and the Administrator on at 12:00 PM validated the nurse transcribed the wrong, making the MOR inaccurate for the administration of the in relation to the resident's needs, once it arrived. Both validated disciplinary action for the nurse was underway.

2. Resident #2 was admitted to the facility on with diagnosis of and . He had a physician's order dated , to receive 28 units of insuiln after breakfast and dinner, if he consumes 50-100% of his meal. On documentation showed the resident consumed 50% of his dinner meal. He was to receive 28 units of . Review of the MOR on showed a blank box regarding the resident receiving the

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An interview was conducted with the 3-11 shift nurse on [redacted] at 12:49 PM. She stated the resident received the [redacted] but she did not record it on the MOR, and validated she made an error.

An interview was conducted with the Wellness Director on [redacted] at 1:00 PM, who validated the MOR was not accurate for the [redacted] administration.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Clare Bridge Of Tequesta
211 Village Blvd
Tequesta, FL 33469

Dear Administrator:

Re: CCR #2014004497

This letter reports the findings of a state licensure survey that was conducted on . 2014 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 . **2014** 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 representative. Should you have any questions please call this office at (561)381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/jw

XG90

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