STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966484	06/27/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bridge At Inverrary (the)	4291 Rock Island Road Lauderhill, FL 33319	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced licensure complaint surveys, CCR#2014003317, CCR#2014002734, and CCR#2014002970 were conducted on thru and at The Bridge At Inverrary. The facility had a deficiency found at the time of the visit.

Deficient practice identified at CCR#2014003317 at A 010.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on interview and record review, the facility failed to monitor the resident's appropriateness for continued residency, in light of behaviors demonstrated, posing a danger to self and others, over a period of months; and the facility failed to ensure an updated, complete Resident Health Assessment form (AHCA form 1823) , was in place, for 1 of 3 residents reviewed (Resident #1).

The findings include:

a) Resident #1 was admitted to the facility on with diagnosis of Behavioral Issues, Memory Loss, and Resident #1's AHCA Form 1823 dated, did not address, as required, if the resident's needs could be met in an assisted living facility; the section to indicate yes or no and comments was left blank. The section to document special precautions was marked with an asterisk, but left blank. This was the 1823 in place for the resident during his stay. The record showed the resident was discharged to the hospital on after a self-inflicted eye injury was noted by licensed staff, and the physician was made aware. The record reflected the resident was tall and large in stature. The resident had and his daughter was his power of attorney. The resident was noted on admission to have an to an anti-ps medication.

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b) Review of the resident's medical record showed a history of behaviors, as follows:

A progress noted dated at 11:00 AM, revealed the resident refused his morning medications. Further review of the record showed the resident refused medications, care, and leaving his , at times throughout his stay. He refused monitoring for his which was eventually discontinued. The record reflected Resident #1 had difficulty sleeping at night, and would nap in chairs in dining lobby after meals. The resident was seated at meals with other residents. Staff reported the resident would sleep in a dining chair with his legs stretched out and torso tilted back, posing a safety risk of sliding from the chair, and required to be awoken to relocate for safer seating in the lobby.

The resident's service plan, dated documented under the behaviors section, "alert and oriented, and disoriented with the word circled, and a written notation to reorient @ x's (at times) as needed." The service plan showed a written update, dated after the resident was discharged to the hospital on , and did not return to the facility, which stated, "Report aggression/hostility immediately, approach calmly - do not rush resident, do not turn back on resident, if resident's behavior escalates, becomes hostile - maintain distance, guide to quiet area - maintain calm, quiet area."

Review of a progress note, as well as an incident report, both dated , revealed the resident was found on the floor in his . The time was noted 7:05 AM, before breakfast. He refused vital signs to be monitored. A progress noted dated at 3:00 PM indicated the resident was aggressive in the dining , at a nursing assistant, dietary aides, and the dining . His family was notified and visited the facility. The physician was notified. On the report under steps taken to prevent reoccurrence, "Resident was told to call for assistance and to use the walker."

On , documentation revealed the resident was observed in the dining , cups and his walker. The family was made aware and visited the facility.

On documentation revealed the resident was observed sleeping in the dining staff encouraged the resident for 30 minutes to sit in the lobby instead. At 6:30 PM, the security staff notified the nursing staff the resident was in the Independent Living section. The resident was returned to the Assisted Living section and notes described the resident as appearing tired all the time and when awake, needs redirection.

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

On documentation revealed at 10:00 AM the physician ordered a psych consult for Resident #1. Later on the resident was noted leaning to the right side, was hard to arouse and kicking at staff when aroused. The physician was made aware and the resident was transferred to the hospital. The psych evaluation was put on hold until he returned from the hospital. The resident returned to the facility on The hospital records documented the resident had history of sleep issues. The history and physical form completed at the hospital dated indicated the resident "was admitted for He returned with a new order for to treat his

On at 9:00 AM, documentation showed the dietary staff summoned the nursing staff to the dining The resident was asleep at the table, and when attempting to wake him up, he became aggressive and combative. The notes stated, "when attempting to wake up resident, the resident became very aggressive and combative, resident began swinging and kicking at staff, pushing tables." The General Manager was made aware. The resident was returned to his a wheelchair. He slid from the wheelchair onto the floor and refused to move. The facility called 911 who came and returned the resident to his bed.

On documentation on an incident report revealed the resident ambulated with his walker and the security guard found him in the parking lot wandering around. The family and physician were made aware. The report indicate under steps taken to prevent reoccurrence, "keep resident under staff supervision, given as ordered." The resident had a current physician's order for 0.25 mg by mouth daily as needed.

On documentation revealed the resident at 1:00 PM, while at a table with other residents in the dining threw food and flatware at staff and another resident at the table. He was removed from the dining was swinging his walker at staff. The physician and family were made aware. As a corrective measure, the facility documented, "redirect resident to a calm, quiet area if behavior escalating or inappropriate, remove residents away from danger of thrown objects, do not put hands on resident, speak calmly and softly - allow space and do not crowd him." The physician ordered to increase 0.25 mg by mouth every 6 hours as needed.

An interview was conducted on at 11:34 AM, with the resident's tablemate on The tablemate reported the resident began an altercation by throwing food. The tablemate expressed his shirt was soiled with food which Resident #1 threw at him. He expressed the staff intervened and Resident #1 threw his walker. He expressed the resident had frequent outbursts he witnessed, and stated "things set him off." He stated anger was noted from Resident #1 towards staff.

The record showed the resident received a dose of on at 9:15 AM and reported relief

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966484	06/27/2014
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

with

On , an incident report revealed the resident scratched his left calf, causing a laceration, and walked around the causing to get on the carpet and bed. The physician and family were made aware. The report indicated the resident received first aid. The incident report was blank in the section of steps to take to prevent reoccurrence.

On , an incident report revealed at 9:00 PM, the resident was seated in a chair with his walker in front of him, and swung his walker at a nursing assistant who was standing to the side of him. The nursing assistant was injured in the ear and was sent to the emergency . The nursing assistant did not return to work right away due to the injury. An interview was conducted with the nursing assistant on at 3:06 PM. She stated she was assigned to care for the resident regularly on the evening shift. She stated on the resident was seated in a regular chair, the walker in front of him, and he was in the hall on the third floor. She was speaking to the med tech on duty, heard another random resident summon her, and as she turned to go in the direction of the random resident, Resident #1 saw her, and unprovoked, swung his walker up and to the side, striking her in the ear ,causing immediate injury. She expressed she received a hematoma that was drained and several stitches to the ear. She noted she was to the side of the resident and not in front of him. The physician and family were made aware. The incident report was blank in the section of steps to take to prevent reoccurrence. The nursing assistant expressed the resident was a large man who "grabbed his walker all the time to threaten people" when caring for him."

On the progress notes indicated the resident at 9:15 AM, was asked if he ate breakfast and he indicated he did not want to eat. However, staff investigation revealed he did eat his breakfast that morning. At 8:42 AM, he was given a dose of which documented mild relief from

On at 2:00 PM the progress notes revealed "increased sleepiness noted, speech slurred and incoherent answer to simple yes/no commands, seen by psych nurse, family refusing to change medication, Dr. notified." At 4:00 PM, the notes documented, "family agreed to medicate resident, notified Dr, new orders faxed to pharmacy." A physician's order dated at 4:00 PM documented 0.25 mg 1 tab by mouth at night *stat*." At 8:33 PM, he was given a dose of and reported relief from

On at 12:00 PM, the record reflected, the resident's daughter, "contacted the nurse's station to make sure resident has not been put on any new medication, family stated she refuses for the resident to start medication." The physician was notified and the was discontinued. The Administrator was made aware.

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

On [redacted] at 3:00 PM, the resident approached the nurse's station indicating he could not find his keys, made a fist, and threatened to spit on the med tech.

On [redacted] an incident report documented at 11:00 AM, the resident was [redacted] and approached the nurse's station. The staff attempted to redirect the resident, however , the resident became irate. The resident and the nurse were in a struggle to close the nurse's station door. The resident began using his walker to hit the door and was screaming. The Administrator was contacted, as well as the police, physician, and family. The record reflected the resident received [redacted] at 11:33 AM, with mild relief of [redacted] noted. A physician's order was received on [redacted] at 12:00 PM, "OK to [redacted]" The incident report was blank in the section of steps to take to prevent reoccurrence.

At 1:30 PM, on [redacted] an incident report noted the resident was found on the second floor in another resident's [redacted] a female resident. Resident #1 resided on the third floor and the second floor [redacted] corresponded with his [redacted] on the third floor. He was in a female resident's [redacted] through drawers and picking up items. He was screaming. Staff redirected the resident out of the [redacted] the notes documented, "resident remained in an aggressive manner, until his daughters arrived." The Administrator was made aware, and the physician. The incident report was blank in the section of steps to take to prevent reoccurrence. Documentation showed the facility discussed the issues with the daughter who was the power of attorney, and the resident, and a 45 day notice was given.

On [redacted] the record reflected at 3:00 PM, the resident was observed hitting his eye. He was assessed by a Registered Nurse (RN) who documented the eye was red and irritated, along with an intervention of flushing the eye with water to reduce pain. The physician was made aware. At 5:30 PM, the record reflected the resident's sister reported to the RN the resident was continuing to stick his fingers in his eye. The RN assessed and documented "eye appears bloodshot and [redacted] flushed eye and provided ice pack to control [redacted]" An incident report was completed at 7:00 PM, and was blank in the section of steps to take to prevent reoccurrence. At 7:45 PM, the record showed the resident was "upset and hitting face, throwing items in his apartment." A call was placed to the physician. The resident was sent to dinner. The physician returned the call and ordered the resident to be "sent to the hospital for evaluation, as he was presenting as a danger to staff and other residents." The resident was sent to the hospital and did not return to the facility.

c) A review of Physician Progress Evaluation notes indicated the resident was visited on two occasions by a psych nurse, however the notes were not dated. One note documented the resident had [redacted] with behavior and the power of attorney was refusing any medication changes. A second note documented a conference call with the resident's two daughters and both refused any changes in the resident's medications. The note documented, "they request [redacted] and walker to be cushioned

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and closely monitored by staff; and they want their father to be treated like a toddler when approached by staff." The psych nurse further documented was covered by the resident's insurance and the "family refusing any med changes at this time!"

Record review revealed the resident was receiving for for sleep, and for and for He was receiving Tears solution to his eyes twice daily.

A telephone interview was conducted with the psych nurse on at 11:54 AM. The nurse was unable to confirm the dates of his 2 visits. However, he validated the documentation on the evaluation notes and the resident's pattern of aggressive behavior. He stated the resident was agitated, and He stated the resident needed medication to control and minimize the behaviors. He also validated the family was aware the resident was having mental issues. He stated the family complained the resident's behaviors were the fault of the staff.

An interview was conducted with the current Resident Care Director on at 1:32 pm. She expressed she witnessed the resident behavior frequently and was the nurse involved on when the police were called to the facility. She stated she was involved removing the resident from the female resident's that day as well. She expressed the resident was not appropriate for the Assisted Living and stated she reported this to the Administrator on many occasions ongoing, throughout the resident's stay. She expressed she had to frequently intervene to ensure safety of the other residents and staff ongoing. She expressed she was afraid of the resident. She stated the family was aware of the behavioral issues and the resident's tendency to throw his walker or use it as a weapon, to strike things. She expressed the family asked the nursing staff to bubble wrap the walker and approach the resident as a child. She stated the family would not permit medications to be used.

An interview with the former Resident Care Director, beginning on and continuing throughout the survey, revealed she was off on medical leave during the resident's stay, but expressed she was called at home during her leave, several times regarding the resident's behavior witnessed and escalating episodes. She validated the resident was not appropriate for the Assisted Living and presented as a danger to self and others.

An interview was conducted with the General Manager on at 2:13 PM. He stated he was not made aware the resident showed violent aggression, until the incident on when a staff member received an injury to her ear from the resident. The resident's chronological display of behaviors after admission, was discussed with the General Manager. He validated the resident's demonstrations of behavioral issues ongoing, along with the inability to attempt medical management with medications, indicated he was not appropriate for the Assisted Living, and his continued residency was not properly

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evaluated on several occasions. He expressed that the former Administrator did not make him aware of these incidents.

Class III

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Bridge At Inverrary (The)
4291 Rock Island Road
Lauderhill, FL 33319

RE: CCR #2014003317, #2014002734 and #2014002970

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 12 and 27, 2014 by a representative from 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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