STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964525	11/18/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Clare Bridge Of Tallah	1980 Centre Pointe Blvd. Tallahassee, FL 32308	

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= G
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= G
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

0000-Initial Comments
An unannounced complaint survey CCR 2014011199 was conducted at Clare Bridge of Tallahassee Assisted Living Facility on . Deficiencies were cited.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on staff interview and record review the facility failed to provide adequate supervision to 1 of 3 residents (#3) reviewed for who was identified as being a high risk for . Also, the facility failed to properly assess the resident after a for the need for additional interventions. As a result, the resident sustained multiple leading to emergency hospitalization.

The findings are:

A review of the clinical record revealed that on resident #3 sustained a in the facility leading to an injury severe enough that Emergency Medical Services was called by the facility to transport resident #3 to the emergency .

Review of the facility incident log and report summary revealed Resident #3 was found on the floor in his rounds at approximately 3:30 AM by the resident assistant D. At approximately 4:15 AM arrived. The resident was covered in and had a soaked brief and shirt. There was only one resident assistant in the building with 21 residents at the time of the incident. The other scheduled resident assistant was on a meal break.

A review of the hospital emergency for resident #3 on revealed the resident had sustained a and a head injury.

A review of the clinical record for #3 revealed an 1823 (resident health assessment) dated The resident had a diagnosis of Episodic Memory Loss and The special precaution section indicated the patient has a history of frequent The resident required total assistance with ambulation, bathing and transfers and assistance with dressing eating, and toileting. Documented in the additional comments of the health assessment again states resident has a history of frequent

On at approximately 2:30 PM an interview was conducted with the Health and Wellness Director (HWD). She was asked what interventions had been put in place for the resident on admission. She stated, "For all residents they are checked on every two hours. No specific interventions were put in place" for resident #3.

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Further interview was conducted with the HWD on at approximately 2:30 PM. She stated that resident #3 had previously been admitted for respite care. She stated that when he was admitted this time the resident's sister-in-law had informed them he had experienced a decline and was having more at home. When he had been here previously he had used a walker. When the HWD was asked, knowing this information what interventions were put in place, she stated there was not a mat and he was being assisted with ADL's (activities of daily living).

A review of the nursing progress notes revealed on resident #3 had a with no injuries. Review of the admission/discharge log revealed an entry dated at 12:50 PM. Resident #3 on the 11p-7a shift and was sent out to the hospital and was admitted. The LPN documented the nurse from the facility called the hospital and spoke to the unit secretary who was not able to give information over the phone. The nurse then called a family member who stated she did not have the power of attorney and family could not come to town at that time. There was no further documentation regarding this incident until it was documented the family came in on at 6:00 PM to get residents (#3) medications and belongings.

Further interview with the HWD on at approximately 2:30 PM was conducted. When asked what interventions were put in place for resident #3 after falling on she stated, "Nothing was put into place just that they (the staff) would continue to monitor and do every two hour checks". She further stated a post assessment would have been initiated by the nurse.

A review of the post investigation from revealed the nurse documented the but the assessment had not been completed. The HWD stated that she would have completed it and put interventions in place but she had not done this because the resident was supposed to be discharged.

A review of the staffing schedule for revealed three resident assistants were scheduled for the 11-7 shift. Only two resident assistants were working and at the time of the incident there was 1 resident assistant for 21 residents due to the other resident assistant being on break.

A review of the staffing records for staff B, C, and D revealed none of the resident assistants scheduled for the 11-7 shift had First Aid or training certificates.

An interview was conducted with the Administrator on at approximately 11:30 AM. She stated they had no policy requiring employees to have She stated they go by the regulations. She confirmed that none of the resident assistants on the schedule for 11-7 shift had or First Aide Training. She was not aware that only two resident assistants had been working.

Class II

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0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on staff interview and employee record review the facility failed to maintain minimum staffing requirements. The facility failed to ensure a staff member who had completed [redacted] and First Aid training was in the facility at all times to provide adequate resident supervision. 2 of 2 resident assistants (B & D) on the 11-7 shift did not have proof of [redacted] and First Aid training.

The findings are:

On [redacted] an incident occurred in the facility with a resident (#3) falling and having a severe injury. The resident was found on the floor in his [redacted] approximately 3:30 AM by resident assistant D during her rounds . At approximately 4:15 AM emergency medical services [redacted] arrived at the facility. Record review revealed the resident was covered in [redacted] and had a [redacted] soaked brief and [redacted] shirt on. There was only one resident assistant in the building with 21 residents at the time of the incident.

Review of the hospital record revealed the resident arrived by [redacted] at 7:29 AM. X-rays revealed resident #3 had a [redacted] at C7 (7th [redacted]

A phone interview conducted with resident assistant D on [redacted] revealed she had not provided any type of first aid to the resident, stating she was not going to move him. She stated he was lying on his stomach and she knew he had a head injury from the amount of [redacted] she saw. She stated she did not attempt to put pressure on the [redacted] to stop the [redacted] She stated she had been doing her rounds and monitoring a resident who was wandering in the facility at the time she found resident #3 on the floor around 3:30 AM. She stated she had tried to find the other resident assistant but was unable to find her due to her being on break. She stated she called 911 for assistance. She stated she had to leave the resident alone while she went to look for the other staff member and to call 911. She stated she had to leave the resident alone again in order to open the doors to allow [redacted] to enter the building.
The resident assistant D stated they frequently work with only two staff members on the 11-7 shift due to a low census.

A review of the schedule for [redacted] revealed 3 resident assistants were scheduled for the 11-7 shift. A review of the weekly staffing hours indicate the facility maintains the required number of hours for the week.
A review of the time punches revealed only two resident assistants had worked the 11-7 shift on [redacted] (B and D).

A review of the staff record for resident assistant B revealed a hire date of [redacted]. There was no documented certification for training in [redacted] or First Aid for this staff member.

A review of the staff record for resident assistant D revealed a hire date of [redacted]. There was no documented certification for training in [redacted] or First Aid for this staff member.

An interview was conducted with the Administrator on [redacted] at approximately 11:30 AM. She stated they had no policy requiring employees to have [redacted] She stated they go by the regulations. She confirmed that none of the resident assistants on the schedule for [redacted] 11-7 shift had [redacted] or First Aide Training.

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0083-Training - First Aid and . . . . 58A-5.0191(4) FAC

Based on staff interview and staff record review the facility failed to ensure a staff member who had completed courses in First Aid and . . . were available in the facility at all times. . . . on the 11-7 shift 2 of 2 direct care staff (B and D) did not have First Aide and . . . . certificates.

The findings are:

A review of the schedule for . . . revealed 3 resident assistants were scheduled for 11-7.

A review of the time punches revealed only two resident assistants had worked the 11-7 shift on . . . . . (B and D).

A review of the staff record for resident assistant B revealed a hire date of . . . . . There was no documented certification for training in . . . . or First Aid for this staff member.

A review of the staff record for resident assistant D revealed a hire date of . . . . . There was no documented certification for training in . . . . or First Aid for this staff member.

An interview was conducted with the Administrator on . . . at approximately 11:30 AM. She stated they had no policy requiring employees to have . . . . She stated they go by the regulations. She confirmed that none of the resident assistants on the schedule for . . . . . 11-7 shift had . . . . or First Aide Training.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interviews and record review, the facility failed to report an adverse incident for 1 (Resident #3) of 3 residents who was transferred to the hospital due to a . . . with injuries resulting in a . . . . . (Broken Neck).

Findings include:

Record review of the facility's Incident reports revealed Resident #3 had . . . on . . . . . at approximately 4:00 AM with a head injury. Resident #3 was found lying face down on the floor next to his bed. Resident #3 was talking and asking for help getting off the floor. The staff called 911.

Review of the resident Log dated . . . . . at 12:50 PM revealed Resident #3 . . . on the 11 PM-7 AM shift and was sent out to the ER (Emergency . . . and admitted to the hospital.

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Review of the (Emergency Medical Services) Pre-hospital Care Report Summary dated revealed was dispatched to a possible at the facility. Upon arrival the EMT (Emergency Medical Technician) found Resident #3 lying on the floor in prone (face down) position in and Resident #3 stated he getting out of bed.

Review of the hospital medical records revealed Resident #3 arrived at the hospital by and assigned a hospital bed on at 07:29. The resident had an oblique of the mid third of the spinous process at C7 (7TH with moderate angulation of fragments. Resident #3 was diagnosed with a of spinous process.

During an interview at 12:08 PM on , the Administrator reported that Resident #3 was a respite resident from 13-15, 2014. The Administrator reported she was not aware of Resident #3's or his hospital visit until the day of the survey. The Administrator reported she was responsible for reporting the facility's adverse incidents. She confirmed she did not report the adverse incident for Resident #3.

During an interview at 12:15 PM on , the Wellness Director confirmed she was notified on about 7:00 AM that Resident #3 had and transferred to the hospital. She reported she notifies the Administrator when residents are transferred to the hospital. However, she did not notify the Administrator that Resident #3 was transferred to the hospital.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Clare Bridge Of Tallahassee
1980 Centre Pointe Blvd.
Tallahassee, FL 32308

RE: CCR #2014011199

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2014 by representatives 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 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

for Patricia McGatlin, RN
Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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