STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968507	**10/05/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPORT SENIOR LIVING-PORT ISLE LLC	**3619 ROTHBURY DR BELLE ISLE, FL 34786**

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

0000 - Initial Comments

A complaint investigation (#2017006837) was conducted on and . Bridgeport Senior Living-Port Isle LLC, license #12372, had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observations, record reviews, and interviews, the facility failed to follow medication orders from a health care provider for 1 of 4 residents (#3) and failed to maintain a written record for 1 of 3 residents (#4) who sustained injuries.

Findings:

1. Record review for resident #3 revealed a health assessment form 1823 that was dated on . The form indicated he had a diagnosis of , Body . He required assistance with self-administration of his medications.

Review of the 2017 Medication Observation Record (MOR) for resident #3 revealed that his , 25 milligrams (mg) was to be given by mouth once every other day. It was signed as given daily from through .

His Align Probiotic Chew was to be given by mouth once every other day. It was signed as given daily from through .

His D 50,000 units was to be given by mouth one time a week. It was signed as given daily from through .

A resident care note that was dated on indicated that the errors were discovered, the MOR was corrected, and his family and health care provider were notified.

A resident care note that was dated on at 2 pm indicated that a staff meeting was held to discuss proper medication observation.

However, review of the personnel record for staff F, an unlicensed caregiver who was identified by the administrator as one of the staff who did not follow the health care provider orders, revealed she was due to receive the required 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility on . Staff F did not receive the required training until .

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On at 1 pm, the administrator confirmed the findings.

2. Observations made of resident #4 on at 8:50 am revealed she was seated in a wheelchair in the TV . She had a , the size of a ping-pong ball, to her left anterior wrist, an undated dressing to her right bicep area, two separate scabbed areas to her left , and one scabbed area to her right . When questioned, resident #4 was unable to explain the cause of the injuries.

Record review for resident #4 revealed a health assessment form 1823 that was dated on . She had a diagnosis of and she required assistance with all of her daily care.

A facility skin report that was dated on at 6:45 am indicated that she sustained an injury to her right during a transfer to her wheelchair.

A facility skin report that was dated on at 6:30 am indicated that she sustained an injury during a transfer when her leg appeared to hit the wheelchair. The specific location of the injury was not documented on the report.

A home health start of care assessment that was dated on indicated that she had a hematoma on her right upper arm, two scabbed areas to her left lower leg, and 2 scabbed areas to her right lower leg.

The record for resident #4 did not contain documentation to indicate when she sustained the to her left wrist, the hematoma to her right arm, and the two scabbed areas to her left lower leg. In addition, there was no documentation to indicate a health care provider was notified when the injuries occurred.

During an interview with the administrator on at 10 am, she said with the exception of the skin reports that were completed on and , there was no documentation to indicate each time a skin , was observed on resident #4 and there were no investigations conducted to determine possible causes of the injuries. She said she learned about the hematoma on the right arm when a staff member sent her a picture of it on . She said she then informed a health care provider via a text message.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observations, record reviews, and interviews, the facility failed to ensure the unlicensed staff

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who assisted 1 of 1 sampled resident (#3) with self-administration of medications followed the correct procedure.

Findings:

Observations made during a medication pass for resident #3 on . . . . at 12:20 pm revealed that staff C, an unlicensed caregiver, removed a basket that contained the medications for resident #3 from a secured kitchen cabinet. She took the medications and the Medication Observation Record (MOR) to resident #3 who was lying in his bed. She placed a pill onto a spoon and instructed resident #3 to hold the spoon. The resident had his eyes closed and he did not hold the spoon. The pill . . off the spoon two times when staff C attempted to place the spoon in the resident's hand. During her attempts to get the resident to hold the spoon, staff C said, "He can't do it." While holding the spoon, staff C positioned the handle of the spoon so that the fingers on the resident's left hand were on top of the handle. Staff C then spooned the pill into his mouth. She held a cup of water and instructed the resident to drink from a straw.

Staff C did not read the prescription labels in the presence of the resident, as required.

In addition, one of the medications that staff C gave to resident #3 was . . The bottle of . did not contain a prescription label, as required. Staff C said the facility no longer had the original container for the bottle, which contained the prescription label.

During an interview with staff C following the medication pass, she confirmed that she did not read the labels in the presence of the resident and said she did not know that she was supposed to.

During an interview with the administrator on . . . . at 12:40 pm, she confirmed the facility no longer had the original container that contained the prescription label for the . .

Class III

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

Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) was updated for 2 of 4 sampled residents (#3 and #5).

Findings:

1. Record review for resident #3 revealed a health assessment form 1823 that was dated on . . .

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The form indicated that he required assistance with self-administration of his medications.

Review of the , 2017 MOR for resident #3 revealed an entry for D 50,000 unit capsules; take 1 capsule by mouth every week as a supplement that was scheduled at 12 noon. The doses on 9/3, , and were not signed as given.

2. Record review for resident #5 revealed a health assessment form 1823 that was dated on . The form indicated that she required assistance with self-administration of her medications.

Review of the , 2017 MOR for resident #5 revealed entries for , 81 milligrams (mg,) take 1 tablet by mouth in the morning that was scheduled at 8 am and , 500 mg, take 1 tablet by mouth twice a day for pain that was scheduled at 8 am and 8 pm. The doses for both medications on 9/1 and 9/2 were not signed as given.

On at 11:39 am, the administrator said resident #3 and resident #5 were given their medications on those dates but the staff forgot to sign the MOR.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observations and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience and allowed unlicensed staff to administer medications to 1 of 1 sampled residents (#3).

Findings:

Observations made during a medication pass for resident #3 on at 12:20 pm revealed that staff C, an unlicensed caregiver, removed a basket that contained the medications for resident #3 from a secured kitchen cabinet. She took the medications and the Medication Observation Record (MOR) to resident #3 who was lying in his bed. She placed a pill onto a spoon and instructed resident #3 to hold the spoon. The resident had his eyes closed and he did not hold the spoon. The pill off the spoon two times when staff C attempted to place the spoon in the resident's hand. During her attempts to get the resident to hold the spoon, staff C said, "He can't do it." While holding the spoon, staff C positioned the handle of the spoon so that the fingers on the resident's left hand were on top of the handle. Staff C then spooned the pill into his mouth. She held a cup of water and instructed the resident to drink from a straw.

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During an interview with staff C following the medication pass, she confirmed that she administered the medications to resident #3.

Class III

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

Based on record reviews and interviews, the facility failed to report an allegation of . . . . . to the Department of Children and Families (DCF) for 1 of 1 sampled resident (#1.)

Findings:

Personnel record review for staff D revealed her employment with the facility was terminated on . Further review revealed she was terminated related allegations of resident . . . . . and neglect that involved resident #1.

During an interview with the administrator on at 12 pm, she said that she did not report the allegation of resident . . . . . to DCF, as required.

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observations, personnel record reviews, interview, and review of the Agency's background screening clearing house, the facility allowed 2 of 4 staff (A and B) to provide direct resident care without eligible background screening results.

Findings:

On . . . . , observations revealed that both staff A and staff B provided direct care to the residents.

Personnel record review for staff A revealed she was hired in the capacity of a caregiver on . . . . .

Personnel record review for staff B revealed she was hired in the capacity of a caregiver on . . . . .

The personnel records for both staff A and staff B did not contain results of a background screening.

Review of the Agency's online background screening clearing house revealed that both staff A and staff B required a new screening and that their prints were not retained.

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During an interview with the administrator on [redacted] at 11:20 am, she confirmed the findings.

Unclassified