STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965603	11/08/2017
NAME OF PROVIDER OR SUPPLIER **BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF ORLANDO**	STREET ADDRESS, CITY, STATE, ZIP CODE **3201 ROUSE ROAD** **ORLANDO, FL 32817**	

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

0000 - Initial Comments

A complaint investigation #2017008773 was conducted on , & . The Bridge Assisted Living at Life Care Center of Orlando, license #9958, had deficiencies at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to honor resident rights and did not prevent the loss of personal property when residents were out of the facility (#1).

Findings:

Observation during the tour of the facility on revealed a census of 73 residents. Five residents were out of the facility in the hospital or rehab at the time of the visit. At lunchtime, it was observed that several residents went away from their for lunch and left their apartment doors wide open with no one in the .

Observations on the 1st, 2nd and 3rd floors revealed no resident with a gray "ball" lock on the door. The lock system and a key sign out process for the locks was instituted on when the previous administrator arrived. This was after a personal property loss had occurred for resident #1.

Review of the "ball lock" key sign out log revealed the last use of the key log was recorded on .

Review of the grievance log for 2017 did not reveal any reports of missing items in the facility

Review of the record for resident #1 revealed she was admitted on and discharged on . Notes regarding the resident's admission to the hospital on were present. There was a 30-day notice of discharge given by the resident's daughter on due to her mother's need for a higher level of care documented. There were no notes in the record referring to the loss of personal property after the resident was admitted to the hospital.

Review of the adverse reports for the facility revealed no reports of the police being called for theft.

In an interview with resident #1's daughter on at 10:40 AM, She stated her mother left the facility on to go to the hospital for emergency surgery. On the daughter stated she called the nurse at the facility to alert them her mother would need a higher level of care and she was giving her 30 day notice, which she also put in writing to the facility. On , the daughter went back to her mother's

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retrieve a pair of earrings her mother requested and to start making plans to pack up and move her to her new location. When she arrived at the , she found her mother's jewelry was missing. She reported it to the administrator, who installed a gray "ball" lock on the door to prevent further unauthorized entry. The daughter stated the administrator said the daughter could contact police or the facility would. The daughter said she preferred to make the call and contacted Orlando Police on . She provided an inventory of the missing jewelry and Hummel figures to the officers, but had not heard anything from them since .

In an interview with the former administrator on at 3:00 PM, she answered questions concerning the loss of personal property during her term as administrator at the facility. She stated she was administrator from - . She said there was no process in place to conduct or document an inventory of a new resident's belongings when they moved in. When asked how a resident's secured when the resident was in the hospital or away for a period of time, she stated, "I don't know what they did prior to . On , I implemented a system where a special lock was placed on the apartment door. Whoever entered the required to sign the key out from the front desk. Maintenance and the front desk had the only 2 keys. She stated she did not know who had the keys to the "locked drawer" in the resident apartments and the drawers were never used during the time she was in the facility. When asked about the facility policy for items that were reported missing, she stated, "In the case of the missing jewelry, I called the regional director and was instructed to have the family member call the police or offer that we (the facility) would call the police. In this case, the resident's daughter called the police. We gave a report to the police. They requested staff schedules and time sheets, which I provided. The police never came to the facility to speak with staff. The detective told me there was one employee who was a suspect, but that staff is no longer employed at the facility. I never heard from the police again."

In an interview on at 1:45 PM, the police detective stated as of she had not interviewed anyone regarding the missing jewelry, but did have some leads. She said she did visit 3 local pawn shops with the resident and her daughter recently and looked at jewelry pawned by a person of interest. None of the jewelry they saw belonged to the resident.

In an interview with the current administrator on at 2:35 PM, she said she began working at the facility on . She had not heard anything about conducting an inventory of personal items when a resident moved in. Concerning the locked drawers in the resident apartments, the administrator said she thought the resident was the only person she knew had the key. When a resident was out of the facility for a hospital stay or other reasons, the administrator stated there was a lock out "ball" that was placed on the door that required the key to be signed out to gain access to the . She provided the sign in/out book for review. She also stated the maintenance director was no longer with the facility and it

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appeared this process was not being consistently done at the current time.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on observation record review and interview, the facility failed to ensure a Health Assessment (form 1823) was complete and documented the type of assistance required for medications for 1 of 4 sampled residents (#4).

Findings:

Observations in the apartment of resident #4 revealed a pill organizer and supplies in an unlocked drawer in the resident's desk.

Record review for resident #4 revealed she was admitted to the facility on . Her original Health Assessment (form 1823) was dated and documented , II, chronic kidney , and . Another 1823 in the record had a hospital bar code sticker on the bottom of each page. That form was not dated and did not document the credentials of the person completing the form and did not indicate the type of assistance required for medications. A third 1823 in the record had a date of with an unreadable year documented. This form also did not document the type of assistance required for medications.

In an interview with the resident on at 1:20 PM, she stated she had lived in the facility since 2011, but was moving out soon because it was too expensive. She stated her daughter filled a pill organizer for her every week and she kept it in the drawer tn her desk. She said she always locks the apartment when she goes out. She said she is a and cannot do the sugar checks or injections anymore due to her tremors. She said she stores the and supplies in her apartment and one of the nurses come to the do the sticks for her.

In an interview with the regional nurse on at 2:00 PM, she confirmed the findings, took the form and said she would give it to the nurse in charge (Staff B).

At 2:40PM on , the administrator confirmed the findings and said she would make sure it was corrected.

Class III

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0163 - Records - Resident, Penalties for Alteration - 429.49 FS

Based on observation record review and interview, the facility failed to ensure a Health Assessment (form 1823) was complete, and documented by a licensed health care provider, for 1 of 4 sampled residents (#4).

Findings:

Observations in the apartment of resident #4 revealed a pill organizer in an unlocked drawer in the resident's desk.

Record review for resident #4 revealed she was admitted to the facility on . Her original Health Assessment (form 1823) was dated and documented , II, chronic kidney , and , . Another 1823 in the record had a hospital bar code sticker on the bottom of each page. That form was not dated and did not document the credentials of the person completing the form and did not indicate the type of assistance required for medications. A 3rd 1823 in the record had a date of with an unreadable year documented. This form also did not document the type of assistance required for medications.

In an interview with the resident on at 1:20 PM, she stated she had lived in the facility since 2011, but was moving out soon because it was too expensive. She stated her daughter filled a pill organizer for her every week and she kept it in the drawer to her desk. She said she always locks the apartment when she goes out. She said she is a and cannot do the sugar checks or injections anymore due to her tremors. She said she stores the and supplies in her apartment and one of the nurses come to the do the sticks for her.

In an interview with the regional nurse on at 2:00 PM, she confirmed the findings, took the form and said she would give it to the nurse in charge (Staff B).

At 2:40PM on , the administrator confirmed the findings and said she would make sure it was corrected.

At 2:45PM, Staff B, came in with a copy of the "new" 1823 that she said was just faxed over from the provider. She stated she had not received the original incomplete form from the regional nurse. Review of the new form found it was identical to the previous form with the addition of a checkmark next to "no," answering the question, "Does the individual need help taking his/her medications?" Staff B repeated that this was a new form she just received. She restated that she did not get the old form from the regional nurse.

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After reviewing the photographs of the original form I had obtained, the administrator confirmed on at 2:50PM that this new form was identical on every page to the old form. The only change was the checkmark was new, but it was not initialed or dated. The administrator stated she would speak with Staff B and would also confirm with the provider.

Class III