STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968507	R 11/30/2017
NAME OF PROVIDER OR SUPPLIER **BRIDGEPORT SENIOR LIVING-PORT ISLE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3619 ROTHBURY DR** **BELLE ISLE, FL 34786**	

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

0000 - Initial Comments

A revisit to complaint investigation #2017006837 was conducted on . Bridgeport Senior Living, license #12372, had deficiencies at the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED
Based on observation, review or the Medication Observation Record (MOR) and interview, the facility failed to ensure that unlicensed staff who assisted with self-administration of medication for 2 of 2-sampled resident (#2 & #5) followed the correct procedure.

Findings:
Observation of the medication pass for resident #3 on at 7:55 AM revealed Staff A walked into the kitchen. She then opened the already unlocked medication cabinet and removed a small red cup with resident #2's first name written on the side in black marker. She handed the cup to resident #2 and said, "Here are your pills." The resident took the cup, lifted it to his mouth, put the pills in his mouth, and swallowed them with water. He handed the cup back to Staff A, who turned and told the surveyor, "Now I will get the medicines for resident #5."

When asked to see the MOR for resident #2, it was already documented the resident received his/her morning pills. The pills were in the cup and the MOR was signed before the resident was in the the med pass.
Review of the MOR for resident #2 revealed the following medications were initialed as given at 8AM on : , 81mg, 100mg, , 10mg, , 20mg, , 0.5mg.

Staff A stated at 8:00 AM on , "I had them ready and then I had to go check on another resident. So, I put them in the cabinet and just came back and gave them to him."

Observation of the next med pass revealed Staff A left the kitchen to wake up another resident , then returned to the kitchen, opened the unlocked med cabinet, and retrieved the med basket. She said it was time for resident #5's med pass. Staff A went to resident #5, who was seated at the dining table, and said "Miss (first name), I bring you your pills." She handed the resident a glass of water and placed one pill (50mg) in the resident's open palm. The resident sat with the pill in her hand and drank the water. Staff A instructed her 3 times to lift up her hand and put the pill in her mouth. The resident did put the pill in her mouth and swallowed it with more water. Staff A placed a second pill (, 500mg) in resident #5's hand and said, "This is your , for pain." The resident took the pill. Staff A placed a third pill (, 20mg) in the resident's hand and said her name. The resident

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took the pill. Staff A place the 4th pill (, 81mg) in the resident's hand and said, "Miss (first name), your . ." After the resident swallowed the pill, Staff A took the medication basket back to the cabinet and documented in the MOR that the pills were given.

Staff #A did not read the label aloud in the presence of the resident each medication provided, as required.

In a phone interview with the administrator on at 10:45 AM, she stated she would provide an in-service.

Class III

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

DEFICIENCY REMAINED UNCORRECTED
Based on record reviews and interviews, the facility failed to ensure the Medication Observation Record (MOR) was updated for 2 of 4 sampled residents (#1 and #5).

Findings:
Observation on of the MOR for Resident #1 found the MOR blank on at 8:00 PM for , 15mg, 1 tab at bedtime; 0.4mg 1 cap at bedtime; 40mg 1 tab at bedtime, and , 5mg 1 tab twice a day (8pm blank).

Observation on of the MOR for resident #5 found the MOR blank on at 8:00 PM for 50mg 1 tab at bedtime and , 0.5mg, 1 tab at bedtime.

Review of the staff schedule for 11/ at 8 PM found staff #C was scheduled to work.

In a phone interview with the administrator on at 10:45 AM, she confirmed that Staff #C had worked the previous night and said she would re-educate her about documenting the MOR.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interview, the facility failed to ensure that all Over the Counter (OTC) medications were properly labeled with the resident's name for 1 of 2 sampled residents (#5).

Findings:

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Observation of the medications for resident #5 revealed 3 unlabeled OTC medications. ..., ... 81mg and , 20mg were in the med basket for this resident. In addition, a box containing eye drops was sitting on the kitchen counter, not locked in the med cabinet.

At 8:10 AM, Staff #A stated "No over the counter meds have the names of the residents on them since I have been here." She also said she found the eye drops on the counter when she arrived at 7am for her shift on .....

In a phone interview with the administrator on .... at 10:45 AM, she said she would make sure all meds were properly labeled.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on Agency Clearinghouse Website review, personnel record review and interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 2 of 5 sampled staff employees (#A & #E).

Findings:

Review of the Agency's Background Screening website for 5 sampled staff revealed that Staff #A and #E were not on the clearinghouse roster for the facility.

Review of the personnel record for Staff A, hired on ..., found a copy of her background screening results showing eligibility as of .

Review of the personnel record for Staff E, hired on , found a copy of her background screening results showing eligibility as of ..... .

In an interview with the administrator on ... at 10:45 AM, she confirmed the employees were not on the roster.

Unclassified