| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968616** | **02/14/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**BRIDGEPORT SENIOR LIVING-PORT SPRINGS LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**404 SPRING VALLEY RD**<br>**ALTAMONTE SPRINGS, FL 32714** | |

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

**0000 - Initial Comments**

Relicensure survey was conducted on . . . . Bridgeport Senior Living-Port Springs, License 12477 had deficiencies at the time of the visit.

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

Based on observation, resident record review and interview, the facility did not provide care and services appropriate to meet the needs to ensure the safety through proactive measures to minimize the potential for resulting in injuries for 1 of 2 sampled residents (#2), and did not document a significant change and that the family and health care provider were aware for 1 of 2 sampled residents (#1).

Findings:

1. Observations on at 9 AM, revealed resident #2 was heard saying help me. She was lying on the tile floor next to the kitchen, with a pillow underneath her head. Staff B said the resident was on the floor because she could not get her up without the assistance of another staff. She said she was waiting for staff from one of their other facility's to come to assist. She said the resident was pushing the kitchen chair while she was walking, she began to , so she lowered her to the floor. She said the resident had been on the floor for about 20 minutes. The resident said the floor was hard and . At 9:10 AM, staff B placed a cover over the resident because she said she was . . . .

On at 9:15 AM, a staff member from a laboratory agency came to obtain . . . . She obtained the specimen while the resident was on the floor.

On at 9:25 AM, a staff member arrived from a hospice agency to see resident #1. She and staff B lifted the resident from the floor.

Resident #2's record revealed a resident health assessment form 1823, dated , that noted diagnoses including , mini , , , and a history of .

Review of the facility's incident/accident reports revealed some examples of her are as follows:
at 12:05 PM-resident got up from her recliner and walked to pick up her belongings from floor. She on her bottom. Steps taken to prevent recurrence - caregiver will assist her and stay in her.

at 1:16 PM - resident wanted to go home and walked outside on patio and and hit her face

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on floor
Injuries - upper skin above lips skin peeled, front ... cracked, left knee ... . Steps taken to prevent recurrence - redirect resident to another area of the house

at 8 AM - resident was in her was getting out of bed and walk over to her desk with her walker present and ... She backwards unto the floor hit the back of her head and a large lump was present
Injuries-large lump on back of head. Steps taken to prevent recurrence-sat her in wheelchair at table to keep an eye on her.

at 2:35 PM - resident woke up and on side of floor. Injury-bump to left head. Steps taken to prevent recurrence-resident not to be alone and supervised at all times.

... at 8:24 AM - resident #2 was getting out the recliner and ... on the floor, she was lying on her back.
Steps taken to prevent recurrence-keep resident with us at all times.

at 6 PM - staff was in the kitchen, resident #2 was eating her dinner, she stood up and before the staff could get to her, she was not hurt.

-1:52 PM - resident #2 packing up her clothes and walked into the closet to pick up her clothing. She hit her head on shelf and on her bottom. Injuries- ... forehead, left and right wrist. Steps taken to prevent recurrence were left blank.

at 9:20 PM - resident kept asking to go home, got up and sat in chair and got up walked in the kitchen and on her knees. Injuries- ... on fore head and left knee. Steps taken to prevent recurrence-redirected to chair.

-3:15 PM - resident went from chair in the kitchen without her walker and went to the family ... . The staff was at the sink doing dishes and heard her shoes squeak and she was "prone" on the floor. "To clarify, her walker was next to the chair." Injuries noted forehead, eyebrow and arm. Steps taken to prevent recurrence-continually remind her to use her walker.

... 10:18 AM - resident #2 was walking very fast and she tripped and forehead hit slide glass door, landed on her side. Left side bump on forehead, to both knees and back of the left arm ... . Steps taken to prevent recurrence-encourage to use walker.

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3:55 PM - resident #2 walked into living by couch and hit her nose on floor, lump above her eyebrow. Steps taken to prevent recurrence-encourage to use walker.

6:50 AM - resident #2 was walking without her walker from the kitchen to the living , staff was at the front door unlocking it for the morning shift staff, when she heard resident #2 scream out. Her walker was next to the chair. left eye and left side of lip injury and left knee. Steps taken to prevent recurrence-continue to let her know she needs to use her walker each time she gets up.

-at 10:30 AM - resident was walking with her walker but, forward and hit the bar on the walker and the floor. The staff was walking along side her but was unable to prevent a hard , but was able to cushion it. The form noted she was transported to the hospital.

at 7:01 AM - staff noted walking in house and saw resident #2 getting up from chair and she slowly lowered herself to the floor, slid down on floor. Steps taken to prevent recurrence was -raise her up in chair.

- 5:55 AM - staff noted she had just turned her back to get something and when she went inside resident #2 was already on the floor, on her left side-cut/laceration on left temple. Steps taken to prevent recurrence was left blank.

at 8:16 AM - the staff noted she was in a , giving another resident medication, she heard screaming, resident #2 was on the floor on her right side, said she was walking around and on the floor. Steps taken to prevent recurrence was to remind resident to move around in the wheelchair.

at 11:19 AM - the staff noted she was in the kitchen making lunch, resident #2 got up from her wheelchair and started walking in the hallway with her shoes and on her left side. There was a left elbow
steps taken to prevent recurrence-walk behind resident while walking.

-3:34 PM - resident on the floor, trying to get up out of wheelchair. Staff was in the , care to another resident. No injuries. Steps taken to prevent recurrence was left blank.

at 3:34 PM - resident #2 got up from wheelchair, carrying her cup of coffee and the staff tried to grab her, slipped out of the staff's hand, and in the kitchen floor, landed on her . Steps taken to prevent recurrence - remind resident #2 not to get up from seat and get around in her wheelchair. resident is ongoing risk as she stands up from wheelchair frequently.

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at 9:33 AM - resident got up from wheelchair to walk to her recliner and she on her right side. Steps taken to prevent recurrence - redirected resident#2, remind her she cannot walk to stay seated in her chair.

at 9:19 AM - resident got up from wheelchair to walk to fireplace and . Steps taken to prevent recurrence-redirect resident #2 to not get up. risk

at 9:49 AM - resident #2 was walking from her wheelchair to recliner and she on floor. Redirecting her all day. Steps taken to prevent recurrence-redirect to stay seated to prevent falling, -Aid only needed for fingers. This resident has private sitter 10 AM-6 PM to monitor.

at 9:30 AM - resident #2 got up from her recliner and on floor. Steps taken to prevent recurrence-redirect to stay seated.

(possibly wrong date written-should have been ) at 8:30 AM - resident #2 pushed kitchen chair to hall. Staff tried to assist her to the chair. She started to on her knees, the staff lowered her to the floor.

On at 9:45 AM, an interview was attempted with the resident and she could not answer the questions appropriately due to her

On at 10 AM, Staff B could not provide interventions given to the resident to help to minimize the .

Resident #2's record did not reveal any documentation to confirm that the health care provider was contacted to discuss the resident's frequent . There was no documentation of any proactive measures that were in place to minimize the .

On at 10:30 AM, the resident was observed with a caregiver who was with her at all times. The resident was observed at times throughout the survey trying to get out of her wheelchair and had to be reminded to sit.

On at 1:30 PM, the executive director said the resident's family had hired a private duty caregiver to be with her at all times 7 days a week from 10 AM through 6 PM, so that the resident could remain at the facility. The private caregiver who was present was also a staff that was employed by the facility who worked the night shift.
The resident continued to have during the time the private care was not present. There were no

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interventions or additional staff available to supervise the resident during the time the private duty care giver was not present. The staff continued to document that the had to redirect the resident and remind her to use her walker as steps taken to prevent recurrence. Resident #2 had and was and and was not capable of remembering to use a walker or ask for assistance before trying to walk.

2. On at 9:15 AM, staff B said resident #1 received hospice services.

Review of the hospice record revealed the resident was admitted into hospice service on . Resident #1's record did not reveal any notes documenting the decline in the resident's health that resulted in the need for hospice services, and did not document that the family and health care provider was contacted.

On at 3 PM, the executive director confirmed the findings.

Class II

**0053 - Medication - Administration - 58A-5.0185(4) FAC**

Based on record review, medication observation record (MOR) review and interviews, the facility failed to ensure medication administration was provided by a licensed nurse for 1 of 2 sampled residents (#1) and allowed unlicensed staff to administer medications.

Findings:

On at 9 AM, staff B said resident #1 received hospice services.

Observations on at 10 AM of resident #1 revealed she was lying in bed, she was spoken to but did not respond due to her . Resident #1's hands were contracted and was not capable of assisting with the self administration of her medication.

On at 12:45 PM, a caregiver was observed feeding resident #1 her lunch.

On at 1 PM, the executive director said, the family had paid private caregivers to come to the facility to give the resident her medications because the unlicensed staff at the facility could not give the medications. She was asked at the time if the staff that were private caregiver were nurses and she said they were not.

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Review of the MOR for revealed there were initials on the MOR next to the medications and a indication that the medication was administered and on the back of the MOR were initials with the names written next to the initials.
The executive director said at the time that staff e was a private duty care giver for resident #2 and she also gave medications to resident #1, staff e's initials were in the space as giving her medications at 10 AM. Further observations of the back of the MOR revealed there were other staff of the facility's initials on the back of the MOR also.

The executive director said at the time they were also hired as private caregivers who gave the medications to the resident. She said they were not nurses.

Staff E said on at 1:15 PM, she was hired by the family to provide private duty for resident #2 and gave medication to resident #1. She said resident #1's hand was contracted and she would have place the medication on a spoon and lift the resident's hand to her mouth to take the medications.

On at 1:30 PM, the executive director, a nurse, revealed that the private caregivers hired by the family to give medications were actually staff that worked at the facility and would come when they were off to administer medications. At 3 PM, the executive director said she was not aware that the unlicensed staff, could not be hired as private caregivers to administer medications. The executive director was informed at the time that the unlicensed staff could not administer medications to the resident while they were at the facility working and could not come on their time off to administer medications. Only nurses could administer medication.

Class III

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

Based on record review and interview, the facility failed to have evidence that 2 of 4 sampled staff had documentation of annual assessment for ( ) signed by the healthcare provider (A & D).

Findings:

1. Personnel record review for staff A, the administrator, revealed the last documentation to confirm she was free from was dated .

2. Personnel record review for staff D, a caregiver, did not reveal any documentation to confirm she was

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free from .

On at 3 PM, the executive director confirmed the findings.

Class III

**0079 - Staffing Standards - Levels - 58A-5.019(3) FAC**

Based on observations, staff schedule review, record review, incident/accident report review and interviews, the facility did not have enough staff to meet the needs of 1 of 2 sampled residents who remained on the floor after being lowered to the floor for 45 minutes and did not maintain a staff schedule that accurately reflected its 24-hour staffing pattern for a given time period (#2).

Findings:

Observations on at 9 AM revealed resident #2 was heard saying help me. She was lying on the tile floor next to the kitchen, with a pillow underneath her head. At this same time, caregiver B said the resident was on the floor because she was working alone and could not get her up without the assistance of another staff. She said she was waiting on a staff from one of their other facility's to come to assist. She said the resident was pushing the kitchen chair while she was walking, and she began to , so she lowered her to the floor. She said the resident had been on the floor for about 20 minutes and was not hurt. Review of the staff schedule that was posted for the month of , 2018 noted that the third shift staff worked from 9 PM through 10 AM. Staff B said the schedule was not correct, and the third shift staff never worked until 10 AM. They would leave the facility at 8 AM. While lying on the floor, Resident #2 said the floor was hard and .

On at 9:10 AM, staff B placed a cover over the resident because she said she was .

Observations at 9:15 AM revealed, a staff from a laboratory agency came to obtain . She obtained the specimen while the resident was lying on the floor.

On at 9:25 AM, a staff from a hospice agency, here to see resident #1, assisted staff B and lifted resident #2 from the floor to her wheelchair.

Record review for resident #2 revealed a resident health assessment form 1823 that noted diagnoses including , mini , , and a history of .

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Review of incidents reports revealed the resident had numerous .

On at 10:30 AM, the resident was observed with a caregiver who was with her at all times. The resident was observed at times throughout the survey trying to get out of her wheelchair and had to be reminded to sit.

On at 1:30 PM, the executive director was informed that the resident remained on the floor for about at least 45 minutes, waiting because there was not enough staff to assist her from the floor. The executive director said resident #2's family had hired a private duty caregiver to be with her at all times 7 days a week from 10 AM through 6 PM, so that the resident could remain at the facility. The private caregiver who was present was also a staff member employed by the facility who worked the night shift. The executive director said the staff could call 911 for them to come to get the residents off the floor. The facility had called before for their assistance. She said there was a typographic error on the schedule and it was changed to reflect the correct time for the third shift.

Class III

**0080 - Training - Core & Competency Test - 429.52(1-2) FS; 58A-5.0191(1) FAC**

Based on personnel record review and interview, the administrator failed to have evidence that she had participated in 12 hours of continuing education in topics related to assisted living every 2 years.

Findings:

Personnel Record review for the administrator revealed there was no documentation found to confirm she had participated in 12 hours of continuing education in topics related to assisted living every 2 years.

On at 2:40 PM , the executive director confirmed the finding.

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observations, menu review and interview, the facility did not maintain the meal substitutions for 6 months.

Findings:

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Observations of the menu on . . . . at 12:15 PM revealed it noted beef stew over noodles, mixed vegetables and salad. Observation of the meal served at 12:30 PM revealed the residents were served pork stew, mix vegetables, salad and yellow rice.

On at 1 PM, staff B was asked if she maintained a substitution log. She provided a substitution log. Review of the log revealed the last entry was . . . . . Staff B confirmed she did not write the substitutions as required on the log.

On at 1:15 PM, the executive director provided menus to review, and said the substitutions should be located on the menus. Review of the menus provided did not reveal any substitutions noted.

Class

**0181 - Emergency Plan Approval - 58A-5.026(2) FAC**

Based on interview and facility records, the facility did not have evidence that the comprehensive emergency management plan (CEMP) was submitted for review and approval to the local emergency management agency.

Findings:

On at 9:45 AM, the executive director was asked to provide the facility's comprehensive emergency plan (CEMP) approval letter. The executive director provided a letter . . . . from the office of emergency management that noted the facility had submitted it's Emergency Power Plan (EPP). The letter read, "This approval is specific for, the Emergency Power Plan as required by Emergency Rules 58AER17-1 and 59AER17-1 and is not an approval document for your Comprehensive Emergency Plan. Your CEMP is due annually to this office 30 days prior to the approval date of this letter to allow time for the review process."

On at 2:30 PM, the executive director said the CEMP had been submitted for approval and the facility did not have an approval letter.

Class III

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

Based on the observations, interview and the agency's background screening website, the facility did not initiate all Criminal history checks through the clearinghouse before employment.

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Findings:

Observations on [redacted] at 10:15 AM, Staff C was observed providing care to the residents.

Review of the agency's background screening website revealed she was not listed on the facility's background screening roster.

On [redacted] at 2 PM, the executive director confirmed the findings.