STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969039	**04/12/2018**
NAME OF PROVIDER OR SUPPLIER **BRIDGEPORT SENIOR LIVING-PORT MAITLAND LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **955 STONEWOOD LN** **MAITLAND, FL 32751**	

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

0000 - Initial Comments

The re-licensure survey was conducted on . . . . . Bridgeport Senior Living-Port Maitland LLC Assisted Living Facility, license 12851 had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interview, the administrator failed to monitor the continued appropriateness of placement for 1 of 3 sampled residents (#2) and retained the resident who required total care with all activities of Daily living, (ADL's) and could not transfer and ambulate which exceeded the continued residency criteria.

Findings:

Observations on . at 9:15 AM revealed resident #2 was observed sitting in a recliner, an interview was attempted and she did not respond.

On at 11 AM, staff B a caregiver was asked if resident #2 was capable of assisting with her ADL's such as , , dressing, toileting. She was also asked if she could ambulate with assistance. Staff B said that resident #2 did not assist with any of her ADL's and she could not ambulate. She would have to be lifted.

On . . . . at 12 PM staff C a caregiver was asked if resident #2 was capable of assisting with her ADL's and ambulate with assistance. Staff C said that resident #2 did not assist with any of her ADL's and she could not ambulate. She also said resident 2 had to be lifted.

Record review for resident #2 revealed there was no documentation found that she received hospice services.

On at 1:30 PM, the administrator said resident #2 had a hospital admission and had declined; she was not aware she required total care with her ADL's and could not ambulate.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observations, record review and interview the facility failed to ensure 1 of 1 sampled resident

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(#1) assessed as elopement risk had identification on her person.

Findings:

On at 9:30 AM, resident #3 said that resident #1 would often try to open the front door to leave out of the facility. She said the resident broke the door handle because she was pressing on it very hard trying to leave the facility.

Record review for Resident #1 revealed a Resident Health Assessment Form 1823 that was dated that included a diagnosis of . The health care provider noted the resident was an Elopement Risk.

On at 10:30 AM staff B confirmed the resident broke the handle on the door trying to exit.

On at 10:45 AM, observation revealed there was no identification on the resident that would have included her name and the facility's name, address and telephone number.

On at 2 PM, the administrator confirmed resident #1 did not have any type of identification on her person.

Class III

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

Based on medication observations and interview, the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times.

Findings:

On :45 AM staff B came to the surveyor to say that she was going to give medications. She went to resident#1 with a small red cup that already had medication inside of them. She told the resident she was giving her, her medications. Staff B took each pill out of the cup with her bare hands and gave them to the resident to take. A review of the Medication Observation Record (MOR) revealed it was already signed prior to giving the resident her medications.

Staff B did not follow the proper steps when she assisted with the residents medications, she did not in

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the presence of the resident, read the label, open the container, remove the prescribed amount of medication from the container and observe the residents take their medications and update the MOR.

On at 11 AM staff B said she was, not she was required to take the medication containers and read in the presence of the resident.

Class III

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

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

Findings:

Observations on at 2:15 PM revealed Resident #2 was in bed and had to be awaken, staff B an unlicensed caregiver poured out of a bottle , 500 milligrams (mg) 30 Milliliters (ml) in a small cup, she told the resident the name of the medication and attempted to hand the cup to the resident to take. The resident was not capable of holding the cup steady, nor could she bring the cup to her mouth even after being cued by both staff B and staff C. When resident #2 tried to lift the cup to her mouth with the assistance of staff B, she would almost spill it. Staff B had to take the cup from the resident and poured the medication in the residents mouth herself. Resident #2 was not capable of assisting with the self-administration of her medications.

On at 2:15 PM both staff B and C confirmed the resident was not capable of assisting with the self-administration of her medications.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on medication observation record review (MOR), medication review, observations and interview, the facility did not ensure the unlicensed staff who assisted with the , gel 1 % (Generic for Voltaren 1% gel) for 1 of 2 sampled residents (#1) was aware of the dosage amount to ensure the effectiveness of the medication and the medication prescription label was available.

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Findings:

Observation on at 11 AM PM-staff B a caregiver (non-nurse) , revealed a tube of gel 1 % that was located along with resident #1's other medications that did not have a prescription label on it.
Staff B was asked at the time how much did she apply. Staff B said she would just remove some of the gel and applied it to the resident's knee. She was not aware of the amount required and did not have the dosing card that would have been included with the gel.

Further review of the tube of gel revealed it noted: Apply to skin over the affected area four times daily use dosing card provided to measure the amount of , gel to be applied. See accompanying prescribing information. There was no accompanying prescribing information found.

Record review revealed an health care providers order dated that noted Voltaren gel 1% apply to left knee twice daily. The MOR noted the same. There was no dosing amount on the label nor the health care providers order. There was no way for the facility staff to determine the appropriate amount to apply on the resident for effectiveness.

On at 2 PM, the administrator confirmed the findings.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on personnel record review and interview, the facility maintained a secured area and provided special care for persons with 's and related (ADRD) did not have evidence that 3 of 4 sampled staff (B, C and D) who had regular contact with persons with 's and Related (ADRD) obtained 4 hours of continuing education annually.

Findings:

1. Personnel record review for staff B hired revealed her level II ADRD training was conducted on . There was no 4 hours of continuing education for ADRD available for review.

2. Personnel record review for staff C hired revealed she her level II ADRD training was conducted on . There was no 4 hours of continuing education for ADRD available for review.

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3. Personnel record review for staff D hired . . . . . revealed she her level II ADRD training was conducted on . There was no 4 hours of continuing education for ADRD available for review.

On at 1:45 PM, the administrator said the staff was scheduled to have the annual training.

Class III