STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968408	09/19/2018
NAME OF PROVIDER OR SUPPLIER **BRIDGEPORT SENIOR LIVING, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **8341 LAKE CROWELL CIR** **ORLANDO, FL 32836**	

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, LLC, license #12280, had deficiencies at the time of the visit.

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

Based on Medication Observation Record (MOR) review and interview, the facility failed to ensure medications provided to 1 of 6 residents (#1) were documented on a MOR with the correct resident's name on it.

Findings:

Review of the MOR for resident #1 following a medication pass observation found the 2 medications given on . . . . at 10:15 AM were documented on a MOR pre-printed with the name of a different resident on it. The , MOR for resident #1 was on 2 pages. Page 1 of 2 was documented with resident #1's name and information. However, page 2 of 2 had the header and footer information (name, date of birth, physician, diagnoses, , etc.) for a different resident who also lived in the facility. No medications were pre-printed on page 2 of 2. All medication entries were -written. The name of resident #1 was written at the top of the form just above the still visible (not crossed out) name of the other resident. All of the other resident's pre-printed information, including . . . , were still legible. (Photographic evidence obtained)

On at 10:30 AM, the administrator confirmed the finding and stated she was the one who wrote the medications on the form, she explained she took a blank form and did not realize it was for a different resident. She confirmed she wrote the name of resident #1 above the name of the other resident.

Class III

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

Based on observation, medication observation record (MOR) review and interview, the facility failed to ensure all medications prescribed by a licensed provider were properly labeled and stored in the original containers as dispensed by a pharmacist for 1 of 1 resident sampled (#1).

Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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Observation of the medication pass for resident #1 on at 10:15 AM revealed 2 medications given. Observation of the medication containers found the container for " 5mg, Take 1 tablet every day," was filled on with a quantity of 90 tablets. There were still at least 20 tablets in the container on , which was 120 days past the date the prescription was filled. Observation of another container in the basket revealed a vial labeled " " that was filled on and documented "discard after ." The name of the patient for whom this was prescribed was not the name of a resident in the facility. Resident #1's name was written on the prescription label. The strength of the medication was marked out and 20mg was handwritten on the label. Instructions to "cut pills in half" was also handwritten on the label. The bottle contained more than 20 "half pills."

On at 10:30 AM, the administrator stated resident #1's daughter brings her mother's medications to the facility. The in the expired bottle had the daughter's name on the label. She stated the daughter wrote the information on the label and brought it to the ALF. The administrator confirmed she understood this was not proper procedure and said she did not know this was happening. She also stated she believed the staff were getting new bottles of medication and pouring the new pills into an old, not quite empty container to "save space." The administrator confirmed she understood this procedure was not allowed.

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 provided by the resident's family were not expired for 1 of 1 resident sampled (#1).

Findings:

Following the medication pass for resident #1 on at 10:15 AM, the medication basket for the resident was reviewed. The basket contained one bottle of Walgreen's OTC , , 81mg marked with resident #1's name. The bottle had an expiration date of printed on the top of the bottle. (Photographic evidence obtained)

On at 10:25 AM, the administrator confirmed the finding and said she was not aware it had expired and would inform the resident's daughter, who brings her medications.

Class III

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

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on personnel record reviews and interview, the facility failed to ensure that 1 of 4 sampled staff (B) received the required in-service training within 30 days of hire.

Finding:

Personnel Record review for Staff B (caregiver, hired), revealed no certificates documenting training in 1) Activities of Daily Living & Behavioral Needs and 2) safe food handling, as required within 30 days of hire.

On at 3:30 PM the manager confirmed the findings.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on personnel record review and interview, the facility failed to ensure 1 of 4 staff sampled had obtained the required training in 's and Related and provided the appropriate documentation of the training (A).

Findings:

Review of the personnel record for Staff A, caregiver hired , revealed a certificate documenting ADRD Level "II" Four Hour Training dated which appeared to be altered.
The Roman numeral "II" was written in marker over something else after the certificate was printed. (Photographic evidence obtained)

On at 3:30 PM, the administrator confirmed the findings. She stated that training occurred before she was administrator at the facility, so she was not aware of any of the circumstances.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview, the facility failed to ensure 2 of 4 staff sampled had obtained certificates that included the trainer's name for required in-services training classes (A & B).

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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:

1. Review of the personnel record for Staff A, caregiver hired , revealed a document dated entitled "Care , Training Certificates" that included topic of "Incident and Emergency (1hr)." The document included the date signed and a line for the administrator to sign. There was no trainer identified on the document.

2. Review of the personnel record for Staff B, caregiver hired , revealed a document dated entitled "Care , Training Certificates" that included topics of "Residents Rights and (1hr)," "Resident's Needs and Behaviors (3 hrs.)," "Incident and Emergency (1hr)," and " Control (2hrs)." The document included the date signed and a line for the administrator to sign. There was no trainer identified on the document. (Photographic evidence obtained)

On at 3:30 PM, the administrator confirmed the finding. She said they used to issue individual certificates, but she had not noticed this format, which combined several classes, did not include a place for the trainer's name and credentials.

Class