STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965603	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE ASSISTED LIV AT LIFE CARE CENTER OF ORLANDO	**3201 ROUSE ROAD ORLANDO, FL 32817**

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

0000 - Initial Comments

The re-licensure survey was conducted on . The Bridge Assisted Living at Life Care Center of Orlando, license #9958, had deficiencies at the time of the survey.

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

Based on observation, record review and interview, the facility retained a resident who exceeded admission criteria and required total assistance to perform activities of daily living (ADLs) for 1 of 2 resident's sampled (#1).

Findings:

Observations during a tour of the facility on revealed resident #1 seated in a wheelchair in the bedroom of his apartment. He responded when greeted and answered questions about his care in the facility. There was a private companion present in the room at the time of the visit. She stated the family had private caregivers/companions with resident #1 every day from 6 AM until 9 PM, 7 days a week. She stated resident #1 was unable to ambulate and required a 2 person assist to transfer from his wheel chair to the bed or another location. She said she did not provide assistance with transfers, but called for help from the facility staff when he needed to be moved or changed.

Observations at 12:50 PM in resident #1's room revealed 2 staff caregivers (staff A and staff E) responded to the companion's call for assistance for changing the resident's brief. The resident was seated in his wheelchair in the living room on his apartment. There was a 3 high white bookcase dividing the living room and kitchen. It had a modified blue pool noodle, cut and taped to the edge of the top shelf as a cushion. The 2 caregivers rolled the resident in the wheelchair up to the bookcase, locked the chair and placed his on the floor. The caregivers lifted the resident under both arms and helped him lean over the bookcase. They then changed him in that standing position and lowered him into the wheelchair. Both caregivers A & F stated they have to move resident #1 to and from the wheel chair or bed. He cannot assist.

Resident #1's record revealed a facility admission date of . His admission 1823 health assessment form, dated , indicated that he required only assistance with his Activities of Daily Living (ADLs.)

His most recent 1823, dated , indicated that he required total assistance with bathing and , which together with his inability to transfer with assistance, exceeded the continued residency

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criteria in an Assisted Living Facility holding only a standard license.

On at 3 p.m. the director of nursing confirmed the findings and was unable to provide additional documentation.

Class III

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

Based on record reviews and interview, the facility failed to notify a health care provider when 1 of 2 sampled residents (#1) had significant changes.

Findings:

Resident #1's record revealed a facility admission date of . His diagnoses included , , and , , .

His most recent 1823 health assessment form, dated , indicated that he required assistance to total assistance with his Activities of Daily Living (ADLs.)

Resident #1's recorded indicated that on he ( ) and on he ., which was a significant gain of .

Additionally, on he . and on he ., which was a significant gain of .

Resident #1's record did not contain documentation to indicate the facility contacted a health care provider when he experienced significant gain.

On at 4:10 p.m. the director of nursing said the facility did not notify a health care provider of the significant gains.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver (F) who assisted a resident (#11) with self-administered medications followed the correct

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procedure.

Findings:

Observations made during a medication pass for resident #11 on at 12:43 p.m. revealed unlicensed caregiver F unlocked the medication cart, removed a bottle of spray then handed the spray to resident #11, who sat in a chair next to the cart. The resident self-administered the spray. The caregiver then removed medication packages and bottles from the cart. She told the resident the name of each medication then she placed them one at a time into a cup. She handed the cup to the resident, who took them with water and without assistance. She observed the resident take the medication then she signed the electronic medication observation record.

Caregiver F did not read each medication labels aloud, as required.

On at 1 p.m. caregiver F confirmed the findings.

Class III

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

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was updated for 1 of 2 sampled residents (#1) who received assistance with self-administered medications.

Findings:

Resident #1's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated that he required assistance with self-administered medications.

Resident #1's MOR contained an entry for Solution 0. .5 milligram (mg) per 3 milliliter (ml) 1 vial, inhale by three times a day for . The 1 p.m. dose on , , and was not signed as given.

125 microgram (mcg,) 1 tablet by daily for . The dose on , and was not signed as given.

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The MOR nor the record contained documentation to indicate why there were blanks on the MOR.

On at 4:10 p.m. the director of nursing confirmed the findings and said the medications were given but the MOR was not signed by the staff.

Class III

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

Based on observations, review of medication bottles and interview, the facility failed to ensure an Over the Counter (OTC) medication was properly labeled for a resident (#11) who received assistance with self-administered medications.

Findings:

Observations made during a medication pass for resident #11 on at 12:43 p.m. revealed caregiver F gave the resident medications from an OTC bottle of D3 and Women's Adult gummy . Neither bottle was labeled with resident #11's name, as required.

On at 1 p.m. caregiver F confirmed the findings.

Class III

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

Based on personnel record review and interview the facility failed to obtain an annual statement from the health care provider for 2 of 6 sampled Staff (A & B) documenting freedom ( ).

Findings:

1. Personnel record review for staff B hired revealed the last documentation to confirm she was free from was dated (due and).

On at 1 PM, the business office manager confirmed the findings.

2. Review of the personnel record for staff A, hired , revealed the most recent documentation indicating freedom from was dated . There was no documentation in 2018.

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On at 1 PM, the business office manager confirmed the findings.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on personnel record review and interview 2 of 6 sampled unlicensed staff (B and F) who provided assistance with the residents medication did not receive annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility provided by a licensed registered nurse, or a licensed pharmacist.

Findings:

Personnel record review for staff B who provided assistance with the resident's medications revealed the last 2 hour annual continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility was dated (due).

On at 1 PM, the business office manager confirmed the findings,

Observations made on at 12:43 p.m. revealed unlicensed caregiver F assisted resident #11 with self-administered medications.

On at 1:17 p.m. the business office manager said caregiver F was hired on .

Review of certificates revealed that caregiver F received the initial 4-hours of training on providing assistance with self-administration of medications on and a 2-hour annual update on .

There was no documentation to indicate caregiver F received the required annual 2-hour update training in 2018.

On at 1:30 p.m. the business office manager confirmed the findings.

Class III

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

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Based on the menu review and interview the facility did not maintain the dated menus for 6 months.

Findings:

Review of the menus provided revealed the only menus available for review were dated for the weeks of [redacted].

On [redacted] at 1:30 PM, the dietary manager confirmed the dated menus were not maintained for 6 months.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to maintain a clean and decent living environment due to peeling paint and damaged walls in a resident room (#1).

Findings:

Observations during the tour of the facility found the bedroom in apartment 131 had damaged walls in the bedroom along the [redacted] and sides of the current location of the resident's hospital bed. There were vertical scrape black marks and significant areas where the paint had been scraped off the wall, exposing the drywall. There were also scrape marks on the wall next to the dresser. The carpet in the bedroom had black marks in many areas.

On [redacted] at 10:30 AM, the private caregiver stated the whole hospital bed frame raised and lowered electronically. She thought it must have been located to close to the wall and scraped it when they lifted and lowered the bed. She said the maintenance man had been in the room to see it.

On [redacted] at 3:15PM, the administrator said she had not been made aware of the damage and was seeing it for the first time. She knew the family moved the furniture around often. She stated the maintenance workers had not reported this to her.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled resident contracts

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(#1) contained all of the required and correct information.

Findings:

Resident #1's residency agreement, dated , did not contain a provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility.

Additionally, the contract indicated that only a 30-day discharge notice would be provided if the resident fails to meet the in the agreement however, the facility is required to give at least 45 days discharge notice unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents.

On at 1:51 p.m. the business office manager confirmed the findings.

Class

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

Based on facility record review and interview, the facility failed to ensure the Comprehensive Emergency Management Plan (CEMP) for the facility was submitted and approved by the county Office of Emergency Management on an annual basis as required by 58A-5.026(2) FAC.

Findings:

Request to review the facility's CEMP and approval letter revealed there was no approval letter received. The Emergency plan was present and reviewed.

On at 2:30 PM, the administrator stated she had submitted their plan for approval on line in the summer, but did not have a current approval letter from the county.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observations and interview, the facility had no evidence to confirm that 1) their emergency power plan (EPP) was submitted for review and approval, 2) they developed and implemented written policies and procedures to ensure the assisted living facility could effectively and immediately activate

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operate and maintain the alternate power source and any fuel required for the operation of the alternate power source, 3) did not have 72 hours of fuel on site in the event of the loss of primary electrical power and did not have a written contract with a vendor to provide additional fuel when required and 4) did not, within five (5) business days, notify each resident and the resident's legal representative in writing when the plan was submitted to the county Office of Emergency Management (OEM) for review and approval as required by 58A-5.036 FAC .

Findings:

Review of the facility documents did not find an emergency power plan or approval letter, or documentation the residents or responsible families were notified in writing of the submission of the facility plan.

Observation during a tour of the facility found there was an 800 gallon large tank for diesel fuel on the property. The maintenance director and the administrator both stated this would supply 61 hours of power to the generator. They said they have an agreement with a local company to deliver more fuel, but they did not have a written contract for that service.

On at 2:30 PM, the administrator stated she had submitted their plan for approval on line in the summer, but did not have a current approval letter from the county. She confirmed the findings.

Class III