STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966866	**01/29/2019**
NAME OF PROVIDER OR SUPPLIER **BRIDGE OF HOPE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **5265 LONGLEAF ST** **JACKSONVILLE, FL 32209**	

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

0000 - Initial Comments

On , -29, 2019 an abbreviated relicensure survey and emergency power plan monitoring was conducted at Bridge of Hope Assisted Living Facility. Deficient practice was identified during the survey.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on staff interview and facility document review the facility failed to create a written policy and procedure for Third Party Services Policy and Procedure outlining the requirements for coordinating the delivery of services to residents by third party providers.

The findings include:

During an interview with the administrator on at 2:25 pm she stated that none of the four residents living in this facility had services provided by a third party provider. When asked for the facility Third Party Services policy and procedure, she stated she did not have one. She stated she did not think she needed one.

The administrator produced the resources she used to train her staff. No policy and procedure outlining the coordination of third party provider services was found among the documents produced. She was informed that the information she produced did not reflect specifically what this facility's coordination of services and expectations would be with a third party provider if one of the residents chose to have services provided from a third party. She was informed that she would need to develop her own written policy and procedure. She expressed understanding.

Class III

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

Based on observation, record review, staff interview and physician interview the facility failed to provide medication administration according to the physician's order for one resident (#2) out of four sampled residents.

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The findings include:

Resident #2 was observed to be seated at the dining room table on at 8:30am eating his breakfast. He continued to eat and finished at 9:10 am.

Assistance with administration of medication was provided by the administrator (Licensed Practical Nurse) on at 9:35 am. She reviewed the Medication Observation Record (MOR). She washed her with soap and water and dried them appropriately. She opened the refrigerator and took out one prefilled multi-use . Resident #2 was seated at the dining room table. His plate and glass had been removed from the table. She read the label and then the MOR again. She dialed the pen up to 6 units and walked over to the resident and told him "[Resident #2], you are going to get your now." The resident acknowledged it and sat still for her to inject the medication. The administrator lifted his left arm shirt sleeve and wiped a spot on his skin with an . The resident held his shirt sleeve up for her. She injected the medication and asked him if he was okay. He stated yes. She returned the pen to the refrigerator.

Review of the clinical record for Resident #2 revealed a physician's order dated that read: Change to 6 units. Give 10 minutes before meals (Photographic evidence obtained).

Review of the label on the box of multi-use read: Injectable. 100 units/milliliters. Inject 6 units three times a day with meals (Photographic evidence obtained).

Review of the MOR dated , 2018 read: 6 units three times a day at breakfast, lunch and dinner (Photographic evidence obtained).

During an interview with the administrator on at 9:55 am, she stated that the order for the is to give it with meals. When shown the order, she stated that the order was changed and now it is to give with meals, not prior to meals. When asked why she gave it twenty-five minutes after he was finished eating, she stated that it was because this surveyor was here at the facility today and she got behind.

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During an interview with Resident #2's physician on at 11:50 am, she stated she called the facility yesterday and talked with the administrator. She faxed the newest order to the facility. The new order says to administer with meals. When asked if it was okay to give after the meal, she stated, "No, it really is best to give it as soon as the resident starts eating the food." When informed that the was given 25 minutes after he finished eating, she stated "Well, it won't work as well. It really should be given as soon as he starts eating."

Class III

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

Based on record review and staff interview the facility failed to ensure the medication label for for one resident (Resident # 2) out of four sampled residents was the same as the physician's order and the Medication Observation Record (MOR).

The findings include:

Review of the clinical record for Resident #2 revealed a physician's order dated that read: Change to 6 units. Give 10 minutes before meals (Photographic evidence obtained).

Review of the label on the box of multi-use read: [Resident #2] Injectable. 100 units/milliliters. Inject 6 units three times a day with meals (Photographic evidence obtained).

Review of the MOR for Resident #2 dated , revealed it read: 6 units three times a day at breakfast, lunch and dinner (Photographic evidence obtained).

During an interview with the administrator on at 9:58 am, she stated that the order is an old order and the is to be given with his meals not 10 minutes prior to them. She stated the physician's order dated is the only order she has for this resident but she knows it was

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changed a while and the pharmacy label is the correct order.

During an interview with Resident #2's physician on at 11:50 am, she stated she had called the facility yesterday and talked with the administrator. She faxed the newest order to the facility. The new order says to administer with meals.

Class III

0076 - ( ) - 58A-5.0186 FAC

Based on staff interview and facility document review the facility failed to provide the facility's written policy and procedure for ( ), which has the potential to affect 4 of 4 sampled residents.

The findings include:

During an interview with Employee C on at 8:45 am, she stated that she was not sure what the acronym stood for. When asked if she had training on when to conduct , ( ) and when not to, she stated she thought she might need more training on it.

During an interview with the administrator on at 2:20 pm she stated that all four of the residents living in this facility had signed a ( ). When asked for the policy and procedure, she stated she did not have a policy and procedure for . She stated she did not think she needed one.

The administrator produced training resource flyers she uses to train her staff and asked if that would be considered a policy and procedure. She was informed that the information she produced did not reflect specifically what this facility would do in an emergency situation where a decision would need to be made whether or not to perform on one of the residents in the facility. She was informed that she would need to develop her own written policy and procedure. She expressed understanding.

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Class III

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

Based on employee record review and staff interview the facility failed to ensure two employees of the facility (Employees B and C) had obtained a statement from their physician stating that they were free of communicable ( ) within 30 days of hire. Employee B had not received a test annually.

The findings include:

Review of the employee file for Employee B (hired) revealed no documentation of a statement by a health care provider that the employee was free of communicable . There was no documentation of a test done in the last year.

Review of the employee file for Employee C (hired) revealed no documentation of a statement by a health care provider that the employee was free of communicable . The form documenting a physical dated read: "Appears healthy and capable" (Photographic evidence obtained).

During an interview with the administrator on at 1:33 pm, after reviewing the employee's files she stated that she thought that Employees B and C had a statement by a physician indicating they were free of communicable in their file. She indicated she knew they both needed the form and a negative test.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, document review and staff interview the facility failed to ensure the acquisition of sufficient fuel, and safe maintenance of that fuel at the facility to run the gas powered generator for 48

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hours in the event of the loss of primary electrical power. The facility failed to ensure a monoxide alarm was present in the facility. The facility failed to notify in writing within 5 business days of submission of the comprehensive emergency management plan to the local emergency management agency and upon final implementation of the plan, the residents and the residents' legal representative. The facility failed to develop a written policy and procedure to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. This has the potential to affect all residents in the event of power loss.

The findings include:

A tour of the facility was conducted on as part of the biennial licensure survey. A gas powered portable generator was observed up against the wall in the dining room of the facility. It was not plugged in or running. No fuel was observed in the facility that could be used in the generator. Observation of the property surrounding the facility revealed no storage shed on site. During the tour no monoxide alarm was observed.

Review of the facility document entitled Emergency Management Planning Criteria for Emergency Environmental Control 58A-5.036 and 59A-4.1265 Nursing Home Assisted Living Facility with approval date , revealed the facility plan was to store 38 gallons of gas needed to run the portable generator for 48 hours on site in a shed house (Photographic evidence obtained).

During an interview with the administrator on at 1:55 pm, she stated she does not have any fuel stored on site to run the generator in case of a power outage. She stated that she had always been told that fuel "goes bad" after a while and she did not want to buy all that fuel and then have it go bad on her. When asked if she had a monoxide alarm, she stated no, she did not know she needed one. When asked if she had notified the residents or their legal representatives of the submission and implementation of the emergency power plan, she stated no and that she did not know she needed to. When asked if she had developed a policy and procedure for the implementation of the plan she stated no, that she did not know she needed to.

Class III

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Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on employee record review and staff interview the facility failed to ensure 3 of 3 sampled employees' (Employees A, B and C) files contained and Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008.

The findings include:

Review of the employee files for Employees A, B and C revealed no Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008.

During an interview with the administrator (Employee A) on . . . . . at 2:05 pm, she reviewed the employee files and then stated that she wasn't sure what the form looked like. An example of the form was shown to her. She stated she thought each file contained the form. She did not produce the form for Employees B and C and produced the last page of an old form from her background screening in 2006. She stated she did not know the form was required to be part of the employee files.

Unclassified