STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966484	**04/09/2019**
NAME OF PROVIDER OR SUPPLIER **BRIDGE AT INVERRARY (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4291 ROCK ISLAND ROAD** **LAUDERHILL, FL 33319**	

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

0000 - Initial Comments

A Operation Spot Check Monitoring survey was conducted on at Bridge at Inverrary (The). The facility had a deficiency identified at the time of the visit.

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

Based on observation, interview and record review, it was determined that the facility failed to ensure a resident met the criteria for continued residency and that the facility could meet all of the care needs of the resident after exhibiting a significant health change, for 1 out of 1 sampled resident's records reviewed (Resident #1). As evidence of the facility failing to implement an control protocol (policy and procedure) and monitoring system within the facility upon allowing Resident #1 to return from the hospital; after the resident tested positive for a contiguous ..

The findings include:

During the initial tour of the facility, Resident #1 room was selected for observation and a possible interview. Upon entrance of the surveyors (with no protective clothing due to lack of proper notification), the room was noted to be very dark with a resident laying on a hospital bed, with a hospital gown on. Observations revealed personal protective equipment (PPE) on a table (gloves, gown, mask and shoe covers).

During an interview on at 10:07 AM with Resident #1, it was revealed the resident had been newly diagnosed with ( ). The Resident stated he was diagnosed with C. Diff two weeks ago. He stated today ( ) was the last dose of his medication and he would be tested to see if the had been cleared. The resident stated due to having the highly he agreed to stay inside of his room and have all meals delivered until he tested negative for C. Diff.

During an interview on at 11:31 AM with the Director of Nursing (DON) revealed the DON created a sign to be placed on the resident door. The DON further stated the sign was placed on the door about two weeks ago, when she informed the resident was returning to the facility with C. Diff. She stated she was off for weekend and did not return to work until today ( ). She stated no staff members came to her upon her return to work today to inform her there was no sign on the resident door and she did not check today upon her return to work to ensure the sign was on his door.

She further stated the resident was cleared to return to the facility after the diagnoses from the hospital

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receiving clearance from her Regional Director of Nursing (RDON). It was further stated the RDON informed her that the resident could return to the facility with appropriate steps and following the facility protocol on and . She further stated the protocol was to have an in service training, place a sign on the resident room door regarding , provide personal protective equipment in the room for direct care staff members who would render care and services to the resident, bring all meals to the resident, the resident and provide supplies in the room such as biohazard bags for waste and soluble bags for soiled linen.

During confidential staff interviews conducted on between 11 AM and 12 PM, confirmed the facility had provided staff with an in-service training regarding control (C. Diff) regarding Resident #1. It was further stated, that they had attended the in-service training. At this time, staff stated there was never a sign posted on the resident door until surveyor intervention on . The interviews also revealed the facility had not made any attempts to follow-up with them to ensure compliance with safety protocol or any other concerns.

Record review also confirmed the facility policy (not dated) stated they must have an in service or briefing to inform all staff members regarding the resident condition, place a sign on the resident room door regarding , provide personal protective equipment (PPE) in the room for all employee and visitors that enter the room, provide supplies in the room such as biohazard bags for waste, the resident, bring all meals to the resident and always have soluble bags for soiled linen inside of the room. The policy does not illustrate how the facility will monitor this process (and/or the effectiveness) with respect to Resident #1.

Record review of Resident #1's filed revealed the resident was admitted to the facility on , the resident was sent out to the hospital on for and generalized , . The hospital diagnosed and admitted Resident #1 due to testing positive for C. Diff. The hospital began for three days and he was discharged with oral to continue with treatment within the facility. The file also failed to illustrate an evaluation of Resident #1 by the facility upon confirmation of this diagnosis to ensure the care needs could be met and the protocol to be implemented upon the return of the resident. The facility was also unable to provide any documentation to illustrate safety protocol monitoring compliance.

During an interview on at 11:32 AM with the Administrator, she stated she could recall a sign being placed on the door. She stated it was ultimately her responsibility overall to ensure the sign was posted and she believe someone must have taken it down over the weekend. However, the Administrator could not provide a reason why staff would take down a sign that is company policy to have up during the process. The Administrator confirmed the findings and provided no further

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explanation.

Class III