STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965390	07/21/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Clare Bridge Of West Melbourne	7199 Greenboro Dr Melbourne, FL 32904	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D

Specific Tag Findings:

0000-Initial Comments
A complaint investigation CCR #20014003738 in conjunction with complaint investigation CCR # 2014004104 was conducted on [redacted] to [redacted] Clare Bridge of West Melbourne Assisted Living Facility had deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observation, record review and interview the administrator failed to monitor the continued appropriateness of placement 2 of 8 (#1 and #7) sampled residents and retained the resident (1) who required total care with bathing, dressing and [redacted] and could not ambulate and Resident (7) who required 24 hour supervision and 24 hour nursing or [redacted] care that exceeded requirements for continued residency in the ALF and did not obtain an complete and accurate Resident Health Assessment (AHCA form 1823) after a significant change (hospital Admission) for 1 of 8 Sampled residents (#1).

Findings:

1. During the facility tour on [redacted] at approximately 2:30 PM resident #1 looked as if he required a higher level of care, He was lying in bed and His legs were contracted. An interview was attempted with the resident. The resident was [redacted] and could not provide any information. The License Practical Nurse stated the resident was not under the care of hospice.

Record review for resident #1 revealed that was transported to the hospital on [redacted] and returned on [redacted] Review of the Resident Health Assessment Form (1823) that was dated [redacted] revealed it was signed by a health care provider. Further review of the 1823 revealed the health care provider did not include their medical license number, the address and telephone number. The section of the 1823 that noted in your professional opinion, can this individual's needs be met in an assisted living facility which is not a medical, nursing or [redacted] facility was left blank. Further record review revealed there was no documentation to confirm the facility staff had attempted to contact the health care provider to obtain the information that was missing. Further review of the 1823 revealed the resident was total care

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with bathing, dressing, eating, self -care and toileting.

Observations of on at approximately 4:40 PM revealed one staff looked for a gait belt before he went to resident #1's . Two staff had to come to get resident #1 dressed so that he could eat dinner. One staff had a gait belt. The staff explained to resident #1 what they were about to do. The two staff repositioned him, to provide peri care; the resident's leg remained in the same position, as when he laid down. He was stiff. The staff then repositioned resident #1 again to dress him and proceeded to put his pants on him. The resident was not able to assist at all with getting dressed. The two staff then sat the resident up with the help of the gait belt. Once the resident sat up, one staff moved the wheelchair close to the resident and the two staff sat the resident in the wheelchair. The resident was unable to assist with the transfer from the bed to the wheelchair because his feet were contracted.

2. Review of an adverse incident report revealed that Resident #7 had a physical altercation with Resident #8 and sustained injuries and was sent to the hospital.

Record review for resident #7 revealed a Resident Health Assessment Form with a diagnosis that included type and was dated . The form noted he required 24 hour supervision. Under special precautions the health care provide noted "to be supervised 24/7". Further record review revealed a Resident Health assessment form that was dated that noted the resident: Required 24-hour nursing or care.

During an interview with the administrator on at approximately 3 PM, she confirmed that the forms were not completed as required and were not accurate.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview the facility failed to provide care and services appropriate to meet the needs and ensure safety through protective measures to minimize the potential for elopement and injuries and residents behavior resulting in numerous with injuries for 4 of 8 residents reviewed #2,#6,#7 and #8.

Findings:

1. Resident record review conducted on revealed a Facility Health Assessment Form (AHCA 1823 Form) for resident #2 revealed diagnosis of , and Resident requires assistance with all activities of daily living. The physician noted the resident is a risk. Record review further revealed physician orders for a low bed,

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½ side rails, bed alarm and mattress pads on floor, wheel chair and chair alarm.

Observation conducted on at 4:14 PM revealed resident #2 has a low bed with half side rails, mattress pads on floor, bed alarm, and wheelchair with chair alarm. Resident #2 was observed ambulating without his wheelchair.

Review of the incident report log for the facility over the past month revealed the following incidents regarding resident #2:

Heard Door Alarm, found resident standing on patio outside front door, unharmed. 2x during shift this evening 2130, small scratch to head, treated.
7:45 PM in dining head on corner of table. Steri Strips applied. Daughter, Dr. Steward and hospice called.
11:30 AM Resident #2 found lying on floor in another resident's noted on left elbow, no complaint of pain or discomfort.
in dining of chair. Small red area on head no Vitas, daughter contacted, stated do not send to hospital.

surveyor asked the nurse at approximately 7:17 PM the whereabouts of resident #2. His wheel chair with chair alarm was sitting in the common area near the living him. The nurse stated I asked the direct care staff 1/2 an hour ago to go find him. It was stated by another aide that resident #2 is in another resident's on the bed. The surveyor went to his he was not there. Search by staff found resident at approximately 7:30 PM sleeping in a bed in B (not his The resident was missing approximately 45 minutes.

2. Resident Record review conducted on for resident #6 revealed a Facility Health Assessment Form (AHCA Form 1823) dated revealed diagnosis of The physician indicated the resident is independent in all activities of daily living. The physician checked the box indicating the resident is an elopement risk.

Review of Incident Reports concerning resident #6 revealed:

Incident Report dated male admitted to facility around 5 PM. Resident agitated with being placed in facility and angry with family for leaving without his knowledge. Resident #6 held front door alarm down for over 15 seconds and the door opened. Resident would not be redirected. Staff member accompanied resident #6 outside of building and

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followed him. Walked to gas station and purchased soda and walked back to facility.

Incident report dated [redacted] 3:20 AM, Front door alarm sounded. Staff followed protocol and conducted head count. Resident #6 noted as missing. Law enforcement contacted. Law enforcement returned resident to facility at 5 AM. Nursing Assessment conducted no injuries noted.

Incident report dated [redacted] at 2:30 AM resident #6 observed going outside door and refused to be redirected back inside and walked 1000 feet up main road. The resident was walking into oncoming traffic to kill himself. Law enforcement contacted. Law enforcement transported resident to Holmes Regional Hospital Circles of Care under a [redacted]

3. Review of the Adverse incident report dated [redacted] revealed that Resident #7 and #8 both who had [redacted] were involved in a physical altercation, both sustained cuts and first aid was given, 911 was called. Both residents were transported to the hospital and returned later that day.

Record review for resident #7 and resident #8 revealed that there was no documentation in their records of what had occurred nor was there documentation they were transported to the hospital after the altercation. Further record review revealed there was no documentation to confirm their health care providers and family or representative was contacted to inform them of the incident and that Resident #7 and Resident #8 were transported to the hospital.

During an interview with the administrator on [redacted] at approximately 2 PM, she stated the information should have been written in the file. She later returned with the record and a late entry was written regarding the incident.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on observations, staff schedule review and interview the facility failed to have enough staff available to assist the residents with meals resulting in a residents eating their breakfast late.

Findings:

Through interviews during the survey on [redacted] and [redacted] revealed when staff who was scheduled to work called out, there were no replacements sent in for the staff although the schedule would reflect that the staff worked. It was revealed they were often short staff due to employees calling in. It was also revealed that residents would often eat late; staff had to bring

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the residents to the dining eat. If they were providing care there was not enough staff to bring the residents to the dining . During interviews it was also revealed there were approximately 22 residents (the census was 37) who required cueing to eat and needed someone to escort them to the dining to their or physical they would not know to come to the dining eat and could not ambulate without assistance.

The facility was a secured memory care unit and the residents were

The following Observations were made by surveyors during breakfast:

Observations I:

Observations of the staff Schedule on revealed that there were 5 caregivers scheduled including a Licensed Practical Nurse (LPN) for the 6 AM-2 PM shift. Further observations at 6:30 AM revealed there were only 4 caregivers including a nurse present.

During an interview with the LPN on at 6:30 AM, she stated that a staff had called in and there was no replacement called in. The LPN stated she had to redo the staff assignments.

Observations at 7 AM revealed residents were sitting in the dining They were eating cereal and milk. During an interview with staff it was revealed they were waiting for the cook to arrive and he would not arrive until around 8 AM and they needed to serve the residents something to eat. They stated when the cook arrived he had to prepare the meal and the residents had to wait.

There were two dining Dining was where the residents who could feed themselves had their meals

Dining was on the other side where the resident who the facility considered "feeders" needed assistance with eating their meals and they also were higher level of care.

At around 7: 30 AM the cook arrived. Residents were sitting on both sides Dining and Dining #2.

Observations at approximately 8 AM revealed there were a few residents sitting in both dining eating. In Dining there was no one in the the Feeders.

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Random Sampled (RS) #4 was observed sitting at the table holding her spoon over her oatmeal not eating.

At 8:15 AM, the LPN was observed in the dining . She was asked why a resident who had been in the dining 7 AM was not eating anything. She stated the cook left. She was asked why the cook left. She stated he had left to go buy towels. The LPN stated she was busy and needed to do her med pass. Staff N was present in dining ; she was going in the kitchen and preparing food for a resident. During an interview with Staff N, she stated she was preparing the food because the cook had left to go to the store.

Further observations at approximately 8:20 AM, revealed that there was no staff in the dining supervising the residents who were present including the feeders.

RS#4 was still holding her spoon over her oatmeal sleeping.

At approximately 8:35 PM the facilities regional nurse was informed of what was going on. She was informed that residents were waiting in the dining not being fed. She was informed that the cook had left to go to the store to buy towels. She was surprised, she was not aware that he had left. The regional nurse arrived to the dining area; she knocked several times on the kitchen door because it was locked. The LPN came and unlocked the door. The regional nurse observed that the cook was gone. The regional nurse began to serve food that the cook had already prepared. She was informed that RS#4 who was a feeder had been holding her spoon over her oatmeal since around 8 AM. The regional nurse went to the table where RS#4 was who was still holding her spoon and asked if she wanted to eat. The Regional Nurse was informed that the food was probably by now. She took the bowl of oatmeal away.

8:35 AM-A cook from the other building (sister facility) arrived and stated that they had asked her to come over to help. She stated she had finished with breakfast in the other building and the residents were eating.

Further observations revealed that there was new staff arriving from the other facility to assist. There was another LPN that arrived. The housekeeper was observed bringing residents into the dining . The staff began bringing food out to the residents.

8:40 AM-the cook returned

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During an interview with the housekeeper at approximately 8:55 AM she stated she was asked to bring the residents to the dining assist with feedings.

Further observations revealed the housekeeper sat at the table with RS#4 and began to assist her with her meal.

The Regional Nurse was also observed feeding a resident.

At approximately 10 AM, the staff gave an account of all of the residents who did not have breakfast. There were approximately 3 other residents that a staff stated had not had breakfast because they were waiting on showers.

During an interview with Staff N on at approximately 10:35 AM she stated that hallway B was divided among the staff because a staff called in, residents in that hall required showers also. She also had a hallway that she was responsible for if residents needed showers or assistance with coming to the dining. Hallway B was where the residents who required more care lived. She explained she was just bringing RS#2 to breakfast because she had to shower other residents and did not have time. She stated that RS#1 was still in bed because she would hit staff and two people were required to get her up and there was no one available to assist her. She stated that the resident had hit her before. RS#1 had not eaten breakfast. She further stated that RS#3 was still in bed because she had to shower her also. At approximately 11:20 AM RS#3 was observed being wheeled in her wheel chair to the dining eat breakfast.

Observations II:

At approximately 8:50 AM Staff # I stated resident #4 would be given a bath after she finished with another resident. Resident #4 will eat after she was showered.

At approximately 9 AM resident #4 was in bed and unable to fed herself and ambulate without assistance, the caregiver had just finished bathing her. The hospice nurse came to do care. The care ended at approximately 9:43 AM. The resident was dressed by nurse and the caregiver and taken to dining. She was fed by staff # G the housekeeper.

At 9 AM Staff L stated she was about to be done with a resident and she would then feed resident #3 who was unable to feed herself and was bedbound.

At 9:17 AM Staff #L went to the resident #3 woke her up for breakfast. She elevated

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the head of the bed. The resident was offered her orange juice, ice water, scrambled eggs, toast and oatmeal. At approximately 9:22 AM she started to eat. The staff stated the resident normally ate at about 9 AM.

During an interview with the Administrator on [redacted] at approximately 12:45 PM, she stated there was a staff that called in and she was not aware that the residents were previously eating breakfast late.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Clare Bridge Of West Melbourne
7199 Greenboro Dr
Melbourne, FL 32904

RE: CCR #2014003738

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2014 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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