STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966484	**10/10/2016**
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

An unannounced licensure complaint survey, CCR# 2016010654 was conducted on 10/05/2016 -10/10/2016 at The Bridge at Inverrary, license # 10669. The facility had deficiencies found at the time of the visit.

0007 Admissions - Criteria

Based on observation, interview and record review, the facility failed to ensure that 2 of 3 sampled residents, (Resident #1 and #2) met admission criteria. This was evidenced by the readmission of Resident #1 with a non-healing sacral requiring a pressure vacuum dressing, with multiple extensive non-improving chronic wounds on lower legs,who was dependent for activities of daily living and required a and Resident #2 with a chronic non- healing sacral , and significant decline in mental status and mobility.

The findings include:

1. Review of the medical record for Resident #1 indicated an original admission date of with medical diagnoses including severe , and . Review of Resident #1's facility progress note on admission indicated the resident was alert and oriented and able to make her wishes known to staff. The note further indicated that the resident was observed to have an open on the right ankle and which was being treated every other day by a home health agency care nurse. On , the resident is documented as going out to the physician for evaluation and an angiogram was performed of the lower extremities. Further review of the note indicated that Resident# 1 went to a follow-up appointment at her physician's office and was admitted to the hospital.

Review of Resident #1's hospital admission record dated on indicated that the resident was admitted to the hospital with extensive non-healing leg wounds. The note indicated that the resident had been evaluated prior to admission and underwent angiogram and angioplasties to improve her . The record indicated that Resident #1 received outpatient care but resulted in extensive superficial wounds on the lower extremities, that were and weeping fluids. Further review of the hospital record indicated that was administered and extensive surgical debridement was performed. The record further indicated that the Resident #1 was assessed to have a sacral . (see photo evidence) on admission. The resident was discharged to a skilled nursing facility on / for rehabilitation services.

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Review of Resident #1's hospital admission record dated on 11/11/2015 indicated that the resident was admitted for evaluation of a episode secondary to / loss from leg during an outpatient dressing treatment at the physician office. The resident was still admitted to the skilled nursing facility. The record further indicated that Resident #1 received a and was assessed with a sacral (see photo evidence). The resident was treated with , cultures obtained, care treatments performed, along with an consultation. Resident #1 was assessed to be alert and orient and able to make her own medical decisions. Resident #1 was transferred to another skilled nursing facility for care and rehabilitation services.

Review of Resident #1's hospital admission record dated on indicated that the resident was admitted from the skilled nursing facility for evaluation of possible and treatment of abnormal labs, an elevated white count. The Emergency note dated indicated that Resident #1 had a large sacral and lower extremity wounds (See photo evidence). Resident #1 was admitted with a diagnosis of , related to and leg , severe , and functional decline. An care consultation was completed on / and the resident was ordered and cultures. The culture results indicated that the numerous lower extremity macerated wounds were positive for organisms, including -resistant aureas ( ). The note further indicated that Resident #1's lower extremities were with multiple excoriated wounds involving the dorsal aspect of the feet, ankles and - areas and the pulses were diminished. The note indicated that the resident had a sacral as well. Review of a surgical care consultation dated on / indicated that the resident had a sacral with muscle exposure. The resident was documented as of bowel and had a in place. The sacral measurement was noted as 5 cm x 6 cm x 2 cm with some small areas of necrosis. The note indicated that the physician recommended a vacuum dressing system to promote healing as well as offloading, proper nutrition and physical . Review of the physician order dated on indicated an application of a negative (NPWT) dressing for Resident #1's sacral and care orders including the dressing to be changed on Monday, Wednesday and Friday and vacuum set at 125mmhg continuous pressure. Review of Resident #1's hospital discharge note dated indicated that Resident #1 was diagnosed with severe functional decline, unhealed leg and sacral . Review of physician orders dated on indicated that the resident was admitted to hospice care services and was required to be turned and positioned every 2 hours to promote healing.

Review of Resident #1's medical record dated on indicated that the resident was readmitted to the assisted living facility with a sacral and a vacuum device attached,

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draining fluid, with extensive lower extremity wounds which were wrapped with dressings, a and receiving 24- hour hospice nursing crisis care services. Review of the facility progress notes from indicated no documentation of any observation of the NPWT vacuum/ settings, or extensive lower extremity wounds. Review of the progress note dated on / indicated that the resident was discharged from Hospice 24- hour nursing crisis care.

Review of Resident #1's Health Assessment form dated on indicated the resident required total care for activities of daily living (ADL) for ambulation, bathing, transfers and assistance with dressing, self- care and toileting. The form further indicated that Resident #1 had a " " sacral . The form did not indicate that Resident #1 had an additional fold , , required a or a vacuum dressing device was in use.

Review of Resident #1's hospice nursing notes from / indicated that the hospice nurse visited the resident every other day to perform an assessment and complete prescribed care to the resident's sacrum and extremities. The notes indicated that Resident #1 was noncompliant at times with allowing care to be performed and had episodes of pain and ( ).

Review of the facility progress notes from / to indicated no documentation of any facility nursing observations of the vacuum device function, function or repositioning of the resident, until when a facility nurse documented that the resident would be transferred to the hospice inpatient hospital unit for for abnormal work results and possible .

Review of Resident #1's hospice note dated indicated that the resident was transferred to the inpatient hospital hospice unit for treatment. Review of a hospice care evaluation/consultation dated on indicated that Resident #1 was admitted with a sacral with vacuum device. The measured 5.5 cm x 7.0 cm x 0.2 cm with the bed covered by non- viable fibrotic tissue. Additionally, a left fold with clustered, eroded skin was noted. The note documented that the resident had extensive lower extremity wounds from and calf to heels. heel wounds were observed covered with tissue and greenish drainage noted. Review of a care note dated on indicated the sacral had bone exposure and the measured 5.0 x 7.0 x 0.6 cm with 60% and 40% adhered . The care plan of care was noted as: "complete care 2 x weekly, check the vacuum device collection canister and vacuum machine for proper function every day. Turn and position the resident every 2 hours and as needed, and to off load heels with pillows."

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Review of resident #1's hospice progress note dated on 4/4/2016 indicated that the resident was again readmitted to the Assisted Living facility. The resident was admitted on 24- hour hospice nursing crisis care services with a sacral with vacuum device, , extensive lower leg wounds with toes and a left . The note indicated that the resident was experiencing pain with repositioning and dressing changes, and medicated regularly with with relief. Resident #1 was discharged from 24- hour hospice crisis care on . The vacuum device was discontinued on / and the resident was transferred to a skilled nursing facility on . Review of the facility ' s nursing progress notes indicated no documentation of any nursing observation or interventions of the vacuum device, , or repositioning of the resident, when the resident is removed from 24 -hour hospice nursing care.

Review of the resident ' s care assessment upon admission to the skilled nursing facility dated on , indicated Resident #1 had a sacral with exposed bone, an unstageable left ischial , a right ischial and extensive extremity wounds which extended to the muscle tissue with toes. The resident on

In an interview with the facility Director of Nurses on at 11:00 AM ,she stated that Resident #1 was readmitted in late 2015 from the inpatient hospital hospice unit with a sacral and vacuum device treatment. Additionally, the resident had extensive lower extremity wounds and also required a . The nurse stated that the resident was on hospice services and that the hospice nurse came daily to monitor/assess the resident. When the nurse was questioned if the facility nursing staff participated in the resident ' s care and made observations, she stated that they were not involved with care observations, or care since the resident was on hospice services. She stated that the facility nursing staff did not document observations of the vacuum settings, function or any nursing interventions such as turning and repositioning to promote healing. She stated that the resident had been on and off 24- hour nursing crisis care and the hospice nurse would monitor the resident when she visited. The nurse stated that the hospice was responsible for the resident's care.

In an interview with the Assisted Living (AL) facility manager on at 11:45 AM, she stated that Resident #1 returned to the facility on with hospice 24- hour nursing crisis care services. She stated that the resident was admitted with a large sacral , with vacuum device and extensive lower extremity wounds. Additionally, the resident had a and required extensive ADL care. She stated that the resident was allowed to be readmitted because the hospice staff were providing the required nursing care for the resident and the resident had requested to

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return. When questioned how long the resident had remained on hospice 24 hour crisis care services, and what role did the facility nursing staff play in the resident's care, the manager stated that the hospice nurse came every day to monitor and change the dressings for the sacral and leg wounds. She stated that the resident initially had been receiving 24 -hour hospice care and the hospice nurse would monitor daily function, and device function. She stated that the hospice nurse was responsible for the resident ' s care. The facility manager stated that she felt the resident's numerous admissions to the facility were appropriate, even though the resident had a , wound vacuum device, , extensive chronic leg wounds, was bedbound and required total ADL care for overall decline in medical status. She stated that the resident was under " hospice care " and that she had requested to return to the facility where her husband lived also. When she was questioned if the facility nursing staff participated in the resident's care, made any observations or performed interventions related to the care of the resident's multiple wounds and care when the resident was taken off 24- hour hospice care, she stated that the hospice nurse was responsible for that care. She stated that the facility nursing staff did not routinely provide or document care for the resident. When asked why the resident had not been transferred to or remained in a skilled nursing facility, the manager stated that the resident was placed on hospice services therefore she could return to the facility.

In an interview with the hospice manager on at 11:30 AM, she reviewed the medical record and stated that Resident #1 was placed on hospice services 4 days prior to being admitted to the facility on . She stated that the resident required a higher level of nursing care due to her numerous medical conditions and the hospice nurse provided the services as ordered. The manager stated that the hospice medical director had authorized the vacuum treatment to be continued while on hospice care. The manager stated that Resident #1 was scheduled to be admitted on but the facility DON did not have the " staff to assist with the vacuum device " She stated that the admission was postponed until , when Resident #1 was admitted under 24 hour nursing hospice crisis care. She stated that the AL Manager agreed to accept the resident back to the facility with a , , extensive lower extremity wounds and overall decline requiring total ADL care. When questioned about the daily nursing observations required when Resident #1 was not on 24 hour nursing crisis care, the manager stated that the hospice nurse was assigned to that facility and to care for all residents that were on hospice services. She stated that the nurse would " check in " on Resident #1 frequently but not as a scheduled visit and the " visit was not documented ". She stated that the nurse was scheduled to perform care 3 times a week and as needed, and she monitored the vacuum device, empty the drainage collection unit and would monitor the function. The manager was unaware if the facility care givers had repositioned the resident for comfort and healing or if the nursing staff had participated in any care for the resident. The manager stated that when Resident #1 was not receiving 24- hour hospice nursing care, the hospice nurse was not scheduled to visit every day. Review of the hospice Integrated Plan of Care

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dated on 1/6/2016 indicated that Resident #1's, needs were to be met by a coordinated effort between the hospice and facility, which included assistance with ADL care and any required care needs.

2. Review of Resident #2 ' s medical record indicated that the resident was admitted on with medical diagnoses of , and . Further review of Resident #2's record dated indicated that the resident was being treated by a 3rd party provider for a slow healing sacral measuring 8.0 x 4.0 x 0.3 cm. Resident #2 was of and bowel and required the use of a diaper. The resident was documented as having motor skills, requiring to transfer and use a wheelchair for mobility. The resident had at times and required supervision for care. Review of the Home Health nurse note dated on indicated that Resident #2 was wheelchair bound and was required to be offloaded / to alternate her position thru out the day to alleviate pressure to the sacral area. The note further indicated that the facility caregivers were instructed to position the resident on her side in bed after meals, to off load the sacral area and promote healing. Review of the Home Health nurse note dated / indicated that Resident #2 was found soiled with stool by the nurse. Review of a note dated indicated the sacral measured 8.0 x 4.0 x 0.2 cm with 50% . Review of a Home Health note dated / indicated the Resident #2 was found with the sacral dressing off and the resident sitting in a and stool soaked diaper. The note further indicated that the caregivers should notify the Home Health nurse if the dressing is removed or soiled. Review of the Home Health note dated on indicated the sacral measured 8.0 x 4.0 x 0.2 cm with 90% , the had not improved in 60 days. Review of a Home Health note dated on / indicated the resident is found with the sacral dressing off and the is documented as deteriorated since the last visit. Review of a Home Health note dated on 9/ indicated the measured 7.0 cm x 3.0 cm x 0.3 cm with 50 % .

During an observation of Resident #2's sacral with the physician on at 12:00 PM, the resident was observed to be unable to assist with transfer and required 2 caregivers to lift her to the bed. Resident #2 was unable to turn and position herself on her side and required the care staff to turn her. During the observation, the two caregivers stated that Resident#2 was incapable of moving in the wheelchair, turning herself in the bed or transferring from bed/ wheelchair. They stated that Resident #2 preferred to stay in her wheelchair and attend activities and was placed in bed after lunch for 1 hour, then returned to her wheelchair. The resident's bed was observed with no pressure reducing mattress. The physician removed the sacral dressing and the resident's sacral area was observed with 2 excoriated, open crusted areas of redness, a measuring approximately 8 cm x 5 cm and another measuring approximately 3 cm x 3 cm were observed. The dressing was observed with drainage, along with feces. When questioned, at the time of the observation, the physician stated that he needed to evaluate the since he had not seen the

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recently. He was informed by the surveyor that Resident #2 had received home health care for the sacral from and the care documentation showed little improvement of the . The physician stated that he was unaware any concerns with the sacral . He stated that Resident #2 had just recently returned from the hospital after being evaluate for a decline in condition. He questioned the DON, who was also present at the time of the observation, why Resident #2 had not been transferred directly to the skilled nursing home for rehabilitation and care. The DON stated that the resident's family requested that she return to the facility, and not be admitted to a skilled nursing home. The physician stated that he would recommend that Resident #2 be transferred to the skilled nursing home to receive more aggressive care interventions and he would speak with the resident's family. He stated that he was unaware that the sacral had shown no significant improvement for 4 months, even with prescribed care.

In an interview with the DON on at 12:25 PM, she was requested to provide any documentation that the Home Health nurse's instructions had been followed, to off load the resident's to promote healing and to keep the resident clean and dry with the dressing intact. The nurse stated that there was no documentation of any facility nursing observations or interventions related to the . She stated that the facility had no log or notes to indicate that the resident was turned or repositioned as instructed to promote healing. She stated that she was unaware if the resident's had shown any improvement.

In an interview with the Home Health Nurse on at 9:45 AM, she stated that she had been providing care to Resident #2's sacral area since , 2016. She stated that Resident #2 had been admitted from another facility with the . She stated that initially Resident#2 had been able to turn and position herself in bed, transfer with assistance but she preferred to remain seated in her wheelchair for most of the day. She stated that the resident was a large person who would sit all day, from breakfast until bedtime and the behavior did not facilitate healing. The nurse stated that she instructed the facility caregivers to off -load the resident ' s and to keep the area clean and dry since the resident was . The nurse stated that when she came to visit the resident, she would often find Resident #2 in a soiled diaper and the dressing off. She stated that she had instructed the facility staff/ managers to inform her when the dressing became soiled or off and she would return to replace it. She stated that she was rarely called. She stated that the combination of Resident #2 remaining seated in her wheelchair all day and the exposed to / feces contributed to the lack of improvement. The nurse stated that Resident #2 had been transferred to the hospital on / for a decline in medical condition, / , and when readmitted to the facility, the sacral had deteriorated. She stated that Resident #2 was more , had a decline in verbal communication and was unable to assist with transfers or repositioning herself. The nurse stated that she had notified the physician of the condition, requested new orders and had expressed her concerns with the noncompliance with off- loading the .

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In an interview with the facility manager on at 1:30 PM, she was informed by the surveyor that Resident #2 had been receiving care for a sacral from until present, with no documented improvement noted in the record. The manager stated that she had not been notified by the Home Health nurse that the had any significant improvement. The manager was unable to explain why the resident had been readmitted on with a non- healing and a history of care treatment over the prior 4-month period and also with a significant decline in medical condition resulting in bed/ chair immobility, requiring 2-person assistance with ADL care. She stated that the resident's family member had requested her readmission.

In an additional interview with the DON on at 1:45 PM, she stated that the physician had ordered that Resident #2 be transferred to a higher level of care for rehabilitation and care treatment.

Class II

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
The Bridge At Inverrary
4291 Rock Island Road
Lauderhill, FL 33319

RE: CCR #2016010654

Dear Administrator:

This letter reports the findings of a licensure complaint survey (CCR #2016010654) conducted on , 2016 and concluded on , 2016, by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **ten business days** of receipt of this faxed report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0007 - 429.26(11) Fs; 58a-5.0181(1) Fac - Admissions - Criteria S-S= G

Directed Corrective Actions:

1. The facility shall implement a written, detailed plan of how the facility will have each resident currently residing at the facility assessed for appropriateness of residency, by their health care provider. The assessment will include obtaining a Resident Health Assessment (AHCA Form 1823), dated after for all residents currently residing in the facility. Any resident who is deemed inappropriate for continued residency according to Florida Administrative Code 58-A0181, the facility will give the required written notice and ensure a safe transfer of the individual to a location in which their needs can be met, with coordination and input from the resident and their primary guardian/ Power of Attorney. The facility shall send notification to the Agency for Health Care Administration, no later than 11/ , of residents who were deemed inappropriate for continued residency. The notification must include the resident's name, Power of Attorney or guardian's name and phone number where they can be reached and location of discharge.

2. The facility shall conduct an in-service training for all staff regarding the criteria for admission and continued residency as stated in Florida Administrative Code 58-A0181. The training must include the minimum criteria for admission and continued residency in an assisted living facility holding a standard license. The facility must have documentation of the completion of this training. This documentation must be kept on file at the facility, and be available for review by the Agency.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

3. The facility shall implement a written, detailed plan of how the Administrator/ Designated Manager will monitor the admission appropriateness of placement for all residents in the facility at all times, pursuant to Florida Administrative Code 58A-5.0181. This plan must include a second member of the staff or hired consultant, who holds a current license as a Registered Nurse, who will audit the appropriateness of all residents in the facility alongside the Administrator. This plan will be completed by // . A form must be developed in which both the Administrator and the Registered Nurse sign that they are in agreement of the audit of continued residency of all individuals in the facility, on no less than a monthly basis. The results of these audits must be kept on file at the facility, and be available for review by the Agency.

All required documentation set forth above, should be directed to the attention of Mrs. Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Field Office Delray Beach
Attention: Tikle Wedges-Phoenix
5150 Linton Blvd. Delray Beach, FL 33484
Phone:(561) 381-5840
Fax: (561) 496-5924

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . Amanda Beagles, Survey and Certification Support Branch, at 850-412-4662 or Tikle Wedges-Phoenix at 561-381-5840.

Sincerely,

T. Wedges-Phoenix

Arlene Mayo-Davis
Field Office Manager

AMD

D7JR