STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965291	10/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Broadview Assisted Living	2110 Fleischmann Road Tallahassee, FL 32308	

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

St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - E205 - 58a-5.030(6) Fac - Ecc - Health Assessment S-S= D
St - A - E206 - 58a-5.030(7) Fac - Ecc - Service Plans S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

0000-Initial Comments

On 1-2, 2013 a unannounced Extended Congregate Care(ECC) Monitoring visit, along with a follow-up to an ECC Monitoring visit was conducted at Broadview Assisted Living, 2110 Fleischmann Road, Tallahassee, Florida. The facility had deficiencies found at the time of the survey.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on interviews, resident record review and observation, the facility failed to ensure that 1 of 4 sampled residents continued to meet residency criteria, and failed to, after having a significant change in condition (unstageable - have those changes and results of an examination recorded on AHCA Form 1823. (Resident #4).

The findings include:

On at 12:50pm an interview was conducted with LPN (Licensed Practical Nurse) #4, she indicated the facility has 1 resident with a on her she is not sure what is, as the resident has Home Health Care (HHC) that takes care of the .

On at 1:15pm, an interview was conducted with LPN #6, she identified the same resident (Resident #4) as having a . She indicated the has gotten a lot better and that Home Health Care performs the care treatment. Last she was told, the was a she believed. She had not seen the .

On at approximately 1:55pm an interview was conducted with the Wellness Director (WD). The WD stated she believed the resident's was a but was unable to locate any documentation from the Home Health Care (HHC) Agency describing the condition of the . The only documentation she was able to locate from the HHC Agency were vital signs. There was no documentation in the resident's record that described the condition of the for Resident #4.

A review of Resident #4's Medical Record failed to reveal any nursing progress notes or assessments related to the resident's development and condition of the to her A fax note to the physician, "Resident has two opens to her area may we have an order for Home health Care to eval and treat?" Order received. The faxed sheet was dated A review of the resident's nursing progress notes, revealed a note, dated at 10:00am - "Resident up OOB (out of bed) sitting in w/c (wheelchair), alert, completed ABT no s/s (signs/symptoms) adverse reaction. No complaint of pain, no discomfort, will

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continue to monitor. The next nursing progress note entry was dated [redacted] - "New [redacted] care order faxed to (name) home health agency."

Additional information found within the resident's record contained a physician progress notes; both from the physician's office and [redacted] care instructions from the [redacted] Care center. Information in the resident's record from the [redacted] Care center did not describe the [redacted] but merely gave instructions for [redacted] care, notes were dated [redacted] and [redacted]. There was an order in the record, dated [redacted] for a RoHo cushion for a diagnosis of an **unstageable** [redacted]. The record revealed one physician office note, dated [redacted] that indicated the presence of a [redacted] on her [redacted] for the last 3 weeks" and that the [redacted] was "at least a [redacted] the [redacted] is the size of silver dollar on her [redacted]. It is open." Received to the facility, via fax, on [redacted] was a note from the [redacted] Care center, with a visit date of [redacted] that described the [redacted] as "chronic [redacted] tissue (unstageable), [redacted] and has received a status of Not Healed. Measurements are 3.2cm length x 3.2cm width x 0.1cm depth, with an area of 10.24 sq cm and a volume of 1.024 cubic cm. No [redacted] has been noted. No sinus tract has been noted, No undermining has been noted. There is a small amount of sero-san[redacted] drainage noted. The patient reports a [redacted] pain of level 3. The [redacted] margin is well defined. [redacted] bed is 76-100% bright red, pink [redacted] no eschar present. The [redacted] is improving."

A review of Resident #4, last health assessment (AHCA form 1823), was dated [redacted]. There was not an additional health assessment (1823) denoting the residents change in condition.

On [redacted] at approximately 2:30p an observation of Resident #4 was conducted. Resident #4 has a private [redacted] Her bed was noted to be up against the wall, so that the resident had a straight on view of the door. The right side bed side-rail, facing the [redacted] - was raised. Resident was in a semi-fowlers position, **on her back**. The resident was capable of answering simple questions, but could not elaborate on her conation. There was signage present in the [redacted] indicate to turn the resident every 1-2 hours and to keep her off her bottom turn her from side to side. Also noted was a dry erase board that indicated that the resident's [redacted] was improving. Just before exiting the [redacted] a facility caregiver for the resident entered and indicated she was just about to get the resident up, indicating that the resident is to be up 20 minutes before meals.

On [redacted] at approximately 3:20pm, an additional interview was conducted with the WD regarding skin assessments. She indicated that the CNAs or Direct Care Staff are to notify the nurse if the resident has any evidence of redness or change in skin condition. The Nurse is then to assess the resident and let her (the WD) know. She also stated, regarding Resident #4, that the nurse from the HHC agency usually will let her know how the resident's [redacted] is doing. The WD had not seen the resident's [redacted] nor had the facility contracted Registered Nurse to determine whether the resident still met criteria for continued residency. Per the WD resident #4 is not receiving extended congregate care (ECC) services.

On [redacted] at approximately 4:40pm an interview was conducted with Resident #4's daughter, who was at the facility assisting her mother with her meal. The daughter indicated that the [redacted] has been ongoing since [redacted] starting out as two open areas to her mother's [redacted] region. It then developed into one larger area. The daughter, stated she was a nurse and was the one taking her mother to the [redacted] Care Center for treatment. She stated that the physician at the [redacted] Care Center indicated it was getting better, but he couldn't tell what was "underneath" the area. She stated, she didn't recall him giving it a stage. She stated that Home Health are performing her dressing changes a couple of times a week and that she is performing them the other times. She was not sure if the facility was aware of this change. She indicated she only finds out about the

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condition of the [redacted] if she calls the Home Health Agency and that was part of the reason she wanted to do the dressing changes.

Class II

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and interview the facility failed to maintain nursing progress notes for 1 of 4 sampled residents with a change in condition. (Resident #4 - [redacted]

The findings include:

On [redacted] at 12:50pm an interview was conducted with LPN (Licensed Practical Nurse) #4, she indicated the facility has one resident with a [redacted] on her [redacted] she is not sure what [redacted] is, as the resident has Home Health Care (HHC) that takes care of the [redacted]

On [redacted] at 1:15pm, an interview was conducted with LPN #6, she identified the same resident (Resident #4) as having a [redacted] She indicated the [redacted] has gotten a lot better and that Home Health Care performs the [redacted] care treatment. Last she was told, the [redacted] was a [redacted] she believed. She had not seen the [redacted]

A review of Resident #4's Medical Record failed to reveal nursing progress notes or assessments related to the resident's condition of the [redacted] to her [redacted] There is a nursing note, dated [redacted] that indicates "Resident has a small breakdown surrounded by redness, cream was applied, informed staff to make sure she is turned every 2 hours and changed. Will continue to monitor area". Resident #4, per a fax note to the physician, "Resident has two opens to her [redacted] area may we have an order for Home health *Care to* eval and treat?" Order received. The faxed sheet was dated [redacted] A review of the resident's nursing progress notes, revealed a note, dated [redacted] at 10:00am - "Resident up OOB (out of bed) sitting in w/c (wheelchair), alert, completed ABT [redacted] no s/s (signs/symptoms) adverse reaction. No complaint of pain, no discomfort, will continue to monitor. The next nursing progress note entry was dated [redacted] for - "New [redacted] care order faxed to (Name) home health agency." There is no nursing documentation from [redacted] through [redacted]

On [redacted] at approximately 1:55pm an interview was conducted with the Wellness Director (WD). The WD stated she believed the resident's [redacted] was a [redacted] but was unable to locate any documentation from the Home Health Care (HHC) Agency describing the condition of the [redacted] The only documentation she was able to locate from the HHC Agency were vital signs. There was no documentation in the resident's record that described the condition of [redacted] for Resident #4.

Class III

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E205-ECC - Health Assessment 58A-5.030(6) FAC

Based on record reviews and interviews the facility failed to ensure that a health assessment, (an examination by a physician or advanced registered nurse practitioner) was conducted for 1 of 3 Extended Congregate Care (ECC) residents, prior to admission into the ECC program. (Resident #1)

The findings include:

On . . . . . a record review was conducted for Resident #1 who was admitted to the facility on . . . . . The Wellness Director (WD) indicated that the resident entered the facility with a G-tube and a . . . . . , however in review of the resident's admitting health assessment (1823), dated . it failed to identify or address either of these conditions.

The resident's record revealed a fax transmittal that went to and was received from the resident's attending physician, authorizing admission into the facilities Extended Congregate Care Services program, the date on the bottom of the fax transmittal was . . . . . There was no other date on the document to indicate otherwise. There was no documentation in the resident's nursing notes to indicate admission into the ECC program. The resident's health assessment, identifying the services to be provided, was dated on . . . . . - **after** admission into the ECC services program (based on fax transmittal) and failed to be signed by the physician. The WD did indicate the resident went out to the hospital and returned to the facility on . . . . - but was not able to clarify when the resident actually entered the ECC program. The resident's initial ECC assessment conducted by the facility was on , again after admission into the program.

Class III

E206-ECC - Service Plans 58A-5.030(7) FAC

Based on record reviews and interviews the facility failed to ensure that a Service Plan that identified the resident's needs, criteria for admission and evaluation of the residents needs was conducted for 1 of 3 Extended Congregate Care (ECC) (#1) residents, prior to admission into the ECC program and failed to update for 1 of 3 ECC (#3) residents the ECC Service Plan at least quarterly.

The findings include:

1. Resident #1 was admitted to the facility on . . . . . The Wellness Director (WD) indicated that the resident entered the facility with a G-tube and a , however in review of the resident's admitting health assessment (1823), dated , if fails to identify or address either of these conditions.

The resident's record revealed a fax transmittal that went to and was received from the resident's attending physician, authorizing admission into the facilities Extended Congregate Care Services program, the date on the bottom of the fax transmittal was . . . . . There was no other date on the document to indicate otherwise. There was no documentation in the resident's nursing notes to indicate admission into the ECC program. The resident's health assessment, identifying the services to be provided, was dated on . . . . . - **after** admission

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into the ECC services program, however the health assessment failed to be signed by the physician. The WD did indicate the resident went out to the hospital and returned to the facility on - but was not able to clarify when the resident actually entered the ECC program. The resident's initial ECC assessment and ECC Service Plan was completed on , again after admission into the program.

2. A record review for Resident #3 was conducted. Resident #3 also receives ECC Services for care of her . The resident's record revealed a Service plan last updated on , 2013. This was identified as deficient on previous ECC monitoring visit - as this should be updated at least quarterly. The facility failed to update the Service Plan to ensure services being provided were still appropriate for the resident. This was confirmed with the Wellness Director.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on staff record reviews, the facility failed to ensure background screening was performed for 1 of 5 staff records reviewed (Staff #3).

The findings include:

On staff record reviews were conducted for the facility Administrator, Extended Congregate Care Supervisor, Extended Congregate Care Coordinator (contracted Registered Nurse [ARNP]) and two Licensed Practical Nurses. Background screening eligibility was requested for review. There was no background screening information for Staff #3, the contracted Registered Nurse.

On at approximately 11:45am, the Administrator indicated that she was not able to locate or obtain background screening results for the facility's ECC Coordinator; the ARNP contracted to provide nursing services for the facility. The Administrator stated the nurse comes in on a monthly basis to perform assessments and then as needed. She stated she was able to access the Agency's Background Screening result website page, but was not able to access Clearinghouse information. The page from the Agency's Background Screening website revealed under "*Status*" "*A New Screening is Required.*" The Administrator indicated she contacted the contracted nurse and the nurse indicated that it has been over five years since she had a screening. The Administrator indicated the nurse was going that down to have her background screening completed.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Broadview Assisted Living
2110 Fleischmann Road
Tallahassee, FL 32308

Dear Administrator:

This letter reports the findings of a state licensure extended congregate care monitoring survey that was conducted on , 2013 by a representative 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.

You are hereby directed to implement a plan of correction for the Class II deficiency identified during the inspection within ten working days of receipt of this faxed report. All deficiencies shall be corrected no later than , 2013.

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

1) A0010 Admissions - continued Residency - Class II
The Assisted Living Facility failed to ensure one resident continued to meet residency criteria, and failed to have a change in condition (unstageable documented on the AHCA Form 1823.

Your plan of correction must include the following:

1) Ensure resident #4 and any other resident who has experienced a significant change in condition is seen by a health care practitioner to update the 1823

2) Develop and implement a policy for third party services.

3) Develop a written roster for all residents who are receiving third party services, and the specific services received. This should be updated on a weekly basis.

4) Develop and implement a written plan to ensure all residents with skin are quickly identified and appropriate care and services are initiated.

5) Conduct an in-service with facility staff regarding your skin check protocol. Ensure that all in-services are documented and include the title/subject of the in-service, date, time, attendees name and presenter's name.

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162

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.

Should you have any questions please call me at 850-412-4540.

Sincerely,

Patricia McIntire, per

for Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure