Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965291	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADVIEW ASSISTED LIVING	2110 Fleischmann Road TALLAHASSEE, FL 32308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments On _____ an unannounced complaint investigation (CCR# 2014000326) was conducted at 2110 Fleischmann Road, Tallahassee, Florida. Deficient practice was identified at the time of the survey.	A 000		
A 025 SS=G	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

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A 025	Continued From page 1	A 025		

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and facility record reviews, the facility failed to ensure that 3 of 3 resident's requiring transport in wheelchairs, utilizing the facility's transportation service (Van), were secured in a manner to ensure safety (#1, #2, #3).

The findings include:

On beginning at approximately 10:00am, the Director of Maintenance (DoM) was interviewed regarding resident safety while transporting. The DoM indicated in 2013, as a result of a resident injury during transport (resident #1); he researched, developed and trained the "then" driver (Staff C) in the proper procedure for securing a resident's wheelchair and use of harness/lap belt to secure the resident during transport. He developed the "Wheelchair and Rider Securement Procedure and Checklist." The DoM stated that Staff C was no longer driving the facility van, after the Administrator replaced him following another resident injury (resident #2) during transport earlier in the month 2014). He indicated the interim driver (Staff D) has been driving the van for approximately 1 ½ weeks, but doesn't know the exact date. He was under the assumption that he got training from Staff C. The DoM indicated he had not personally trained him (interim driver - Staff D).
On at approximately 10:30am an observation was made of Resident #3, who was on the facility's van, in her wheelchair after the facility van driver (Staff D) had secured the resident for transport. Resident #3 was located in the back left hand side of the van, one of two

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A 025	Continued From page 2	A 025		

spots for securing residents with wheelchairs. Accompanied by the facility Director of Maintenance, the wheelchair was observed to be secured correctly, but the harness/lap belt was not applied correctly - this was pointed out by the Director of Maintenance - who proceeded to remove the clasp connected to the wheel bit and correct. The floor of the van was equipped to secure two wheelchairs, side-by-side. However, the facility only had equipment to secure one resident with a harness/lapbelt. The Wellness Director was present during this observation.

The interim van driver (Staff D), approached as the lapbelt/harness was being corrected, and indicated the former van driver (Staff C) showed him how to secure the wheelchair and lapbelt and that it was really just common sense. He stated he had not received any formal training. He indicated he has been driving the facility van for approximately 1 1/2 weeks and has no prior experience in driving a van.

On [redacted] at approximately 10:50am an interview was conducted with the Administrator, along with the Director of Maintenance. The Administrator stated she thought Staff D had received training related to securement of the resident's wheelchair, along with use in the proper procedure for use of harness and lapbelt. She indicated it was the responsibility of the DoM, but ultimately it was her responsibility to ensure staff were trained. The DoM, then explained to the Administrator how the lapbelt/harness was applied incorrectly. The Administrator stated that they have a new driver starting on Monday [redacted]. The facility was also looking into purchasing an additional harness/lapbelt.

At 11:15am staff record review was conducted for

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A 025	Continued From page 3 Staff D. The staff record failed to include training in the proper procedure for wheelchair and resident securement during transport. Class II	A 025		
A 030 SS=G	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline "1(800)9€ or 1(800)962-2873" shall be posted in full view in a	A 030		

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A 030	Continued From page 4	A 030		

common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s [illegible] and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical [illegible] shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including

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A 030	Continued From page 5	A 030		

half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from . . . . . and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or

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A 030	Continued From page 6	A 030		

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [illegible] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible] interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the

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A 030	Continued From page 7	A 030		

residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and facility record review; the facility failed to ensure the rights of the resident to be transported in a safe manner by failing to ensure staff who operated the facility's van were trained and followed wheelchair/resident securement procedures.

The findings include:

On 01/28) at approximately 10:00am, the Director of Maintenance (DoM) was interviewed regarding resident safety while transporting. The DoM indicated in July , as a result of a resident injury during transport (resident #1); he researched, developed and trained the "then" driver (Staff C) in the proper procedure for securing a resident's wheelchair and use of harness/lap belt to secure the resident during transport. He developed the "Wheelchair and Rider Securment Procedure and Checklist." The DoM stated that Staff C was no longer driving the facility van, after the Administrator replaced him following another resident injury (resident #2) during transport earlier in the month indicated the interim driver (Staff D) has been driving the van for approximately 1 ½ weeks, but doesn't know the exact date. He was under the assumption that he got training from Staff C. The DoM indicated he had not personally trained him (interim driver - Staff D).

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A 030	Continued From page 8	A 030		

On _____ at approximately 10:30am an observation was made of Resident #3, who was on the facility's van, in her wheelchair after the facility van driver (Staff D) had secured the resident for transport. She was located in the right rear of the van in one of two spots capable of securing resident wheelchairs. Accompanied by the facility Director of Maintenance, the wheelchair was observed to be secured correctly, but the harness/lap belt was not applied correctly - this was pointed out by the Director of Maintenance - who proceeded to remove the clasp connected to the wheel bit and correct. The Wellness Director was present during this observation.

The interim van driver (Staff D), approached as the lapbelt/harness was being corrected, he indicated the former van driver (Staff C) showed him how to secure the wheelchair and lapbelt and that it was really just common sense. He stated he had not received any formal training and has been driving the facility van for approximately 1 1/2 weeks. He stated he had no prior experience in driving a resident transport van.

On _____ at approximately 10:50am an interview was conducted with the Administrator, along with the Director of Maintenance. The Administrator stated she thought Staff D had received training related to securement of the resident's wheelchair, along with use in the proper procedure for use of harness and lapbelt. She indicated it was the responsibility of the DoM, but ultimately it was her responsibility to ensure staff were trained. The DoM, then explained to the Administrator how the lapbelt/harness was applied incorrectly. The Administrator stated the facility has a new driver starting on Monday, _____ - she also indicated the facility was

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A 030	Continued From page 9 looking into purchasing an additional harness/lapbelt. During the interview a request to review any incident investigations from 2013 through present involving the facility ' s transportation service, revealed (2) incidents related to wheelchair transport - both residents (#1, #2) sustained injury. Resident #1 was admitted to the hospital. resident #2 was treated and returned to the facility. In additional to the incident investigations, the facility policy related to Resident safety during transport was requested - the Administrator stated they did not have a policy, but had developed a checklist. At 11:15am the staff training record for Staff D was reviewed. The staff training record failed to include training in the proper procedure for wheelchair and resident securement during transport. Class II	A 030		
A 077 SS=G	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least 2. If employed on or after , 1990, have	A 077		

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A 077	Continued From page 10	A 077		

a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after 1995, must have a high school diploma or G.E.D.;
3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and
4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must:
1. Be at least and
2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.
(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.

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A 077	Continued From page 11	A 077		

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and facility record reviews, the facility Administrator failed to ensure that transport staff were trained in the proper securement procedures to ensure residents in wheelchairs were safe during transport. This resulted in 2 of 3 sampled residents sustaining injury during transportation in the facility van (resident #1, #2)

The findings include:

On [redacted] beginning at approximately 10:00am, the Director of Maintenance (DoM) was interviewed regarding resident safety while transporting. The DoM indicated in [redacted] 2013, as a result of a resident injury during transport; he researched, developed and trained the "then" driver (Staff C) in the proper procedure for securing a resident's wheelchair and use of harness/lap belt to secure the resident during transport. He developed the "Wheelchair and Rider Securement Procedure and Checklist." The DoM stated that Staff C was no longer driving the facility van, after the Administrator replaced him following another resident injury during transport earlier in the month. He indicated the interim driver (Staff D) has been driving the van for approximately 1 ½ weeks, but doesn't know the exact date. He was under the assumption that he got training from Staff C. The DoM indicated he had not personally trained him (interim driver - Staff D).
On [redacted] at approximately 10:30am an observation was made of Resident #3, who was on the facility's van, in her wheelchair after the facility van driver (Staff D) had secured the resident for transport. She was located in the right rear of the van in one of two spots capable

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A 077	Continued From page 12	A 077		

of securing resident wheelchairs. Accompanied by the facility Director of Maintenance, the wheelchair was observed to be secured correctly, but the harness/lap belt was not applied correctly - this was pointed out by the Director of Maintenance - who proceeded to remove the clasp connected to the wheel bit and correct. The Wellness Director was present during this observation.

The interim van driver (Staff D), approached as the lapbelt/harness was being corrected, he indicated the former van driver (Staff C) showed him how to secure the wheelchair and lapbelt and that it was really just common sense. He stated he had not received any formal training and has been driving the facility van for approximately 1 1/2 weeks. Staff D stated he had no prior experience in driving a patient transport van.

On [redacted] at approximately 10:50am an interview was conducted with the Administrator, along with the Director of Maintenance. The Administrator stated she thought Staff D had received training related to securement of the resident's wheelchair, along with use in the proper procedure for use of harness and lapbelt. She indicated it was the responsibility of the DoM, but ultimately it was her responsibility to ensure staff were trained. The DoM, then explained to the Administrator how the lapbelt/harness was applied incorrectly.

At 11:15am the staff training record for Staff D was reviewed. The staff record failed to include training in the proper procedure for wheelchair and resident securement during transport.

Class II

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A 165 SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report	A 165		

Internal risk management and quality assurance program; adverse incidents and reporting requirements.-
(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.
(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means:
(a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in:
1.
2. or spinal damage;
3. Permanent
4. or of bones or joints;
5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;
6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or
7. An event that is reported to law enforcement or its personnel for investigation; or
(b) Resident elopement, if the elopement places the resident at risk of harm or injury.
(3) Licensed facilities shall provide within 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965291	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADVIEW ASSISTED LIVING	2110 Fleischmann Road TALLAHASSEE, FL 32308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident.
(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident.
(6) . neglect, or must be reported to the Department of Children and Family Services as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action

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by the appropriate board, the agency shall report this fact to such regulatory board.
(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.
(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

Adverse Incident Report.
(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, , 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmtps@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes.
(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form

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3180-1025, Assisted Living Facility Full Adverse Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule.

This Statute or Rule is not met as evidenced by:
Based on interview and facility record reviews, the facility failed to ensure the submission of a preliminary one-day report to the Agency for Health Care Administration for the occurrence of an adverse incident as required by Section 429.23(3), F.S. Transfer to a unit providing more acute care following an event which facility personnel could exercise control.

The finding include:

On a review of the facility's incident reporting system was reviewed along with two incident reports involving the facility's transportation service. The incident report for Resident #2, indicated the "nurse was called to the resident's resident stated she on the bus." The resident was assessed and identified to have two hematoma's into the tissue) to her head. Resident was transferred by ambulance to local Emergency Department for evaluation. There was a statement obtained by the facility's van driver (Staff C), after the incident, which indicated he "heard the seatbelt hit the side of the wheelchair, like it had been unlocked." The statement indicated he told the resident she had to keep her seatbelt on, the resident was trying to "brace herself on the left backseat in front of her but could not hold herself" as as he turned the corner the resident to her right side.

Agency for Health Care Administration

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A "Resident [redacted] Information Form" was attached to the facility incident report - the form indicated the resident was sent to the Emergency Department and will remain seated while transport. There was no other investigation into the incident done to fully determine if the incident was an adverse event.

On [redacted] beginning at approximately 10:00am an interview was conducted with the Director of Maintenance. He indicated he was called to the van just after the incident on [redacted] The van driver, Staff C, demonstrated and it was still a tie down error. He stated that if the chair is moving and she (resident) is moving - causes a reaction of the resident to feel she has to brace herself. He indicated the resident [redacted] because of the lap belt and it started from being tied down incorrectly.

On [redacted] at approximately 11:50am, the Director of Wellness indicated that Resident #2 was transferred to the hospital following the incident on the van and that she was found to have a hairline [redacted] to her thumb. She stated, she didn't think the incident qualified for an adverse incident, that is why she did not report it.

On [redacted] at approximately 12:25pm an interview was conducted with Resident #2. She stated all she remembered was, the driver secured her, secured the wheelchair and applied the harness and lap belt; he turned the corner and out she went. The driver immediately attended to her and drove her back to the facility. When she got back to the facility the nurse came to look at her and she was taken to the Emergency Department. She indicated she broke her thumb (she was wearing a black Velcro

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to her left hand that extended up her The resident stated she did not remove her seatbelt.

A review of resident #2's record, revealed a "Home Care" instruction sheet from the Emergency Department identifying information related to a finger.

A review of the facility's policy and procedure entitled "Incident Reporting", policy number 30.090FL indicates "An adverse incident is an incident that results in any of the following: (per F.A.C.), 1. .... 4. or of bones or joints; .... 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident..... The above listed adverse incidents, the following guidelines apply: The community must complete the Assisted Living Facility Initial Adverse Reaction Incident form. Send report to Agency for Health Care Administration within ONE business day after the occurrence either by electronic mail facsimile or United States mail. The community is to submit a FULL report to the same agency within 15 days."

Class III

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Broadview Assisted Living
2110 Fleischmann Road
Tallahassee, FL 32308

RE: CCR # 2014000326

Dear Administrator:

This letter reports the findings of a complaint survey conducted on , 2014, by a representative of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the survey. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this report.

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

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0165 - 429.23 FS; 58a-5.0241 Fac -Risk Mgmt & QA; Adverse Incident Report S-S=D

Directed Corrective Actions:

1. The Assisted Living Facility is required to ensure the facility van has the needed "tie down" equipment including shoulder harnesses and/or seat belts to ensure residents are safe during transportation.
2. The Assisted Living Facility is required to immediately train all employees in the proper wheelchair/resident securement procedures to ensure all employees are aware of how a resident using a wheelchair should be secured on the van.
3. The Assisted Living Facility is required to document the training in the employees personnel file.
4. The Assisted Living Facility is required to submit the one-day report to the Agency for Health Care Administration for the adverse incident as required .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Broadview Assisted Living
. 2014

Should you have any questions, please call . . . Catherine Anne Avery, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Patricia McIntire, RNC

for Donah Heiberg, M.S.W.
Field Office Manager
DH/pm

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