AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965185	**04/09/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
BROADVIEW ASSISTED LIVING FACILITY	**2310 ABBIE LANE PENSACOLA, FL 32514**	

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

0000 - Initial Comments

An unannounced Biennial Survey (with Extended Congregate Care) was conducted on - At the time of survey, there were deficiencies identified.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observations, review of facility policy and staff interviews, the facility failed to ensure staff protected residents' privacy rights for 3 of 20 residents, who reside on the memory care unit. The facility failed to protect sampled residents #8, 9 and 10's privacy rights by posting personal information, in full visual view, in the unit's dining/ kitchenette area.

The findings are:

Review of the facility's policy titled, "Resident Confidentiality", showed that staff in accordance with legal and professional ethics, communications between a resident and his physician and personal information about the resident are consider as confidential. This privilege or confidence includes facility records and under no circumstances shall any employee discuss with outsiders a resident's condition, treatment, or personal history. Review of the facility's Resident Rights, included in the admission packet, showed that the residents were to be treated with consideration and respect and with due recognition for personal privacy.

Observation of the memory care unit dining area was on done on beginning at approximately 12:00PM. Observation revealed the memory care unit dining area included a small kitchenette area. This kitchenette area was fully visible by all residents, staff and any visitors. The staff prepared the residents plates and served the meals from this area and it was completely visible by anyone in the unit's dining area. The kitchenette area was in full view of the residents, family members and anyone else that visits the dining area. The memory care unit residents had arrived to the dining were being served their meals by staff. There was one family member with sampled resident #7 in the dining area. Observation revealed four white sheets of paper taped to one of the kitchenette top cabinet doors. The sheets could be easily seen and read. One sheet of paper had the hand-written message on it which stated: No chocolate or pork for sampled resident #9's name (allergy). Another white sheet of paper taped to the same cabinet door contained a hand written note which stated 13 all staff-make sure a bell was attached to sampled resident #9's name and sampled resident #8's name at all times. Observation also revealed another typed note stating sampled resident #10's name and described her diet, her food dislikes/likes and what she should be served for breakfast and lunch. It also stated she does not have any chewing or swallowing problems but has some difficulty in fully chewing her food. Observation again on at approximately 3:50PM revealed the same.

Interview and observation of the notes with the unit's licensed practical nurse, sampled staff G, on at 3:59PM revealed her statement that she posted the sign concerning sampled resident #9, allergies to chocolate and pork. She stated the sign which states to make sure a bell was attached to sampled resident #9 and sampled resident #8 was to alert the staff of a possible and for resident safety awareness.

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Observation of the above and interview with the facility Interim Executive Director on at approximately 4:07PM revealed her stating "oh, no these should not be here" and she removed all of notes from the cabinet door and stated these are resident confidentially/ privacy concern and should not be here.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interviews and record reviews, the facility failed to ensure residents' medication observation records were accurate for 1 of 3 sampled residents (#11) who were observed during the medication pass.

The findings are:

Observation of the medication pass for residents on the memory care unit was started on at 9:19AM with the unit's licensed practical nurse, sampled staff C. Observation of the residents' medications in the medication cart revealed no stock bottles of medications and the medications are prepackaged from the pharmacy for each time the medication is due. All of the resident's 9AM medications are packaged in one packet ready for the nurse, the packet contains the resident's information and the name, dosage and amount of each of the 9AM medications. There are no packs or bottles of medications. The nurse removed sampled resident #11's medication packet from the medication cart. The nurse observed each of the medications in the medication packet and compared it with the physician's orders to ensure each ordered medication is present and correct. The nurse took the medications to the resident who took the medications.

Interview with this licensed practical nurse, sampled staff C was done on at 10:12AM. She revealed the facility only has nurses providing medications to the memory care unit residents all three shifts.

Record review of sampled resident #11's 2015 physician orders revealed an order for 100mg one capsule by mouth two times weekly. Review of the 2015 medication administration record revealed the nursing staff have been documenting that the resident was administered this medication on Friday April 3, everyday at 9AM thru Sunday, Interview with sampled staff C on at approximately 10:15AM stated that the resident is getting the medication every Tuesday and Friday morning only, so she did not administer the medication today, Wednesday, There are no physician orders changing this order. This staff reviewed the medication administration for and confirmed the nurses have documented administering the medication, daily at 9 AM from Friday, 3 thru Sunday and the physician order is for two times a week. She showed the surveyor that there are no stock bottles of the medication and the pharmacy prepackage medication packets are set up for the daily medications and there is no way the resident is getting the medication daily as it is not available for the nursing staff to administer. She stated the only way she could explain this was as documentation errors.

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Interview with the facility's registered nurse, sampled staff H on ... at approximately 10:15AM revealed that she is unaware as to why the nurses are documenting they are administering the ... daily when it is only ordered two times a week. She confirmed the way the medications are prepackaged for them from the pharmacy, they do not have the medication to give on the other days. She stated she would contact those involved and asked them. Interview on ... again at approximately 2:00PM revealed she was unable to explain why the nurses documented that the ... was being administered when they did not and that these were just documentation errors by the nurses.

Class III

0086 - Training - ADRD - 58A-5.0191(9) FAC

Based on review of staff records and interviews, the facility failed to ensure direct care staff were provided and maintained documentation of receiving the initial ... and Related ... training for 5 of 6 direct care staff reviewed (A, B, C, D and F). The facility failed to ensure direct care staff received and maintained documentation of receiving an additional 4 hours of training entitled ... and Related ... Level II Training," within 9 months of employment for 2 of 6 sampled direct care staff (A, B).

The findings are:

Interview with the facility's Interim Executive Director on ... beginning at approximately 10:30AM by the survey team leader revealed that the facility has a closed memory care unit with a current census of 20 residents. Further interview also revealed that the facility advertises as providing special care for persons with ... and Related ... (ADRD).

Review of the sampled personnel records revealed the following:
Sampled staff A is a resident aide who provides direct care, with a hire date of ...
Sampled staff B is a resident aide and a medication technician, provides direct care, with a hire date of ...
Sampled staff D is a resident aide who provides direct care, with a hire date of ...
Sampled staff F is a resident aide, who provides direct care, with a hire date of ...
Review of the records failed to reveal any documentation confirming the staff had received the initial ADRD within 3 months of hire.

Sampled staff C is a licensed practical nurse with a hire date of ... Review of this staff record revealed that she did not receive the required initial ADRD training until ... and should have received it by ...

Further review of the sampled personnel records revealed:
Sampled staff A and sampled staff B have also not received the required additional ADRD training within 9 months of employment.

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Interview and review of these staff records was done on [redacted] beginning at 10:36AM with the facility's Interim Executive Director and her administrative assistant. They both confirmed the above findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Broadview Assisted Living Facility
2310 Abbie Lane
Pensacola, FL 32514

Dear Administrator:

This letter reports the findings of a state licensure and Extended Congregate Care monitoring survey that was conducted on , 2015 and , 2015 by representatives 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 surveyors. Should you have any questions please call me at (850) 412-4540.

Sincerely,

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

DH/kb
Enclosure
XG90

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