STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910551	**03/15/2017**
NAME OF PROVIDER OR SUPPLIER **BROXTON'S ACLF**	STREET ADDRESS, CITY, STATE, ZIP CODE **2233 PATE POND ROAD** **CARYVILLE, FL 32427**	

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

0000 - Initial Comments

An unannounced biennial survey with specialty license Limited Mental Health in conjunction with a complaint survey (CCR#2017000976 and CCR#2017001389) was conducted at Broxton's Assisted Living Facility, license number 5856 the dates of - . At the time of survey there were deficiencies identified.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and staff interview, the facility failed to ensure that 1 of 2 sampled residents had a medical examination (1823 health assessment) within 30 days following admission. (resident #1)

The Findings:

On a record review was conducted of resident #1 medical chart to find no resident health assessment form, AHCA form 1823. Further review revealed resident #1 had been admitted on .

On at approximately 1:00pm, an interview was conducted with the Director concerning the health assessment. The Director brought resident #1 medical chart to the table, and stated "whatever is not in the file I do not have it". The Director confirmed that she did not have a health assessment for resident #1.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on staff interview and record review, the facility failed to implement in its residency agreement contract 45 days notice of relocation or termination from the facility for 2 of 2 sampled contracts (#1 and #8).

The Findings:

A record review was conducted of residency agreements/contracts for resident #1 and #8. Both agreements indicated a 30 day notice of discharge instead of the 45 day notice of discharge required by statute.

On at approximately 10:00 am, an interview was conducted with the Administrator who reported that she thought it was a 30 day notice of discharge.

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Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to follow the appropriate assistance with self- administration of medication procedures for 5 of 5 residents (Resident #1, 6, 7, 8, 9 & 10). Specifically, the ALF unlicensed staff failed to read the medication label in the presence of the resident as required in Florida Statute. 429.256. The facility also failed to notify the physician of repeated medication noncompliance for 1 of 1 resident (#1) who on .

Findings include:

During the medication pass observation on at 12:00 PM thru 12:10 PM, the Administrator was observed providing assistance with self-administration of medication to Resident #1, and Residents #6-10. Each resident was called to the kitchen window while the Administrator pushed a pill out of the packet of medication into each resident's hand and each resident drank water to take their pill. The Administrator did not read the medication label in the presence of the residents prior to giving them the packet of medication.

On at approximately 3:00pm, an interview was conducted with the Administrator and Director. The Director stated, "They did not know that an unlicensed staff had to read the medication label in the presence of the resident". The Administrator reported that she did not know the purpose of the medications or why the resident was taking the medication.

On resident #1 was observed walking around in the facility, interacting with other residents, eating his meal at lunch and medication observed with assistance with self-administration of medication, , , 500 mg 1 tab 3 x day at 12:00pm. On at approximately 8:30 am arrived at the facility to learn that resident #1 had the morning of .

A record review was conducted of resident #1 medication observation record which indicated that his medication, 0.4mg (helps with enlarge ,) 1 cap at bedtime at 8:30pm was refused 1-13. , (stomach medicine) 40 mg 1 cap daily was refused 1-13. (,) 50 mg 1 tab at bedtime refused on and , , (high ,) 500 mg, 1 tab 3 x a day refused on at bedtime.

On at approximately 9:15 am, via telephone an interview was conducted with the case manager who was not aware that resident had been refusing his medication. Stated that the ARNP works closely

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with the facility.

On at approximately 9:25 am, via telephone an interview was conducted with the physician who reported that last saw resident #1 on at another facility and that was the last and only time he saw resident. Stated that he did not know who was prescribing resident's medications.

On at approximately 10:49 am, an interview was conducted via telephone with the Advanced Registered Nurse Practitioner (ARNP) who reported that she only prescribed the medications for resident #1 and his primary physician prescribed other medications. The ARNP reported that she only saw resident #1 twice. The ARNP reported that she was not aware that resident #1 had refused his on .

On at approximately 11:43 am, an interview was conducted with the Administrator who reported that she gave resident #1 a note to give to the doctor that he was refusing his medication. Stated that resident stated that he gave the note to the doctor, but not sure if he gave the note to the doctor. The Administrator reported that she never talked with the doctor about resident refusing his medication. The Administrator reported that she did not know resident #1 primary physician. The Administrator confirmed that she did not have any documentation of resident physician's visit nor did she know anything concerning resident's medical history. The Administrator confirmed that the facility had not ensured that resident #1 had a health assessment done by a physician.

Class II

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and Administrator interview the facility failed to maintain medication prescriptions in the facility for 6 of 6 residents observed during assistance with self-administration of medications (residents #1, 6, 7, 8, 9 and 10).

The Findings:

On an observation was made of residents #1, 6, 7, 8, 9 and 10 receiving self-administration of medications from 12:00pm to 12:10pm. At approximately 12:25pm the Administrator was asked for the physician's orders for the medications, the Administrator reported that she did not have the resident's physician orders because she sent the original to the pharmacist and did not retain a copy for her files at the facility.

Class III

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0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, interview and record review, the the facility failed to ensure the administrator was providing oversight of resident care and living environment for 9 of 12 sampled residents (Resident #1, 5, 6, 7, 8, 9, 10, 11, & 12). The Administrator failed to ensure each resident had a comfortable mattress for 3 of 12 sampled residents (#5, 11 and 12). The Administrator failed to ensure medication prescriptions were maintained in the facility for 6 of 6 residents observed during assistance with self-administration of medications (residents #1, 6, 7, 8, 9 and 10). The Administrator failed to ensure the physician was notified of repeated medication noncompliance for 1 of 1 resident (#1) who on .

The findings:

Mattress:

On at approximately 3:00pm a tour was conducted of the facility. During the tour the following area of concerns were identified:

1. was observed to find one of the beds that was located near the window was lopsided

2. was a single resident #5 resided. Resident # 5 reported that her mattress springs were poking out of the mattress. She also reported that she was having minor back pains from sleeping on the mattress. At this point she pulled the bed sheets coverings off the mattress which revealed a large hole with visible spring poking from the mattress with several plastic bags stuffed in the hole and blue tape crossing the plastic bags. (See photographic documentation)

3. was a double . An observation was made of the bed near the wall entering the . The bed was observed to have a large cavity in the middle of the mattress. Resident # 11 entered the stated that she was not sleeping well at night because the mattress was hurting her back. At this point the Administrator quickly interjected and stated, resident #11 is always complaining, stating that she has never informed her of the condition of the mattress and that she can't sleep because she needed medication to help her sleep. Resident #11 stated again that it was the mattress causing her back to hurt and the reason she does not sleep well at night. The Administrator was asked what was her plan for identifying problems with the physical living environment free of hazard, she could not identify a plan. (photographic evidence obtained)

Medications:

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On an observation was made of residents #1, 6, 7, 8, 9 and 10 receiving self-administration of medications from 12:00pm to 12:10pm. At approximately 12:25pm the Administrator was asked for the physician's orders for the medications, the Administrator reported that she did not have the resident's physician orders because she sent the original to the pharmacist and did not retain a copy for her files at the facility.

On resident #1 was observed walking around in the facility, interacting with other residents, eating his meal at lunch and medication observed with assistance with self-administration of medication, , , 500 mg 1 tab 3 x day at 12:00pm. On at approximately 8:30 am arrived at the facility to learn that resident #1 had the morning of .

A record review was conducted of resident #1 medication observation record which indicated that his medication, 0.4mg (helps with enlarge ,) 1 cap at bedtime at 8:30pm was refused 1-13. , (stomach medicine) 40 mg 1 cap daily was refused 1-13. (,) 50 mg 1 tab at bedtime refused on and , , (high ,) 500 mg, l tab 3 x a day refused on at bedtime.

On at approximately 9:15 am, via telephone an interview was conducted with the case manager who was not aware that resident had been refusing his medication. Stated that the ARNP works closely with the facility.

On at approximately 9:25 am, via telephone an interview was conducted with the physician who reported that last saw resident #1 on at another facility and that was the last and only time he saw resident. Stated that he did not know who was prescribing resident's medications.

On at approximately 10:49 am, an interview was conducted via telephone with the Advanced Registered Nurse Practitioner (ARNP) who reported that she only prescribed the , , , medications for resident #1 and his primary physician prescribed other medications. The ARNP reported that she only saw resident #1 twice. The ARNP reported that she was not aware that resident #1 had refused his on .

On at approximately 11:43 am, an interview was conducted with the Administrator who reported that she gave resident #1 a note to give to the doctor that he was refusing his medication. Stated that resident stated that he gave the note to the doctor, but not sure if he gave the note to the doctor. The Administrator reported that she never talked with the doctor about resident refusing his medication. The Administrator reported that she did not know resident #1 primary physician. The Administrator confirmed that she did not have any documentation of resident physician's visit nor did she know anything

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concerning resident's medical history. The Administrator confirmed that the facility had not ensured that resident #1 had a health assessment done by a physician.

Class II

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and staff interview the facility failed to have water sufficient for drinking and food preparation stored in the 3-day emergency supply.

The Findings:

On an observation was made of the facility's 3-day emergency water supply. Upon observation along with the Administrator the facility did not have any water in the 3-day emergency supply. The Administrator reported that she had just removed all of the water out of the 3-day supply because it had expired and had not replaced it. She again confirmed that she had no water in the 3-day supply.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and staff interview the facility failed to provide a safe living environment free of hazard and a comfortable mattress for 1 of 10 sampled residents (#5) and 2 of 2 supplemented residents (#11 and 12) living in (1, 2, and 10).

The findings:

On at approximately 3:00pm a tour was conducted of the facility. During the tour the following area of concerns were identified:
1. was observed to find one of the beds that was located near the window was lopsided

2. was a single resident #5 resided. Resident # 5 reported that her mattress springs were poking out of the mattress. She also reported that she was having minor back pains from sleeping on the mattress. At this point she pulled the bed sheets coverings off the mattress which revealed a large hole with visible spring poking from the mattress with several plastic bags stuffed in the hole and blue tape crossing the plastic bags. (See photographic documentation)

3. was a double . An observation was made of the bed near the wall entering the . The bed was observed to have a large cavity in the middle of the mattress. Resident # 11 entered

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the stated that she was not sleeping well at night because the mattress was hurting her back. At this point the Administrator quickly interjected and stated, resident #11 is always complaining, stating that she has never informed her of the condition of the mattress and that she can't sleep because she needed medication to help her sleep. Resident #11 stated again that it was the mattress causing her back to hurt and the reason she does not sleep well at night. (photographic evidence obtained)

Also observed in was two electrical wall plugs which had no face plates covering the outside. The Administrator quickly stated that the residents are always taking the face plates off of the electrical plugs. The Administrator was asked what was her plan for identifying problems with the physical living environment free of hazard, she could not identify a plan.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and the staff interview the facility failed to initiate a weight record on admission and Resident Health Assessment form, AHCA Form 1823 for 1 of 2 resident's records reviewed (#1).

The Findings:

On a record review was conducted of resident #1 medical chart to find no resident health assessment form, AHCA form 1823 and further review the facility had not initiated a weight record on his admission .

On at approximately 1:00pm, an interview was conducted with the Director concerning the health assessment. The Director brought resident #1 medical chart to the table and stated, "whatever is not in the file I do not have it". The Director confirmed that she did not have a health assessment for resident #1 nor had the facility initiated a weight record on admission.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on record review and staff interview the facility failed to ensure that 4 of 4 employee's record (A, B, C and D) contained a signed and dated Affidavit of Compliance with Background Screening Requirements (AHCA form 3100-0008) or a similar document attesting under penalty of perjury that they are in compliance with Chapter 435, F. S.

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The Findings:

A record review was conducted of employee A, B, C and D's personnel files. None of the four employee's files contained a signed Affidavit of Compliance with background screening requirements.

On at approximately 10:00 AM, an interview was conducted with the Administrator who confirmed that the employee's files did not have a signed Affidavit of Compliance with background screening requirements.

Unclassified