STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965291	**07/12/2018**
NAME OF PROVIDER OR SUPPLIER **BROADVIEW ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2110 Fleischmann Road** **TALLAHASSEE, FL 32308**	

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

0000 - Initial Comments

On , 11-12, 2018, an unannounced complaint survey for allegations contained within CCR #'s 2018007686, 2018007413, and 2018008583 was conducted at Broadview Assisted Living (license #9700). An Extended Congregate Care monitoring visit was conducted in conjunction. Deficient practice was identified at the time of the survey.

0027 - Resident Care - Arrangement for Health Care - 58A-5.0182(3) FAC

Based on interview and record review, the facility failed to ensure assistance in arranging transportation when the facility transportation vehicle was unavailable for use, for 1 of 5 residents reviewed, resident #4.

Findings include:

During the initial tour of the facility on at 9 AM, a flyer was observed in the elevator titled "Transportation Schedule." It stated, "Any doctor appointment scheduled on Mondays, Wednesdays, or Fridays from 9:30 AM to 3:00 PM will result in a $35.00 charge for each round trip and will be added to your monthly statement. Any appointment before 9:30 AM or after 3:00 PM will have to use alternative transportation."

An interview was conducted with the family for resident #4 on at 11:18 PM. The family member revealed in his mother had an afternoon appointment that ran long. He stated when the appointment was complete, he called the facility to request his mother be picked up. He stated he was told by facility staff transportation stopped at 3 PM. When asked how he was supposed to get his mother back to the facility, staff replied he could get a taxi for his mother or bring her back to the facility in his personal vehicle. He stated at no point did the facility offer to arrange a taxi for the resident. A review of the transportation log kept by the facility revealed resident #4 had an appointment at 1 PM. The physician office was approximately 1 mile from the facility.

The facility's admission contract was reviewed. On page 2, "Basic Services" stated the community agrees to provide to the resident the following basic services: scheduling of transportation and appointments. Additionally, on page 21, "Supplemental Services and Charges" were listed. Transportation information included no charge for scheduled group activities and outings and for scheduled doctor transportation days, listed as Tuesdays and Thursdays. Further, a $35.00 per round trip fee would be charged on non-scheduled days, listed as Mondays, Wednesdays, and Fridays.

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No admission paperwork described how the facility would arrange for transportation to be provided outside of the scheduled 9:30 AM to 3 PM schedule on Tuesdays and Thursdays.

The Director of Wellness was interviewed at 12:27 PM. She stated transportation was set up on Tuesdays and Thursdays from 10 AM to 2 PM. She stated she was unsure how residents get to their appointments any other time. Additionally, she revealed some residents used a taxi service instead of the facility's transport vehicle.

An interview was conducted with the Executive Director on at 2:30 PM. He stated that only he and the activities director were licensed to drive the van. He stated after 3 PM taxi services would be offered to residents needing to return from their appointments. He revealed resident #4's family had called the facility after her appointment at which time he was informed transportation had ended for the day. He stated the son was offered to bring his mother back by taxi.

No facility information, including the transportation policy (policy 20.606) explained a taxi would be offered when the facility's transportation vehicle was unavailable.

Class III

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

Based on observation, interviews, and record reviews, the facility failed to honor resident rights regarding grievances for 2 of 6 residents reviewed (#3 and #4), and failed to honor resident rights regarding a decent living environment for 1 of 6 residents reviewed (#4).

The findings included:

Resident #4's observed on at 11 AM. Upon entering the , a very strong , and feces odor was present. Additionally, several dark stains were noticed on the carpeting. Two upholstered chairs were noted along the back wall of the were covered with pillows and folded clothing. A cat litter box was noted in the have copious amounts of animal feces. (photographic evidence obtained)

An interview was immediately conducted with resident #4. She confirmed she had a cat that lived in her . She revealed a housekeeper did clean her was unable to state how often the housekeeper cleaned her . A telephone interview was conducted with a family member for resident #4 on at 11:18 AM. He stated staff never cleaned the . He reported he had complained

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multiple times to the facility, including administration and the corporate office. Further, he stated staff were to be cleaning the cat litter box in the times per week, but did not feel they were. He further stated the odor in the very strong and both embarrassed and made him uncomfortable when visiting. He further revealed he sent a letter to the corporate office on but had not heard back regarding his grievances.

An interview was conducted with resident #3 on at 12 PM. The resident revealed on several occasions he filed grievances with the facility, including one in which he had to report a staff for her behavior towards him. He stated all grievances were discussed with the facility executive director.

An interview was conducted with the Director of Wellness (DOW) on at 12:27 PM. She revealed resident #4 was incapable of cleaning up after her . She stated cat litter box cleaning was required to be performed by housekeeping, but was unsure how often it was being done. Additionally, the DOW was questioned about the facility grievance process and she stated she was not sure what the process was, including who was responsible for receiving, reviewing, and following up on them.

Interviews with caregivers B and C were conducted on at 1:45 PM. Both staff confirmed residents do periodically complain to them. Both revealed when a resident complains about something they report it to their supervisor on shift.

An interview with the Executive Director (ED) was conducted on at 2:41 PM. He stated the facility does not keep a record of grievances, there was no log, and that he does not record any of them. He stated the only person who has had grievances was resident #3. He indicated the resident "complains all the time" but denies ever writing any of the concerns down. He further revealed there was no facility policy related to grievances, and the residents "should just contact the Ombudsman and let them know their complaints." He denied being aware of any grievances from resident #4 or her family.

An additional tour of resident #4's conducted with the DOW on at 9:12 AM. She confirmed the odor in the overwhelming and the cat litter box needing cleaning. Further she revealed housekeeping was responsible for emptying the cat litter box but again was unaware of how often it should be cleaned. She confirmed resident #4's family had previously complained about the cat litter box not being cleaned regularly.

An interview was conducted with staff A, a housekeeper, on at 9:47 AM. She revealed resident #4's constant cleaning and she was supposed to clean the cat litter box 2-3 times per week, as it gets "quite stinky". She further revealed night shift piles clothing on the resident's chairs in the than putting it away leading to clutter in the .

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The facility contract was reviewed and contained the "Resident Rights" form. It outlined the resident should present grievances to any person. Additionally, the facility would establish a grievance procedure. A resident handbook was also provided upon admission. Under the section titled "Administrative Issues" was a heading, "Grievances." It stated, "Please discuss all concerns with a Department Head or the Executive Director. This will enable us to properly respond and/or assist you. If you feel your concerns are not being resolved to your satisfaction, you may contact the Division on Aging's Ombudsman's Office or the Agency for Healthcare Administration."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on staff interview and record review, the facility failed to ensure residents requiring "medication administration" based on their health assessments were provided medications by licensed staff, for 1 of 4 records reviewed, resident #4.

The findings included:

The form 1823, Health Assessment, was reviewed for resident #4. The form was completed by the resident's physician on [redacted] and indicated the resident "needs medication administration." The [redacted], and [redacted] Medication Observation Records revealed daily initialing of medications, indicating medication technicians (med techs) were providing the resident's medications.

An interview was conducted with the Director of Wellness on [redacted] at approximately 9:30 AM. She stated she was not aware resident #4's health assessment indicated only licensed staff could provide medications to the resident. Further, she confirmed unlicensed staff routinely provided the resident her medication.

Class III

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

Based on observation, interviews, and record review, the facility failed to ensure a safe living environment, free of hazards, by allowing broken stairwell doors to remain unfixed for a period of greater than 3 months, for 2 of 4 stairwell doors observed.

The findings included:

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During the initial facility tour on beginning at 9 AM, the surveyor traveled the stairwell nearest the ground floor elevator leading to the 2nd floor. Upon opening and walking through the door, the door slammed shut quite forcefully and quickly. The door was tested by opening the door, and again, it slammed shut. (video evidence obtained). Continuing the tour, a second stairwell door nearest was observed to be warped. The door was tested for opening but would not move.

An interview was conducted with the area Ombudsman on at 10 AM. She stated she had concerns regarding the 2 stairwell doors and had previously reported them to the Executive Director and to the Fire Marshall because they had left them un-repaired for a long time.

A family interview was conducted for resident #4 on at 11:18 AM. He stated the stairwell door near his mother's shut and he was concerned about using it. He stated, "It is a safety hazard for visitors and other residents."

An interview with staff D was conducted on at 2:03 PM. The stairwell door nearest the elevator was tested but did not slam shut. Staff D confirmed the door had been broken and revealed maintenance worked on the door that day.

An interview with the Executive Director was conducted on at 2:30 PM. He confirmed both stairwell doors were broken but stated "maintenance repaired the one nearest the elevator today." He stated the door has only been broken for approximately 3 weeks. He stated a replacement door had been ordered for the stairwell nearest . He provided an invoice dated indicating approximate delivery time was 4-6 weeks.

The resident townhall meeting minutes from were reviewed. Under the "Maintenance" section of the minutes, it stated, "Zone 4 fire/stairs door to the right of apartment 217 will not close properly. Zone 4 right by elevator stairwell door needs to be fixed because it slams shut and someone's hand could get hung in it."

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on interview and record review, the facility failed to maintain a grievance procedure for both receiving and responding to resident grievances. The facility also failed to respond timely to reported grievances from 2 of 6 residents reviewed (#3 and #4).

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The findings included:

A family interview was conducted for resident #4 on at 11:18 PM. He revealed he had complained multiple times to the facility, both to administration and to the corporate office, but nothing was ever corrected or followed up on. An interview conducted with resident #3 on at 12 PM revealed he also had filed grievances on several occasions. He stated all grievances were discussed with the facility Executive Director.

An interview was conducted with the Director of Wellness (DOW) at 12:27 PM. She was questioned about the facility grievance process but stated she was not sure what the process was, including who was responsible for receiving, reviewing, and following up on them.

An interview with the ED was conducted at 2:41 PM. He stated the facility does not keep a record of grievances, there was no log, and that he does not record any of them. He stated the only person who has had grievances was resident #3. He indicated the resident "complains all the time" but denies ever writing any of the concerns down. He further revealed there was no facility policy related to grievances, and the residents "should just contact the Ombudsman and let them know their complaints." He denied being aware of any grievances from resident #4 or her family.

The facility contract was reviewed and contained the "Resident Rights" form. It outlined the resident should present grievances to any person. Additionally, the facility would establish a grievance procedure. A resident handbook was also provided upon admission. Under the section titled "Administrative Issues" was a heading, "Grievances." It stated, "Please discuss all concerns with a Department Head or the Executive Director. This will enable us to properly respond and/or assist you. If you feel your concerns are not being resolved to your satisfaction, you may contact the Division on Aging's Ombudsman's Office or the Agency for Healthcare Administration."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to ensure a quality assurance program which incorporated the assessment of grievances, as the facility had no established procedure for both receiving and responding to resident grievances.

The findings included:

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A family interview was conducted for resident #4 on at 11:18 PM. He revealed he had complained multiple times to the facility, both to administration and to the corporate office, but nothing was ever corrected or followed up on. An interview conducted with resident #3 on at 12 PM revealed he also had filed grievances on several occasions. He stated all grievances were discussed with the facility Executive Director.

An interview was conducted with the Director of Wellness (DOW) on at 12:27 PM. She was questioned about the facility grievance process but stated she was not sure what the process was, including who was responsible for receiving, reviewing, and following up on them.

An interview with the ED was conducted on at 2:41 PM. He stated the facility does not keep a record of grievances, there was no log, and that he does not record any of them. He stated the only person who has had grievances was resident #3. He indicated the resident "complains all the time" but denies ever writing any of the concerns down. He further revealed there was no facility policy related to grievances, and the residents "should just contact the Ombudsman and let them know their complaints." He denied being aware of any grievances from resident #4 or her family.

The facility contract was reviewed and contained the "Resident Rights" form. It outlined the resident should present grievances to any person. Additionally, the facility would establish a grievance procedure. A resident handbook was also provided upon admission. Under the section titled "Administrative Issues" was a heading, "Grievances." It stated, "Please discuss all concerns with a Department Head or the Executive Director. This will enable us to properly respond and/or assist you. If you feel your concerns are not being resolved to your satisfaction, you may contact the Division on Aging's Ombudsman's Office or the Agency for Healthcare Administration."

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on observation, interviews, and record review, the facility failed to honor resident contracts in regards to providing housekeeping services, for 1 of 6 residents reviewed, #4.

The findings included:

Resident #4's observed on at 11 AM. Upon entering the , a very strong , and feces odor was present. Additionally, several dark stains were noticed on the carpeting. Two

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upholstered chairs were noted along the back wall of the were covered with pillows and folded clothing. A cat litter box was noted in the have copious amounts of animal feces. (photographic evidence obtained)

An interview was immediately conducted with resident #4. She confirmed she had a cat that lived in her . She revealed a housekeeper does clean her was unable to state how often the housekeeper cleaned her . A telephone interview was conducted with a family member for resident #4 on at 11:18 AM. He stated staff never cleaned the . He reported he had complained multiple times to the facility, including administration and the corporate office. Further, he stated staff were to be cleaning the cat litter box in the times per week but did not feel they were. He further stated the odor in the very strong and both embarrassed and made him uncomfortable when visiting.

An interview was conducted with the Director of Wellness (DOW) on at 12:27 PM. She revealed resident #4 was incapable of cleaning up after her , . She stated cat litter box cleaning was required to be performed by housekeeping but was unsure how often it was being done.

An additional tour of resident #4's conducted with the DOW on at 9:12 AM. She confirmed the , odor in the overwhelming and the cat litter box needing cleaning. Again, copious amounts of cat feces was observed. Further she revealed housekeeping was responsible for emptying the cat litter box but again was unaware of how often it should be cleaned. She confirmed resident #4's family had previously complained about the cat litter box not being cleaned regularly.

An interview was conducted with staff A, a housekeeper, on at 9:47 AM. She revealed resident #4's , constant cleaning and she was supposed to clean the cat litter box 2-3 times per week, as it gets "quite stinky". She further revealed night shift piles clothing on the resident's chairs in the than putting it away leading to clutter in the .

Resident #4's contract was signed and indicated basic services including weekly housekeeping services. On , a " Care Agreement" was added in response to a cat living with the resident. For a fee of $150 per month, the facility would change the cat litter box 3 times per week.

Class III