STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965291	R 08/29/2018
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

An unannounced revisit survey was conducted on [redacted] and [redacted] at Broadview Assisted Living (license #9700). This was a follow-up to a complaint survey (CCR#2018007686, CCR#2018007413, and CCR#2018008583) originally conducted on [redacted]. A revisit to an Extended Congregate Care monitoring revisit was conducted in conjunction. At the time of the revisit, deficient practice was identified.

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

Based on observation, staff interview and record review, the facility failed to ensure medication administration was conducted by a staff member licensed to provide that service for 4 of 7 residents (#4, #15, #16 and #17) requiring medication administration as identified on their resident health assessments (AHCA Form1823).

The findings included:

On [redacted] at approximately 12:30pm, a list of residents requiring medication administration and a list of residents requiring assistance with self-administration of medication were requested from the Director of Wellness. The director stated it would take her a while to get that list together, as there was no way to identify which residents required medication administration versus assistance with self-administration of medication without pulling each of the resident's 1823s.

On [redacted] at approximately 2:15pm, an interview was conducted with Staff Member B, a Medication Technician. Staff Member B stated that residents who were spoon fed or had feeding tubes would require their medication to be administered by a nurse. She confirmed there was nothing on the medication administration record to indicate whether a nurse or medication technician could administer or assist with medications.

On [redacted] at approximately 2:50pm, an interview was conducted with Staff Member C, a Medication Technician. She stated that because she had been working at the facility so long, she knew the residents and knew which ones required assistance with self-administration of medication versus medication administration by a nurse.

On [redacted] beginning at 7:50am, Staff Member D was observed as she assisted residents with self-administration of medication. A total of seven residents were observed. Staff Member D stated that she had worked at the facility for a long time and she knew the residents. She stated any resident

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that had a feeding tube would need to have their medications administered by a nurse, but she didn't know where it was documented whether the resident needed assistance with self- administration of medication or medication administration. A copy of each resident's AHCA Form 1823, who was assisted by Staff Member D during this observation, was requested for review.

Review of the AHCA Form 1823 for each resident revealed the following:
Resident #4: Form indicated the resident needed medication administration and was signed and dated by the physician on
Resident #15: Form indicated the resident needed medication administration and was signed and dated by the physician on
Resident #16: Form indicated the resident needed medication administration and was signed and dated by the physician on
Resident #17: Form indicated the resident needed medication administration and was signed and dated by the physician on

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on observation, staff interview and record review, the facility failed to correct a class III deficiency regarding having staff licensed to provide medication administration available for residents requiring those services based on the physician instructions on each resident's AHCA Form 1823. The facility is required to obtain a consultant who is a licensed pharmacist or a licensed registered nurse to develop a system that identifies the level of medication assistance needed by each resident based on their 1823, and provide quarterly consultation regarding medication administration practices observed during each consultation visit until the inspection team from the agency determines that such consultation is no longer required. The facility is required to develop and implement a corrective action plan regarding residents requiring medication administration services within 48 hours after notification of this deficiency. The consultant must visit the facility within 7 working days.

The Finding Include:
During survey on , the Health Assessment AHCA Form 1823, was reviewed for resident #4. The form was completed by the resident's physician on and indicated the resident "needs medication administration." The , and 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 at approximately 9:30 AM. She

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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.

During the revisit survey conducted on . . . . . and . . . . . , a list of residents requiring medication administration and a list of residents requiring assistance with self-administration of medication were requested from the Director of Wellness. The director stated it would take her a while to get that list together, as there was no way to identify which residents required medication administration versus assistance with self-administration of medication without pulling each of the resident's 1823s.

On . . . . . at approximately 2:15pm, an interview was conducted with Staff Member B, a Medication Technician. Staff Member B stated that residents who were spoon fed or had feeding tubes would require their medication to be administered by a nurse. She confirmed there was nothing on the medication administration record to indicate whether a nurse or medication technician could administer or assist with medications.

On at approximately 2:50pm, an interview was conducted with Staff Member C, a Medication Technician. She stated that because she had been working at the facility so long, she knew the residents and knew which ones required assistance with self-administration of medication versus medication administration by a nurse.

On beginning at 7:50am, Staff Member D was observed as she assisted residents with self-administration of medication. A total of seven residents were observed. Staff Member D stated that she had worked at the facility for a long time and she knew the residents. She stated any resident that had a feeding tube would need to have their medications administered by a nurse, but she didn't know where it was documented whether the resident needed assistance with self- administration of medication or medication administration. A copy of each resident's AHCA Form 1823, who was assisted by Staff Member D during this observation, was requested for review.

Review of the AHCA Form 1823 for each resident revealed the following:
Resident #4: Form indicated the resident needed medication administration and was signed and dated by the physician on
Resident #15: Form indicated the resident needed medication administration and was signed and dated by the physician on
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Resident #17: Form indicated the resident needed medication administration and was signed and dated by the physician on .

Class III

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

Based on observations, interviews and record review, the facility failed to provide a safe living environment for residents by failing to ensure doors were functioning properly, failing to ensure the air conditioning unit was in good working order and sufficiently cooling the facility for resident comfort and safety, and by failing to ensure 2 of 2 residents (#21 & #22) with special needs (/) were adequately prepared in the event of an emergency.

The Findings Include:

Doors
Observation of the facility stairwells during facility tour on revealed the facility had a total of four stairwells.
1. Northeast Stairwell (stairwell between 231 and 257): Stairwell was located on the second floor. Stairwell door was observed with no strike plate, which meant the door would not latch when shut and would open freely when slightly pushed. This door was a fire rated door.
2. Northwest Stairwell (between and 244): Stairwell was located on the second floor. Stairwell door was observed with no strike plate, which meant the door would not latch when shut and would open freely when slightly pushed. This door was a fire rated door.
3. Southeast Stairwell: Stairwell was located on the first floor. Stairwell door was observed with no strike plate, which meant the door would not latch when shut and would open freely when slightly pushed. This door was a fire rated door.
4. Southwest Stairwell: Stairwell was located on the first floor. The automatic closure on the stairwell door was not functioning and was causing the door to slam. The door was heavy and closed quickly. This was also a fire rated door. (Photographic evidence obtained)

An interview was conducted with the Facility Administrator on at approximately 9:30am. He indicated the doors should have latches for safety and admitted the door that was slamming was dangerous.

Temperatures

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Observation of common areas in the facility revealed elevated temperatures in the common areas of the facility.
On at 1:00pm temperatures were checked in the main entry area and showed a temperature of 78 degrees though the thermostat was set at 70 degrees. The same was observed in this area at 3:00pm on .
On at 1:00pm the activity was read to be 76 degrees with the thermostat set at 70 degrees. At 3:00pm on the temperature was meausred at 78 degrees with the thermostat set at 70 degrees.

An interview was conducted with the Maintenance Director at approximately 9:30 am on in which he stated that temperatures had been high in both areas, and that both air conditioner units had been serviced but were still not cooling as they should be. he stated approval has been given for replacement of the units, but no start date for replacement had been set from their corporate office.

An interview was conducted on at approximately 2:00pm with the Facility Administrator. He stated that the elevated temperatures in the lobby and activity areas was brought to his attention during an Ombudsman visit, but stated he was unsure of the exact temperatures as the facility had not been checking temperatures on a regular basis.
Resident Safety
On at approximately 11:00am, Resident #21 was interviewed regarding evacuation of the facility during an emergency. She stated that she was , but could hear the fire alarm when it sounded. She stated she was not aware of evacuation procedures, but she always exited her the same direction and would just go in the direction she knew if she needed to evacuate in the event of a fire or other emergency. She stated that her , Resident #22, was and could not hear the alarm and was concerned there was no visual alarm system in place.

Review of the residents' no visual alarm system to indicate when an emergency situation was occurring. The surrounding area also failed to have a floorplan diagram to identify evacuation routes.

On at approximately 11:10am an interview with the Maintenance Director was conducted. He stated there used to be more floor plan diagrams with evacuation routes posted in the facility, but stated residents had pulled them off the walls.

On at approximately 11:40am an interview was conducted with the Director of Wellness. She stated they had no special emergency plan for their residents that were /.

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Class III

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

Based on observation, interview and record review, the facility failed to develop and implement plans of action through their Quality Assurance program to correct deficienct practice identified by the State Agency related to medication administration practices, and maintaining a safe and comfortable environment for residents.

The finding include:

Medication Administration
During a survey conducted at the facility on , the facility was cited for allowing unlicensed staff to provide assistance with medications to residents whose AHCA Form 1823 indicated they needed their medications administered to them, which requires the facility to have a qualified staff member available to provide this service.
During a revisit survey on & , the facility was recited for continuing to allow unlicensed staff to provide assistance with medications to residents whose AHCA Form 1823 indicated they needed their medications administered to them (See A0053).

Resident Safety
During a survey conducted at the facility on , the facility was cited for having doors that did not function properly to ensure resident safety.
During a revisit survey on & , the facility was recited for continuing to have doors that were not functioning properly (See A0165)

Class III