STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965185	**04/30/2019**
NAME OF PROVIDER OR SUPPLIER **BROADVIEW ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **2310 ABBIE LANE** **PENSACOLA, FL 32514**	

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

0000 - Initial Comments

An unannounced standard biennial licensure survey with extended congregate care (ECC) services was conducted at Broadview Assisted Living Facility on & . Deficient practice was found at the time of the survey.

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation of medications and staff interview, the facility failed to dispose of medications within 30 days for 2 of 2 residents (#14 and #15) who had , .

The findings include:

Two medication carts were observed for expired medications on at 11:07 AM with Employee C, licensed practical nurse (LPN). The second cart was observed to have medications for resident #14 in the drawer. Employee C stated they counted these medications daily even though the resident had , . (Photographic evidence obtained). Resident #14 was observed to have 6 medication cards of medication. (50 mg: #1 card containing 29 pills, #2 card with 43 remaining pills, #3 card with 45 remaining pills and 3 additional cards with 30 pills. She also had medication , 1 mg with 82 remaining)

Employee C (LPN) was asked if any other medications were being maintained for residents who had , . She said the Director of Wellness (DOW) would know about that. The DOW was interviewed at 11:15 AM on . She was asked when #14 had , . She talked with business office and said the resident , on . The DOW was asked if she had any other medications waiting to be destroyed and said she had some medications locked in a drawer in her office for another resident (#15) who had passed. She said Resident #15 , on . The medications were observed for Resident #15. They were medications 50 mg with 14 remaining, and , 1 mg 26 remaining. The DOW was asked about destruction of medications and stated, "Yes, I know they should be destroyed within 30 days. "

Class III

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

Based on observation of elopement drills, staff and family interview and policy review, the facility failed to report a resident elopement for 1 of 1 resident (#13) to the Agency for Health Care Administration

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(AHCA).

The findings include:

On at 11:10 AM, Resident #13 was observed sitting in his room, which was not on the secured unit, in an arm chair wearing only a shirt and an adult brief on. Staff were observed going into the room to put a blanket over him. At 11:20 AM, the resident was observed again and it was noted that the previously supplied blanket was on the floor beside him.

Review of the medical record for Resident #13 revealed a Resident Health Assessment for Assisted Living Facilities (Form 1823), dated for , which indicated the resident had a diagnosis of and had disorientation at times.

Review of the facility elopement drill book revealed Resident # 13 had eloped from the facility on Friday . The facility searched for the resident from 9 PM to 11PM, when he was found at a Dollar General, which is on the side of the facility on a busy 4 lane highway. Under miscellaneous notes, it indicated the resident was sent to the hospital for evaluation and treatment; however there was no evidence this elopement or transfer to a higher level of care due to the elopement was reported to AHCA.

An interview was conducted with the Executive Director (ED) on at 9:15 AM. When asked about Resident #13, she initially said the resident resided on the memory care unit and was put there last week, then she said he was in the process of being moved to the unit. She said he does spend the day in memory care and his family stays with him at night because he has been into other resident rooms. She was then asked if the resident's elopement had been reported as an adverse incident to AHCA. She said she was not the ED at the time, but if she had been she would have reported it. The ED checked to see if the elopement was reported and returned at 9:34 AM to say she could not find a report. She was asked about the risk of another elopement, and stated she did not believe he was a risk at that time because he just around the building and had been found in other residents' rooms.

The son of Resident #13 was interviewed on at 10:00 AM. He said he was called last week because his father had gone into an empty room and was found sitting on the mattress. He was asked if his father had ever left the building and he said that had happened about a year ago. He left the building behind someone and was later found at Dollar General around midnight. He said his father was at the time. He was then asked if the family stayed with him at night and he said no. He then said he comes in the mornings and his sister come in the evening several times a week but we do not

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spend the night. Resident #13 said his father has declined and that he was put under hospice care in .

Review of the facility policy titled "Missing Resident Code Silver, Policy number: 60614," revealed a plan of action would be implemented when a resident was suspected to be missing from the community, including a thorough search of the community. It indicated at the time the resident was located, the following steps would be taken: Report to manager on duty or executive director, debrief with all staff to assess response and prevention, and notify regional supervisor and follow state reporting guidelines.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review and interview, the facility failed to maintain enough fuel onsite to operate their fixed generator for a minimum of 72 hours, failed to provide evidence that the facility provided the residents/resident representative with a notification of implementation of their emergency plan, and failed to readily provide a policy and procedure fuel procurement and storage, mitigation of heat injuries, refrigeration needs, wellness checks, and a provision for obtaining medical intervention from emergency services in the event of an emergency that required the use of an alternate power supply, which has the potential to affect 37 of 37 current residents in the event of an emergency.

The findings include:

On at approximately 2:00 PM, observation of the facility's generator, with the facility's Maintenance Director, showed a fixed diesel-powered generator. The Maintenance Director stated he kept 125 gallons of fuel in the tank, and that he was unsure of the capacity of the tank because he had not filled it up. Observation of the fuel tank showed no identification of fuel capacity, which the Maintenance Director confirmed.

On at approximately 2:30 PM, review of the facility's generator service binder showed no indication of the fuel capacity for the tank either. Subsequent review of the facility's "Emergency Environment Control Plan", dated and county approved , showed the facility was required to keep 450 gallons of fuel on to ensure air temperature at or below 81 degrees Fahrenheit for a minimum of 72 hours in the event of an emergency. The Maintenance Director confirmed they did not have 450 gallons onsite and stated there was no ordinance nor restriction he is aware of that would limit the amount of onsite fuel storage.

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On at approximately 3:00 PM, review of resident records, resident contracts, medical records, and the facility's emergency management plan failed to show indication of any notification in writing to the residents or their representatives regarding the facility's emergency management plan. The Business Office Manager confirmed the facility could not provide evidence of a notification in writing of the plan to the residents or their representatives.

On at approximately 8:30 AM, an interview with the Maintenance Director revealed he did not know if the facility had any monoxide detectors. The Executive Director expressed that she was also unaware if the facility had any monoxide detectors.

On at 9:56 AM, the Maintenance Director presented a white square device that he stated had been sitting in his office. He was not sure what the box was and expressed he was unsure of its function or what the test tone indicated when batteries were inserted into the device.

On at approximately 11:30 AM, review of facility policies with the Executive Director revealed there was no policy and procedure regarding mitigation of heat injuries, the use of refrigeration, wellness checks, or the provision for obtaining medical intervention in the event of an emergency.

Class II

E206 - ECC - Service Plans - 58A-5.030(6) FAC

Based on record review and interviews, the facility failed to perform quarterly review and update of the service plan for 1 of 1 residents (#4) receiving Extended Congregate Care (ECC) services.

The findings include:

On a review of the ECC record for Resident #4 was conducted and revealed a service plan dated ; however, there was no documentation of reviews or updates to the service plan.

Review of the facility's ECC policy, titled "ECC Care Policies and Procedures" showed ECC service plans were to be reviewed and updated at a minimum of every three months.

On at approximately 2:25 PM, an interview with the Executive Director of Operations was conducted. When asked to verify the date of the service plan, she stated, "yes, this is an old one and I do not know why there was not a new one in the record."

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Class III

E208 - ECC - Records - 58A-5.030(8) FAC 429.07 (3)(b)3, FS

Based on a record reviews and interviews, the facility failed to conduct monthly nursing assessments for 1 of 1 resident (#4) receiving extended congregate care (ECC) services.

The findings include:

On , review of the medical record for Resident #4 revealed the resident was receiving ECC services while on hospice care. The record contained monthly nursing assessments conducted by a licensed practical nurse (LPN) and co-signed by a Registered Nurse (RN); however, review of the Nurse Quick Confirm, multi-licensure website, was conducted and revealed the RN was only authorized to practice in the state of Pennsylvania. She was not authorized to practice nursing in the state of Florida, which was confirmed through a search of the State of Florida Board of Nursing website.

On an interview was conducted with the Executive Director of Operations (EO) who stated the RN who signed off on the nursing assessments was the corporate nurse out of Tennessee. The EO stated she was not aware the RN was not licensed to practice in the state of Florida.

Class III