Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969670	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE FT LAUDERDALE	1031 SEMINOLE DR FORT LAUDERDALE, FL 33304

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A 000	Initial Comments An unannounced Complaint Survey #2021007205 and Generator Monitoring Assessment survey was conducted on and at Belmont Village Ft. Lauderdale. The facility had a deficiency at the time of the survey related to the complaint.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision and implement measures to ensure the safety of residents for 2 of 4 residents reviewed who eloped, Resident #1 and Resident #2, as evidenced by failing to supervise and monitor the whereabouts of the residents resulting in the elopement of Resident #1 and Resident #2 from the facility's secure Memory Care Unit unnoticed. The findings included:	A 025		

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A 025	Continued From page 2 A review of the facilities Memory Care Unit Brochure was conducted which advertises the 'Memory Care Unit program is specifically designed to address Mild [illegible] and varying stages of [illegible], person-centered living in a secured, dedicated memory care neighborhood. Each of our distinctive communities is built to high standards for life safety, comfort and care'. A review of the facility Policy and Procedure last review date of [illegible] titled: Elopement - [illegible] Neighborhood, states in part, 'Policy: To establish procedures for staff to follow in the event a [illegible] resident elopes or exhibits exit-seeking behavior. Under Section 4 the policy states: If a resident is missing and the staff has no awareness of the reason, destination, or whereabouts, do the following: a) Immediately notify the Executive Director or Manager on duty. b) Immediately notify all PAL stations in the community to conduct a building and grounds search per procedure, using the communication devices employed in the community (radios, iPods). c) Immediately notify the residents family member or responsible party to determine if they are aware of the resident's location and to assure them a search is underway. d) If within thirty minutes the resident is not located, notify police. e) Notify the Regional VP of Operations, Regional VP of Resident Care Services and SVP of Licensure and Compliance. f) Notify the residents physician. g) Notify the Licensing Agency: the SVP of Licensure and Compliance will assist with notification.	A 025		

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A 025	Continued From page 3 h) Complete Variance Report. 5) Upon the resident's return, the Director of Resident Care Services LVN/LPN/designee will conduct an assessment of the resident and recommend the appropriate intervention. The resident's physician should be immediately consulted as to whether the resident should be sent out for exam. 6) Within 24 hours of the resident's return, he/she should be assessed by the Director of Resident Care Services and their Resident Service Plan modified utilizing input from the resident's physician to determine continued appropriateness of care and placement. On at 9:40 AM, an observation of the location of the elopements for Resident #1 and Resident #2 was conducted with the facility Administrator in the secured Memory Care Unit (MCU). The 7th floor MCU has two stairwell exits (Northeast and Northwest), and both stairwells lead to the same exit door on the Southeast side of the building. There is a large sign in the center of the stairwell door that reads "Push and Hold Until Alarm Sounds Door Can Be Opened in 15 Seconds." The Administrator pushed and held the door handle and after 3 seconds the alarm sounded loudly until the Administrator manually reset the alarm with a key fob. The Administrator explained the key fob feature was not in place at the time of the 2 elopements. Once the door closed, the alarm automatically shut off. This Surveyor, Administrator, and Director of Resident Care Services walked down the 7 flights of stairs to the first-floor side exit which was located just outside of the facility parking garage and exits to an alley behind the facility, which is at the of a shopping plaza. The stair well is 7 floors with 2 flights of stairs between each floor. To the left of the exterior exit is a gate with an unlocked side	A 025		

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A 025	Continued From page 4 entrance, and to the right of the alley way leads around to the of the facility which is the of a grocery store where there is a gate with an open exit access on the side. The walk took approximately 3 minutes walking at a consistent steady pace. The stairs have rails on each side and skid protection on each step. The location where Resident #1 was discovered was an apartment building located directly across the street from the facility. The exact location of where Resident #2 was located is unknown but was described as just to the Northwest of the facility. Upon returning to the 7th Floor MCU, Resident#1 and Resident #2's rooms were observed to be located in the main hallway of the unit, in clear view from either direction. Review of Resident #1's resident record revealed she was initially scheduled to move into the Independent Living section of the facility on , after she was displaced from her apartment located across the street from the facility, due to a flood. She moved into a hotel instead and was not actually admitted to the Memory Care Unit until . A review of the Agency for Health Care Administration Health Assessment (AHCA Form 1823) completed by an Advance Registered Nurse Practitioner, dated , documents the resident has diagnoses to include , , and , , has an unsteady gait, and requires assistance with all Activities of Daily Living except eating. Resident #1 was not documented as an elopement risk, and required whereabouts be known several times a day, in addition the resident's need can be met in the Assisted Living Facility. Review of a Risk Assessment dated for Resident #1 documented 'Yes'	A 025		

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A 025	Continued From page 5 answers to the following four questions indicating she was at risk for [redacted]; Ambulates independently and exhibits behavior that is new and represents a change of condition; Exhibits increased [redacted], or restlessness, and paces and/or [redacted] aimlessly; Family/responsible party voices concerns about [redacted] tendencies; and Has a history of [redacted] away from home or previous dwelling. The 'Yes' responses indicated Resident #1 was at risk for [redacted]. Further, review of the facility Observation Notes revealed from the admission date of [redacted] up until the elopement date of [redacted], there was no documentation regarding Resident #1 [redacted], or any behaviors that would indicate exit seeking. Resident #1's AHCA Form 1823 had not been updated to reflect Resident #1 was at risk for elopement. A review of an investigative report revealed on [redacted] at 9:30 AM, Resident #1 entered the Memory Care Unit stairwell door and exited the side of the building at 10:11 AM. At 10:18 AM, the facility transportation driver observed Resident #1 across the street near the apartment [redacted]. The driver alerted the community. Analysis of Incident: Resident #1 pushed the stairwell door which opened after 15 seconds and could not return [redacted] in. She then proceeded to the lower level to exit towards her old apartment next door. Shift nurse (Staff A) assumed that it was a staff person and cleared the system without visual check. Community driver saw the resident across the street and escorted the resident safely [redacted] to the community. Corrective Action: Staff Nurse (Staff A) received written counsel and retraining regarding the use of the alert system and retraining was conducted with the care team on	A 025		

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A 025	Continued From page 6 . . . . . and . . . . . . Review of the facility Alarm System Log dated at 9:34 AM, revealed the following timeline for Resident #1: the West Stairwell (7th Floor) alarm was activated by Resident #1. (Staff A cleared the alarm 35 seconds later). The stairwell alarm for the first-floor garage exit was activated by Resident #1 at 10:11 AM and cleared by Staff A 49 seconds later. It was documented Resident #1 was located by Staff C at 10:18 AM across the street and returned to the facility. On at 1:53 PM, a telephone interview was conducted with Resident #1's family member who stated Resident #1 lived in the apartment building across the street from the facility for 18 years. Resident #1 was displaced from her apartment after it was flooded, and all her property was destroyed by the flood. Resident #1 moved into a nearby hotel and was originally supposed to be admitted to the facility on . . . . . as an Independent Living resident. In the resident was assessed and was deemed not to be at risk for . . . . and was eligible to move into Independent Living. When she was displaced, the family member had to take the resident's cat because she could not take it to the hotel. One day she was outside the hotel to look for her cat and the police picked her up and took her to the hospital and she was there for 11 days and then transferred to the Memory Care Unit of the facility where she has been since. She stated when Resident #1 eloped, she was notified right away, and the Administrator and staff have been very responsive to ensure the incident does not occur again. She stated she did not see any signs or behaviors that would cause concern for an elopement risk. She stated since the incident, Resident #1 reports to her that the	A 025		

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A 025	Continued From page 7 staff check on her too frequently. Review of Resident #2's resident record revealed he was admitted to the facility on , the day of the elopement. Review of the AHCA Form 1823 completed by Resident #2's physician dated , revealed Resident #2 had diagnoses to include , , , , and Tinnitus. Resident #2 was independent with ambulating, eating, and required supervision with bathing, grooming, toileting, and transfer. Resident #2 was not documented as an elopement risk and required that whereabouts be known daily. Review of a Risk Assessment dated for Resident #2 documented 'Yes' answers to the following four questions indicating he was at risk for : Ambulates independently and exhibits behavior that is new and represents a change of condition; Exhibits increased , , or restlessness, and paces and/or aimlessly; Family and/or responsible party voices concerns about tendencies; and Has a history of away from home or previous dwelling. The 'Yes' responses indicated Resident #2 was at risk for . Further, there was a notation which stated: 'Wife put alarms on doors because he walks out and downstairs'. Review of Resident #2's AHCA Form 1823 revealed it had not been updated to reflect Resident #2 was at risk for elopement. Review of the facility Alarm System Log dated at 8:37 PM, revealed the 7th floor West stairwell alarm was activated by Resident #2 and cleared by Staff E 26 minutes and 17 seconds later. The first-floor garage door was	A 025		

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A 025	Continued From page 8 activated at 8:38 PM and was cleared by Staff E 45 minutes and 37 seconds later. It was documented that Resident #2 was returned to the facility at 9:15 PM. On at 2:00 PM, a telephone interview was conducted with Resident #2's family member who stated she does not remember all the details surrounding Resident #2's elopement. She stated Resident #2 was admitted to the facility on . . . . . , the same day of the incident and she was with him until about 5:00 PM. She stated he did not want to be at the facility. She stated the staff were aware he was an elopement risk as that was the reason he was being admitted to the Memory Care Unit. She stated Resident #2 had a cell phone and she had a tracker on the phone. She had spoken to the Memory Care Unit Manager several times after leaving the facility. She stated she saw on the phone tracker that Resident #2 had left the facility and she notified the facility. As she was getting ready to call the police, a gentleman called and stated her husband had walked into his home and her husband gave him her phone number. She notified the gentleman that Resident #2 lived at the nearby Assisted Living Facility and gave him the address and he returned him to the facility without harm. Although law enforcement was notified there was no report completed. She stated Resident #2 wears a bracelet with his name and her phone number on it. She stated since the elopement the facility has updated the alarm system and are doing more frequent checks and there have been no additional concerns. An interview was conducted with the Administrator on at 9:45 AM, who stated the 2 incidents were similar in nature.	A 025		

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A 025	Continued From page 9 Resident #1 left the facility through the Northwest stairwell and went down the stairs to the alley and exited through the side gate of the facility. Resident #1 was headed across the street from the facility to her old apartment building where she had resided. The facility driver observed the resident and returned her to the facility. For Resident #2, he went down the Northwest stairwell and out of the door into the alley way. He proceeded to the of the building and ended up at a home in a nearby neighborhood. Once it was discovered Resident #2 was missing, elopement procedures were implemented, and law enforcement was called. Law enforcement stated they had received a report of a resident matching Resident #2's description in a nearby neighborhood. Resident #2 was returned to the facility by the person whose home he entered. The Administrator stated there was a different alarm system in place and the alarm automatically shut off once the door closed. The facility has since implemented an additional alarm in the central area of the unit and each staff member is alerted via iPod when the door is opened. The alarm must be manually reset by staff with a key fob. She stated there are two residents that are documented as elopement risk, Resident #3, and Resident #4. In an interview conducted with the Director of Resident Care Services on at 10:55 AM, she stated for Resident#1 she was not involved as she was out of town. For Resident #2, it was his first night on the unit, she was home and was notified via phone by the nurse, Staff B on duty that Resident #2 was missing. She returned to the facility, and upon arrival she was informed Resident #2 had been returned to the facility by the neighbor. She stated she conducted an investigation, which revealed Nurse Staff B	A 025		

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was called by staff who stated Resident #2 was agitated. Staff B came to the unit and the resident could not be located. Staff B checked the iPod and discovered the Northwest door had been opened. The incident happened in a very short time frame. Resident #2 was last seen in the common area, time unknown, and by the time Staff B arrived on the unit the resident was gone. The staff on duty did not say if their iPod had gone off or not. The facility provided a one-on-one private aid to supervise Resident #2 for one week after the elopement. Resident #1 and Resident #2 have not shown any additional exit seeking behaviors.

In an interview conducted with the Memory Care Program Coordinator on [redacted] at 11:52 AM, she stated she was in the community when Resident #1 eloped. She stated she was with a new admission, and received a call from the Administrator who stated, Resident #1 was found outside and returned to the community. She stated she had to go downstairs and get her and return her to the unit. Resident #1 appeared in no distress. She asked the resident where she was going and she stated home, which was right across the street. She stated the iPod did go off, but was cleared by the nurse, via the iPod.

For Resident #2 she stated she was not in the community. It was Resident #2's first night in the community. She stated she was texting with his wife, and the wife was saying Resident #2 was texting her saying she needed to pick him up and that he wanted to know why he was here, and he wanted to leave the community. In the middle of texting, the wife texted "He Left". I called the Director of Resident Care to inform her Resident #2 had left the community. She stated she returned to the community, and by the time she

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A 025	Continued From page 11 arrived Resident #2 had already been returned to the community. Staff D and Staff E stated Resident #2 was getting agitated, so Staff E called the nurse, and by the time the nurse arrived to the floor the west stair well alarm went off. Staff B went down the stairs and did not see Resident #2. Elopement Procedure were initiated, and the police were called. The police stated they had just received a call reporting someone matching Resident #2's description was walking in the neighborhood and was at the person reporting's home. Resident #2 was returned to the facility by the homeowner. She stated Resident #1, and Resident #2 have not shown any additional exit seeking behaviors. In a telephone interview conducted with Staff A, Licensed Practical Nurse on at 5:05 PM, Staff A stated she was the nurse on duty, and she reset the alarm during Resident #1's elopement. She stated she does not remember all the details but remembers at the time of the incident she was in with a resident when she heard the alarm go off, stating all the door alarms sounded the same, and staff would also use the stairwell. She stated her iPod cleared as when the door shuts, the iPod clears the alarm. She stated she was notified soon after that Resident #1 had eloped and was being returned to the unit by Memory Care Director. She stated she did not conduct a visual check, do a . . . count, or activate the Elopement Procedures, as she was not aware Resident #1 was missing. She stated she received a written reprimand as a result of the incident. She stated she no longer works at the facility. In a telephone interview conducted with Staff B on at 4:53 PM, Staff B stated he was the Nurse on duty when Resident #2 Eloped. He	A 025		

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A 025	Continued From page 12 stated Resident #2 was a new admission and was observed talking to other residents and appeared to be adjusting okay. He stated later that evening he was downstairs on a break when he received a call from the staff stating Resident #2 had become very agitated. He stated he immediately returned to the unit and as he was returning, he heard the iPod go off and he checked and saw that the stairwell alarm had sounded. He stated he went and checked the stairwell and outside and saw no one. He had staff check for Resident #2 and all other residents and noticed Resident #2 was missing. He notified the Memory Care Director and called the police. He stated the police said they had received a report of a person fitting Resident #2's description in a nearby neighborhood. The resident was returned to the facility by the homeowner of the home he had entered. He stated he assessed the resident, and the facility provided a private one-on-one aide for several days after the elopement for supervision. In a telephone interview conducted with Staff C on . . . . . at 9:30 AM, she stated she was returning to the facility, when she recognized Resident #1 walking across the street. She stated she stopped and asked Resident #1 how she got outside, and Resident #1 stated she walked down the stairs. Resident #1 was unable to tell her where she was going. She stated Resident #1 was . . and tired. She notified her supervisor and returned Resident #1 to the facility. Staff C stated she is the transportation driver and does not work on the Memory Care Unit. She stated Resident#1 did not have any marks or . . . . . and did not appear harmed in any way. On at approximately 11:00 AM, during	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969670	A. BUILDING: _____ B. WING _____	08/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT VILLAGE FT LAUDERDALE	1031 SEMINOLE DR FORT LAUDERDALE, FL 33304

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A 025	Continued From page 13 an interview conducted with the Director of Resident Care Services, a list of residents who were documented as elopement risk was requested. A list was provided that documented Resident #3 and Resident #4 were identified as an elopement risk. Resident #1 who eloped on . . . . . and Resident #2 who eloped on were not included on the list for being at risk for elopement. A review of the AHCA Form 1823 for Resident #3 and Resident #4 revealed they both were documented by the physician as an elopement risk. Review of the AHCA Form 1823 for Resident #1 and Resident #2 revealed their forms had not been updated to reflect both residents had eloped and were an elopement risk. On . . . . . at approximately 1:30 PM, the facility Elopement Photo identification book which contains a photo and demographic sheet for all residents at risk for elopement, was reviewed and Resident #1, Resident #2, Resident #3, and Resident #4 were included in the book. On at approximately 2:00 PM, observation of Resident #1, Resident #2, Resident #3, and Resident #4, revealed 4 of the 4 residents observed did not have identification on their person with the facility name, address, and telephone number. During an interview conducted on . . . . . at 4:30 PM with the Administrator and the Director of Resident Care Services, they acknowledged the findings. Class III	A 025		