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
	AL11965472	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE COMMONS OF FORT WALTON BEACH	2000 PRINCIPAL LANE FORT WALTON BEACH, FL 32547

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Complaint Survey for Complaint #2022015781, 2022013624, 2022015786, 2022214272 was conducted at Belvedere Commons in Fort Walton Beach on [redacted] -27, 2022. A complaint survey revisit for (2022008939) was conducted in conjunction. Deficient practice was identified at the time of the survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [redacted] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical	A 054		

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A 054	Continued From page 1 ..., the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure physician orders for medication administration were followed by failing to ensure that new orders were faxed to the pharmacy for inclusion on the Medication Order Records (MOR) for 1 of 2 (Resident #1) residents sampled for assistance with self-administration of medications. The findings include: On at approximately 9:15 AM, an observation was conducted of staff member A, medication technician (med tech), providing resident #1 with assistance with self-administration of medications. The observation included assisting the resident with taking the following medications: , 81 mg (an ..., ...), ... (... / ...)100 mg, , (...) 600, and ... D3 (low ... D) 1 capsule. The med tech questioned an order for ... a medication used for ... ( ) therefore this medication was not self-administered. A record review was conducted of resident #1 which revealed that the resident was discharged to the hospital on ... and returned to the facility on . A review of the hospital discharge medication list revealed the resident was to continue taking the medications ... (...)12.5 milligrams (mg) three times daily, ... (... retention) 0.4 mg daily at	A 054		

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A 054	Continued From page 2 bedtime, [illegible] ([illegible] spasms) 750 mg three times daily, [illegible] ([illegible]) 75 mg every morning, [illegible] (high [illegible]) 10 mg every morning, [illegible] (high [illegible]) 40 mg daily at bedtime, [illegible] ([illegible])12.5 mg every 12 hours, [illegible] ([illegible]) 50 mg at bedtime, [illegible] 100 milligram daily, and [illegible] ([illegible] retention) 5 mg every morning. The paperwork stated the resident was to start taking the medications [illegible] ([illegible] softener) 2 tablets twice a day, [illegible] ([illegible]) one packet three times a day, and [illegible]-yfgn 15 units daily ([illegible]). Three medications observed to be offered to the resident during the medication observation [illegible] D3, or the [illegible] were not noted on the discharge medications listed in the record. A review was conducted of the Medication Order Record (MOR) for the month of [illegible] which revealed the resident had received [illegible] D3, and 40 units of the [illegible] in the mornings on 6 occasions since his discharge from the hospital despite not being reordered upon discharge ([illegible], 21st, 22nd, 23rd, 24th, and 25th). The review also revealed that the resident had received 30 units of [illegible] in the evenings on the 19th, 20th, 22nd, 23rd, 24th and 25th, the date of [illegible] had a circle around it which indicated the medication was not given. The MOR review failed to include the ordered medications [illegible]-yfgn, [illegible] and Polyethylene. There was no evidence that the updated medication list from the resident's hospital stay had been faxed to the pharmacy upon the resident's return to the facility on [illegible].	A 054		

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A 054	Continued From page 3 On at approximately 1:15 PM, an interview was conducted with the Executive Director (ED), who stated that upon return from the hospital during normal business hours either herself or the Wellness Director would fax the medication list to the pharmacy for the pharmacy to update the medications in the MOR. If the resident returns after hours, then it is the medication technician would fax the orders to the pharmacy for the resident. The ED went on to state that there was no process in place to ensure the mediations are updated or reconciled when a resident returns from a hospital stay after hours. Class III	A 054		