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 _____	11/30/2022

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 #2022017374 was conducted at Belvedere Commons in Fort Walton Beach on . Deficient practice was identified at the time of the survey.	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 Resident Care Standards. 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) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 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 observations, interviews and record reviews, the facility failed to provide appropriate supervision and accounting of residents whereabouts to prevent the elopement of 1 (Resident #1) of 7 residents identified as an elopement risk. The findings include: A review of investigation documents into the elopement on [redacted], of Resident #1 revealed that staff Staff D, Medical Technician/Resident Assistant left the Memory Care Unit to obtain supplies and while Staff E,	A 025		

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A 025	Continued From page 2 Medical Technician Supervisor/Resident Assistant was in the bathroom, the alarm for the fire door exiting the Memory Care Unit was heard. Staff responded to the alarm and noted Resident #6 ambulating in the area of the door. Staff members D and E, escorted Resident #6 to his room and secured the door. A . . . count of all residents was not completed following the securing of the door and turning off the alarm. On , , at approximately 1:30 AM, officers from the Okaloosa County Sheriff Department (OCSD) arrived at the facility with a picture of Resident #1, who had been found on a road close to the facility. Staff B, Resident Assistant confirmed that the picture was Resident #1 and that they were a resident at the facility. A full facility . . . count was completed after the OCSD officers departed the facility, which confirmed that Resident #1 was missing from the facility. In a telephone interview on , , at approximately 10:37 AM, Staff D, Medical Technician/Resident Assistant was asked if a . . . count was performed for the other residents in Memory Care to ensure no one else had gone through the door when the alarm sounded on . . . . . She stated they did not do a . . . count on the other residents. She stated she assumed Resident #6 had set the alarm off because he was the only one seen walking away from the alarming door. In a telephone interview on , , at approximately 10:45 AM, Staff E, Medical Technician Supervisor/Resident Assistant, was asked if a . . . count of residents in the Memory Care Unit was completed following the alarm activating on . . . . . or after Resident #6, who was found in the vicinity of the	A 025		

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A 025	Continued From page 3	A 025		

door, was settled in his room. Staff E stated she did not do a count, but Staff D should have.

In an interview with the Administrator on , at approximately 12:45 PM, the Administrator stated that based on her investigation of the incident, the staff did not perform a complete headcount that evening when the alarm went off which would have picked up that another resident had possibly gone out that door. The Administrator stated that staff did not do what they were supposed to, and they were counseled.

A review of written statements from Staff D and Staff E following the elopement of Resident #1, the documentation did not show evidence that a count was done when the alarm door to the memory care unit alarmed. The statements noted that a count of all residents was completed after the authorities from the Okaloosa County Sheriff's Department arrived at the facility and notified Staff B, Staff D, and Staff E that Resident #1 had been found outside the facility by authorities.

A review of the Human Resource policy titled "Elopement and Missing Resident Plan," which had no date of establishment or revision, stated that "When a Resident is missing, the following procedure is activated: An immediate thorough search of the usual and obvious places (resident rooms, bathrooms, patio in their house) and count is completed."

A review of the documents titled "Associate Warning Notice" noted that Staff B, Staff D and Staff E were counseled for not following procedures after hearing an alarm and performing a count to ensure all residents

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A 025	Continued From page 4 were present. Class III	A 025		