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 _____ | 09/07/2023 |

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

| (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<br><br>An unannounced Complaint (#2023004899, #2023010701, and #2023013303) and Generator Monitoring survey was conducted on and at Belmont Village Ft. Lauderdale. The facility had deficiencies identified related to Complaints #2023004899 and #2023013303 at the time of the survey. | A 000 | | |
| A 010 | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency<br><br>429.26 Appropriateness of placements; examinations of residents.-<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is | A 010 | | |

| 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 _____ | 09/07/2023 |

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

| (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 010 | Continued From page 1<br><br>agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.<br>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:<br>a. Move, turn, or reposition without total physical assistance;<br>b. Transfer to a chair or wheelchair without total physical assistance; or<br>c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . .<br>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.<br>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.<br><br>(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must | A 010 | | |

| 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 _____ | 09/07/2023 |

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

| (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 010 | Continued From page 2<br>notify the appropriate contact person in the applicable department.<br><br>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.<br><br>59A-36.006<br>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:<br>(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.<br>(b) A resident requiring care of a may be retained provided that:<br>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, | A 010 | | |

| 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 _____ | 09/07/2023 |

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

| (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 010 | Continued From page 3<br>2. The condition is documented in the resident's record; and,<br>3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.<br>(c) A . , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;<br>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;<br>3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,<br>4. Documentation of the requirements of this paragraph is maintained in the resident's file.<br>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.<br>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.<br>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. | A 010 | | |

| 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 _____ | 09/07/2023 |

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

| (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 010 | Continued From page 4<br><br>(g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that significant changes in treatment and condition were documented for 1 of 3 sampled residents, Resident #2, as evidenced by a significant change in health status was not recorded on the Resident Health Assessment (AHCA form 1823) when Resident #2 was admitted to hospice services indicating a significant change in health status.<br><br>The findings included:<br><br>Review of Resident #2's record revealed he was admitted to the facility on [redacted]. Review of the resident's current Resident Health Assessment (AHCA Form 1823) dated [redacted], did not accurately portray this resident's current health status. On [redacted], Resident #2 was admitted to Hospice services due to a significant change in health status which was not reflected on the Resident Health Assessment dated [redacted].<br><br>On [redacted] at 3:00 PM, during an interview conducted with the Executive Director, he acknowledged that Resident #2 had been admitted to hospice in [redacted] of 2022, and Resident #2's Resident Health Assessment did not reflect this significant health status change.<br><br>Class III | A 010 | | |
| A 166 | 429.23(5) FS; Risk Mgmt & QA; Reporting Reqs. | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 5<br><br>429.23, FS<br>Internal risk management and quality assurance program; adverse incidents and reporting requirements.-<br>(5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to submit a preliminary adverse incident report within 1 business day and failed to submit a full adverse report within 15 days after incidents which rose to the level of being reported to the Agency for Health Care Administration (AHCA) for 2 of 3 sampled residents. (Resident #1 and Resident #2).<br><br>The findings included:<br><br>Review of the Regulatory Reporting Requirements-Florida dated . . . . . specifically addresses the following areas:<br>*An Adverse Incident Report shall be submitted to the Agency for Health Care Administration using the Adverse Incident Reporting System (AIRS) within 24 hours of a reportable | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 6<br><br>occurrence. A follow up report must be made to the AHCA using the AIRS system within 15 days of the occurrence, or if it has been determined the occurrence was not an adverse event, the initial report must be withdrawn within 15 days. An adverse incident is defined in s.429.23(2) F. S. and means:<br>An event over which facility personnel (could exercise control) rather than as a result of the resident's condition and results in:<br>*<br>* or , damage;<br>*Permanent ;<br>* or of bones or joints;<br>*Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;<br>*Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or<br>*An event that is reported to law enforcement or its personnel for investigation.<br><br>1) Review of Resident #1's Resident Health Assessment (AHCA form 1823) dated documented the resident has diagnoses to include , , , severe hearing loss, , and . His status is documented as having . He requires assistance with grooming and supervision with ambulating and . Resident #1 was independent with eating and transferring. Resident #1 resided in the Memory Care Unit of the facility.<br><br>On , at approximately 9:00 PM Resident #1 was observed by 6 PALS (Personal Assistant Liaison) and the Licensed Practical | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 7<br><br>Nurse on duty with a dark red . . . . right . , . . Resident #1 was unable to give any details of the incident or how he sustained the . . . . injuries. All staff were interviewed during the 2:45 PM to 10:45 PM shift and the staff consensus was no one claimed to have actually witnessed how Resident #1 sustained right and left . . . . injuries. The staff reported they were providing patient care in other resident's rooms and thus Resident #1 was unsupervised at the time.<br><br>On at 9:45 AM, an interview was conducted with the Executive Director requesting to review the Adverse Incident Report which was completed regarding the incident with Resident #1. The Executive Director confirmed there was no Adverse Incident Report submitted related to Resident #1.<br><br>On at 11:35 AM, an interview was attempted to be conducted with Resident #1 in his room. The injuries to the right side of his had healed at this point. An inquiry was made if he remembered what happened to his right , to which he responded he did not remember anyone hitting him in the , , stating it does not hurt now.<br><br>On at 11:52 AM, an interview was conducted with PAL Staff E who stated she was working the 3:00 PM to 10:45 PM shift and on . . . . . at around 9:00 PM she was coming out of a resident room and heard PAL Staff D calling out saying come quickly. When she arrived, she observed Resident #1 sitting down and she saw his right , was discolored and red. She further stated another staff member was with Resident #3 and he seemed to be involved in the incident. She stated she called the LPN and the LPN came and assessed the situation and put an ice pack on Resident #1's right , . She stated | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 8<br><br>she never saw Resident #1 and Resident #3 together and both residents required a lot of redirecting. She further stated the residents are always supervised so she does not know why 5 staff persons on duty did not see anything including herself.<br><br>In an interview conducted with PAL Staff A on [redacted] at 3:10 PM, she stated she saw Resident #1 and Resident #3 standing together around the time of the incident however did not witness any altercations. She stated she just asked Resident #1 to come and sit down.<br><br>On [redacted] at 9:45 AM, an interview was conducted with the Memory Care Program Coordinator who stated she was informed by the Director of Resident care that the 2 residents had a conflict. She stated there were 6 staff on duty, but no one saw the incident because they were all providing care in different rooms. She further stated PAL Staff A noticed the 2 residents together but did not see any conflict among them. She stated PAL Staff B was assigned to the pod to oversee the residents, but she got called away by PAL Staff C to help her perform a task, so she left her post. The Memory Care Program Coordinator was asked why Resident #1 did not receive any medical attention or sent to the hospital post a / injury to which she stated the Physician was notified and he ordered ice and . The Memory Care Program Coordinator stated she questioned all PALs and no one saw anything. An inquiry was made what could the facility have done to prevent this incident to which she replied to increase the communication between the PALs and improved training. A further inquiry was made if she could say that Resident #3 hit Resident #1 to which she stated no one can say that, since no one saw it | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 9<br><br>and all staff denied witnessing the incident. The assumption amongst staff was this was a resident-to-resident altercation, however there was no evidence that there was any investigation into a potential staff to resident altercation or if the resident may have sustained a and as Resident #1 suffered severe injuries, he was not sent to the hospital for an evaluation for any or and the local police were not called to the facility as a precautionary measure.<br><br>On at 11:40 AM, a telephone interview was conducted with the family member of Resident #1 who stated the facility did not call the police and 2 days after the incident when the family visited, the resident's right , was closed shut, his and was , so it was the family who called the police. The family member stated no adverse incident was filed with the state. He further stated he was frustrated because there were 6 staff on duty that night, 2 of who were in training and no one saw anything. Review of the photographs taken by the family member revealed Resident #1 with severe black, blue and red , to his right , which was closed shut and some red and blue discoloration under his left , .<br><br>2) Review of the record for Resident #2 revealed he was admitted to the facility on . Review of the Resident Health Assessment dated revealed a diagnosis of . Resident #2 was independent with all activities of daily living and required supervision with and bathing. Resident #2 resided on the Memory Care Unit. Resident #2 was admitted under hospice services on .<br><br>In an interview conducted with the Director of | A 166 | | |

| 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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 10<br><br>Resident Care on . . . . . at 1:25 PM, she stated Resident #2 has sustained multiple and provided a timeline of the resident's . . . and interventions conducted. She stated the resident's last . was on . . . . . which resulted in a left , . as diagnosed by an , .<br><br>Review of Resident #2's Nurse's Notes documented 10 . . from . . . . . to . An , conducted on . diagnosed the resident as having sustained a left , .<br><br>Further during the interview conducted with the Director of Resident Care on . . . . . at 1:25 PM, she stated the Regional Director was called and it was determined they could not manage Resident #2's care at this facility and Resident #2 was transferred on . . . . . to an inpatient hospice care unit. There was no evidence of any interventions implemented post the resident's . with the exception of transferring him out of the facility.<br><br>On . . . . . at 3:000 PM, during an interview conducted with the Executive Director, a request was made for the Adverse Incident Reports submitted regarding the incident with Resident #1 and Resident #2's left , . . . post . . The Executive Director stated she never completed an Adverse Incident Report because she was trained to follow the procedure of adverse incident and the statement that reads an event which the facility personnel could exercise control rather than as a result of the resident's condition. She stated the incidents at this facility have not within the listed criteria.<br><br>Resident #1 sustained severe injuries of undetermined origin with no police notification | A 166 | | |

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 _____ | 09/07/2023 |

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

| (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 166 | Continued From page 11<br><br>and no higher level of medical attention to determine any or injury; and Resident #2 sustained a in the facility resulting in a left , .<br><br>On at 4:00 PM, during an interview conducted with the Executive Director and Director of Resident Care, they acknowledged the findings and no additional documentation was provided for review.<br><br>Class III | A 166 | | |