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 _____	04/28/2026

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, complaint number 2026006812, was conducted at Belmont Village Ft Lauderdale on - . The facility had a deficiency 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 resident record review, the facility supervision policy review, and interview, it is determined that, the facility had failed to provide adequate supervision to 1 of 2 sampled residents (Resident #1) during dining. The findings included: On , , during a visit to the facility, the Director of Resident Services (DRS) was asked to provide the facility's supervision policy. Review of the policy outlined in line item #2 that: In the Memory Care supervision is done in	A 025		

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A 025	Continued From page 2 conjunction with the Memory program Coordinator /Director of Activities and Memory Care (MPC/DAMC) and the Director of Resident Care Services (DRCS) but may extend to the Licensed Practical Nurse (LPN/Nurse) on duty if the MPC/DAMC are not on the premises. In order words, in the MC, supervision is the responsibility of the facility's leadership team. Resident #1's Health Assessment (AHCA form 1823) dated revealed the diagnoses of: Unspecified with Severe disturbance; of per history. . ; Difficulty walking; . The form 1823 outlined that Resident #1 required assistance with all activities of daily living, ate independently, and was on a regular diet with thin liquid. Review of an updated AHCA form 1823 dated , post hospitalization, documented Resident #1 required supervision during eating. The Hospice admission document dated revealed Resident #1 required Assistance for all activities of daily living (ADL). Page 1 of 3 of the Hospice Certification and Plan of Care dated documented Resident #1 presented with of , Unspecified , unspecified severity, without behavior; / / ; Adult ; unspecified. unspecified and Essential . The record further outlined that Resident #1 was on , precaution and consequently required a Mechanical soft Diet. Review of the hospice integrated plan of care dated outlined the facility was responsible to coordinate Resident #1's ADL care	A 025		

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A 025	Continued From page 3 including the resident's dietary need. The facility was required to provide adls assistance, medication assistance and cares, per coordination of care. Review of the facility's dining policy Item #3 documented that the People Assistance Liaison (PAL) will create a positive social climate and will be totally resident-focused throughout the meal. On at 11:10 am, Staff (I) a PAL reported that she was present during Resident #1's incident. She was assigned to care for six residents that day. She believed that Resident #1 choked. Staff I recalled that Resident #1 was eating eggs and other soft foods. She said, she and the lead PAL were present in the dining room. She added that Resident #1 was eating by herself and three other residents sat at the table. Staff I attested that "No staff was by their table". Staff (I) said that the Lead always checked around to make sure everybody is okay. Staff (I) explained that it was one of Resident #1's table mates who called her and told her to check on Resident #1. When she approached Resident #1, she was already unresponsive. Staff I said she tap Resident #1 on the and food particles came out of Resident's . Staff (I) said she did not perform the Heimlich maneuver. Staff I said she called the lead PAL who arrived immediately and intervened. Then, she called the nurse on duty. The Lead PAL reported to the Surveyor on at 11:55 a.m. the following: She stated that she was present when Resident #1 experienced the choking incident. The event occurred during breakfast at approximately 8:30 a.m. She served Resident #1 a meal consisting of	A 025		

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A 025	Continued From page 4 one small pancake, eggs, orange juice, and coffee. She reported that she cut up the pancake before Resident #1 ate it. Resident #1 was nearly finished eating when another PAL alerted her that Resident #1 was unresponsive. She observed food coming from Resident #1's but did not initially believe the resident was choking. Staff attempted blows and thrusts while calling Resident #1's name, but there was no response. When the nurse arrived, she checked Resident #1's and did not observe any food obstruction. The nurse performed thrusts without success. The nurse and the other PAL then moved Resident #1 to another room. She stated that she does not know what occurred afterward because she remained in the dining room and was unable to leave. An interview with the nurse on duty (Staff M) conducted on at 1:38 p.m. revealed that she has been employed at the facility as a Licensed Practical Nurse since . Staff M stated that she works throughout the facility but is typically assigned to the Memory Care Unit (MCU) on weekends. Staff M reported that on Sunday, , , she was in the medication room when she heard a knock at her office door. Staff I informed her that Resident #1 was unresponsive, although Staff M stated she could not fully understand what was being said at the time. She immediately ran to the dining room, where she observed Resident #1 seated in a wheelchair at the table with breakfast in front of her. The meal included eggs and pancakes, and there was a small amount of orange juice remaining in a glass.	A 025		

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A 025	Continued From page 5 Staff M stated that Resident #1's was positioned downward, and another PAL was standing nearby. Upon assessment, she found no , and no , . She observed that Resident #1's , were blue and her , appeared glazed. Staff M also noted a small amount of food on Resident #1's clothing. She immediately performed a sweep of the , during which a significant amount of food mixed with saliva was removed. Staff M stated that Resident #1 gasped once and then became unresponsive again. She instructed staff to call 911 and informed the operator that Resident #1, who was receiving hospice services, was unresponsive. The operator advised her to have an available for emergency personnel. Staff M reported that within approximately five minutes, police officers arrived and took over efforts from another staff member who had initiated . Paramedics arrived shortly afterward, while police continued efforts. Despite these interventions, Resident #1 could not be revived and was pronounced at the facility. On at approximately 9:50 a.m., the Director of Resident Care Services explained that supervision meant "closely monitoring a resident". The DRCS also asserted that no one could confirm that the resident actually choked. She said it is possible that Resident #1 might have had a . On at 12:20 p.m., the findings were discussed with the Executive Director and the Director of Resident Care Services. They provided no additional information.	A 025		

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A 025	Continued From page 6 Class II	A 025		