RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Belvedere Commons Of Fort Walton Beach
2000 Principal Lane
Fort Walton Beach, FL 32547

RE: Bienniel Survey Plus Complaint Number 2015010147

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Helberg, W
Field Office Manager

DH/dh
Enclosure

XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone:850-412-4540; Fax:(850) 922-9162
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965472	10/06/2015
NAME OF PROVIDER OR SUPPLIER **BELVEDERE COMMONS OF FORT WALTON BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **2000 PRINCIPAL LANE FORT WALTON BEACH, FL 32547**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced biennial survey in conjunction with CCR 201510147 was conducted on 10/5- at the Belvedere Commons of Fort Walton Beach. The facility had deficiencies found at the time of the survey.

0030 Resident Care - Rights & Facility Procedures

Based on observations and interviews the facility failed to honor the residents' rights by failing to ensure the residents live in a safe and sanity environment by failing to ensure residents' oral medications were handled in a safe and sanitary manner.

The findings are:

Observation of the medication pass was done on beginning at approximately 7:32AM with sampled staff A a resident aide and medication assistant. Observation of sampled resident # 13 revealed him sitting in his recliner in his . The staff pulled sampled resident's # 13 medications from a drawer on the medication cart and placed them on the top of the medication cart. Continued observation revealed the staff took the medication cart into the resident's . The staff began dispensing the medications into the medication cup; the staff was observed to pushed out the medication, and directly out into her bare hand and then placed them into the medication cup. Continued observation revealed the staff continued to prepare the resident's medications. The staff informed the resident she would place his pain patch on him and she placed it on his right shoulder area; touching the resident's bare skin and clothing with her bare hands. Sample staff then was observed to assist sampled resident #14 with her medications. Sampled staff A has assisted sampled resident #13 and #14 with their medications; including the application of a pain patch to the skin of the right shoulder of sampled resident #13, touching his bare skin and clothing with her bare hands. She was observed to use some hand sanitizer but did not wash her hands. The medication pass observation continued with sampled resident #5 beginning at approximately 7:55AM. Observation at this time revealed her taking sampled resident's #15 , pill from its container and placed it in her bare hands and then placed the pill in the inhaler and hand it to the resident. The resident used the inhaler, the staff hand the resident the inhaler, the resident used it and the staff handed the resident a inhaler which the resident used. Continued observation revealed sampled staff A then dispensed the medication, into her bare hand and placed it into a medication cup. The staff continued with the medication pass and dispensed the resident's medication Isosorb, into her bare hand then dropped them into the medication cup, she dispensed the medication from the pack, the pill onto medication cart missing the medication cup; she picked up the pill and placed it into the medication cup again using her bare hands. The staff

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then placed the medication , , and D3 into her bare hand and dispensed then into the medication cup. The resident took the medications orally. On at approximately 8:08AM sampled staff A confirmed she had handled several of the medications with her bare hands before giving to the resident and she "probably should not have".

Interview with the facility Wellness Director on / at approximately 11:49AM revealed that the residents' medications should not be handled with the staff bare hands at any time. She stated she does not believe the facility has a policy stating this though, but this is her expectation as this is not sanitary or safe for the residents.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations and interviews the facility failed to ensure unlicensed staff provided assistance with self administration of medications appropriately for 2 of 3 sampled residents observed during the medication pass (#13 and #15).

The findings are:

Observation of the medication pass was done on beginning at approximately 7:32AM with sampled staff A an unlicensed resident aide/medication assistant. Observation of sampled resident # 13 revealed him sitting in his recliner in his . The staff pulled sampled resident's # 13 medications from a drawer on the medication cart and placed them on the top of the medication cart. Continued observation revealed the staff took the medication cart into the resident's . The staff had her back to the resident and began to dispensed each medication into a medication cup. At no time did the staff identify or show the resident the medications or read the medication label to the resident before placing them into the medication cup. The staff dispensed eight different oral medications into the medication cup, with her back to the resident and handed them the resident and he took them. At no time did the staff show the resident the medication cards, she did not read the medication labels to the resident. Review of the resident's most recent completed Resident Health Assessment completed by the resident's physician indicated the resident needed assistance with self-administration of medications.

Continued observation on / at 7:55AM was made of sampled staff A. Observation for sampled resident #15 at this time revealed sampled staff A taking the pill from its container and placed it in her bare hand and then placed the pill in the inhaler and hand it to the resident. The resident used the inhaler, the staff handed the resident the inhaler, the resident used it and the staff handed the resident the , inhaler which the resident used. The staff did not attempt to encourage the

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resident to wait the needed 1-2 minutes between the use of the inhalers to ensure appropriate administration of the inhaler medications. The staff then dispensed the medication, into bare hand and placed it into a medication cup. The staff showed her the medication card and dispensed it into the medication cup. The staff continued with the medication pass and dispensed the resident's medication Isosorb, into her bare hand then dropped them into the medication cup, she dispensed the from the pack, the pill onto medication cart missing the medication cup; she picked up the pill and placed it into the medication cup again using bare hand. The staff then placed the medication , , and D3 into her bare hand and dispensed then into the medication cup. The staff did not identify the medications to the resident, she did not read the medication labels to the resident. The staff handed the medication cup to the resident who then stated she did not know what she was taking because she couldn't see them. The resident asked the staff "You want me take this?' and the staff said yes; she would like for her to. The resident took the medications. Interview with sampled staff #A on / at approximately 8:08AM confirmed she did not follow the procedure for assisting with self administration of medications by failing to identify the medications or showing the medication labels to the resident. Review of the resident's most recent completed Resident Health Assessment completed by the resident's physician indicated the resident needed assistance with self-administration of medications.

Class III

0055 Medication - Storage and Disposal

Based on observation and interview the facility staff failed to ensure residents' medications were appropriately stored in 1 of 3 medication carts by maintaining medications in a pill organizer for a resident who could not self administer medications.

The findings are:

An inspection of the medication cart for the secured memory care unit residents was done on at approximately 8:25AM with the facility's Wellness Director. The observations revealed a pink medication pill organizer located in the drawer of the medication cart. The pink pill organizer contained 3 unidentified pills in the Wednesday, Thursday and Friday compartments of the pill organizer. The pill organizer was only marked with hand written "PM" on the box. Interview with the Wellness Director at this time revealed the family of sampled resident #17 brought this in when she was admitted on / , she stated the family wanted the nurses to administer these medications to the resident in the evenings. Interview with the facility Wellness Director confirmed these findings and confirmed the facility staff did not set up this pill organizer and the resident requires the administration of her medication by nurses due to her poor cognition. The facility Wellness Director also confirmed the pill organizer is not

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marked/labeled with the resident's name or any other form of identification.

Class III

0057 Medication - Over The Counter (OTC) Products

Based on review of the facility's policy, observations and interviews, the facility failed to properly label over the counter medications with the residents' names stored in 2 of 3 medication carts.

The findings are:

Review of the facility's Medication Labeling policy dated / revealed the statement over the counter medications are kept in the manufacturer's original container and identified with the resident's name and .

An inspection of the medication cart for 201-216 and 101-110 was performed on at beginning at approximately 8:14AM with sampled staff #A. The inspection revealed an opened bottle of the over the counter medication, Centrum . The medication did not contain any residents' name or . The staff confirmed the absence of the resident's name/ and informed the surveyor the over the counter medication belonged to sampled resident #16. When asked how she knew who the medication belonged to the staff stated because it is always located at this spot in the medication cart drawer.

Inspection and observation of the medication cart for 111-130 was done on / beginning at approximately 8:32AM with the facility's Wellness Director. Observation revealed the following over the counter medications: one opened bottle of 600 plus D, one bottle of Flaxseed oil 1000 milligrams (mg), one bottle of stool softner 100mg, one bottle of 5mg. Observation revealed none of these over the counter medications were labeled/marked with a resident's name or . The Wellness Director confirmed these findings. Continued inspection/observation of the medication cart revealed the following over the counter medications: one opened bottle of D3 5000 international units (IU) not marked/labeled with a resident name or . Continued observation revealed four medication sample cards of 2mg and 4mg tablets, a 2 week sample kit with no identified name on the cards. There is one opened bottle of D3 1000 IU with the hand written note two capsules every morning but is not labeled/marked with the resident's name or . Observation revealed one opened bottle of One Daily Womens Formula without a name. Interview with the Wellness Director on / at approximately 9:00AM confirmed these over the counter medications were not appropriately labeled/marked. She revealed that all over the counter medications are to be appropriately labeled with

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the residents' names and and these were not.

Class III

0093 Food Service - Dietary Standards

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure portion sizes were included on the regular menus or a separate sheet.

Findings include:
1) A review of the regular menus for week 4 cycle lacked evidence of the portion sizes.

2) During an interview on / at 1:15 PM, the Food Service Director reported that the facility did not have a menu or a sheet that included the portion sizes. The Food Service Director stated he was working with the company Sysco to obtain the portion sizes.

Class III