STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965472	03/22/2017
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 complaint survey for allegations contained within CCR # 2017001344 was conducted at Belvedere Commons of Fort Walton (license #9819) on . . . . Deficient practice was found at the time of the survey.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on staff interview and resident record review the facility failed to have an updated Resident Health Assessment for Assisted Living Facilities (1823) completed for 2 of 2 residents (#7 and #10) for a change in condition when it was determined they needed to be put under the care of Hospice.

The Findings Are:

Resident #7 was observed to have an 1823 which was completed on . During the medication review for Resident #7 the Wellness Director said that one of the orders was by Hospice and that she was under the care of Hospice on at 2:45 pm. She confirmed the last 1823 was completed in 2015. When asked about the change in condition and the need for a new 1823 she stated, "When did that change. I did not know that." Further record review revealed Resident #7 has a start of care date of . . . . for Hospice.

The Wellness Director was asked if anyone else had been put on Hospice recently on at 3:00 pm. She said Resident #10 was put under the care of Hospice last week. She was requested to provide the 1823 for Resident #10. The 1823 was found to have a date of . . . . as the examination date completed by her medical provider. The Wellness Director confirmed this date. The start of care date for Hospice was . . . .

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, staff interview, and record review the facility failed to provide assistance with medications according to regulation for 3 of 3 residents (# 8, #7 , and #6) who reside in the memory care unit of the facility.

The findings are:

During tour of the facility on . . . . the memory care medication technician (MT) unlicensed staff was observed to be preparing medications for an unidentified resident out of sight of the resident. At that

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time, observation of medication assistance was completed for residents #8, #7, and #6.

On at 9:41 am Employee A was observed at the medication cart preparing medications for resident #8. She punched the pills into a paper souffle cup out of sight of the resident who was sitting at the dining table after finishing breakfast. Employee A was observed to go to the resident with the cup of pills and say here are your medications. The Resident Health Assessment for Assisted Living Facilities (1823) page 4, dated , indicated the resident needed assistance with the self administration of medications.

At 9:56 am the unlicensed staff was observed to pull Resident #7's wheelchair to the medication cart. After taking the resident's , reading, she prepared the medicines at the medication cart with her back to the resident.
After pouring the medications into the paper souffle cup she turned to the resident and said I have your , , , and your medication for you. She had to continuously remind the resident to take her medications. The 1823 dated indicated the resident needed assistance with self administration of medications.

The MT was observed to assist Resident #6 with her medications beginning at 10:07 am. The MT took the resident's , and then stated, "I have to crush her medicines". The MT had her back to the resident during the preparation of the medication. She poured the medications into the souffle cup, and then crushed them. She then mixed the crushed medications with peach yogurt. She turned to resident #6 and said, "I have your medications." A review of resident #6's 1823 revealed that it was completed on and that the resident required medication administration. The Wellness Directed confirmed she needed administration by a licensed nurse on at 2:45 pm.

Employee A, MT, was interviewed on at 10:13 am . She was asked what her duties were when assisting with medications. She stated, "I am supposed to read the medications to the resident. I know I did not do that."

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation, staff interview and resident record review the facility failed to provide licensed staff to administer medication for 1 of 4 residents (#6).

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The Findings Are:

The medication tech (MT) was observed to assist Resident #6 with her medications beginning at 10:07 am. The MT took the resident's , and then stated, "I have to crush her medicines". The MT had her back to the resident during the preparation of the medication. She poured the medications into the souffle cup, and then crushed them. She then mixed the crushed medications with peach yogurt. She turned to resident #6 and said, "I have your medications."

Employee A MT was interviewed on at 10:13 am . She was asked what her duties were when assisting with medications. She stated, "I am supposed to read the medications to the resident. I know I did not do that."

A review of Resident #6's Resident Health Care Assessment for Assisted Living Facilities (1823) revealed that her 1823 was completed by her medical doctor on . On page 4 the box for needs medication administration is checked. The Wellness Director Licensed Practical Nurse (LPN) confirmed she needed administration by a licensed nurse on at 2:45 pm.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation, and staff interview the facility failed to maintain 2 of 2 refrigerators (front dining and memory care) which are designated for resident use in clean condition.

The Findings are:

The front dining observed to have a small kitchen equipped with a refrigerator on at 10:25 am. The refrigerator ice dispenser was observed to have a yellowish brown substance with dark flecks on it going down into the ice dispenser. (Photographic Evidence Obtained). Employee I, a dietary aide, was interviewed on at 10:29 am. She said residents did use the refrigerator for ice.

The memory care refrigerator was observed to have dirt in the food area and some type of dark substance adhered to the top of the freezer. Food was observed to be stuffed into the ice bin. (Photographic Evidence Obtained)

The Dietary Manager was interviewed on at 4:25 pm. She stated, "Dietary aides are responsible for keeping these refrigerators clean." She confirmed that both refrigerators needed cleaning. She

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stated, " They are supposed to be cleaned weekly but looking at them it does not look like they have been cleaned that often."

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on staff interview, and review of employee file the facility failed to have an approprariarte Level II background rescreening done for 1 of 5 employees (employee F).

The findings are:

A review of Employee F's file revealed a eligible Level II background screening dated . An interview was conducted with the Wellness Director Licensed Practical Nurse (LPN) at 3:50 pm on . She was asked to provide any new Level II screening for Employee F. She came back to confirm this was the only Level II.

The field office director was contacted at 3:58 pm on . The necessary information was provided to her and she also confirmed there was nothing new in the system for employee F and the last was completed on . The re-screening was due by .

Unclassified