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
	AL11969870	A. BUILDING: _____ B. WING _____	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALURA BY INSPIRED LIVING	777 ROY WALL BLVD ROCKLEDGE, FL 32955

(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 Complaint Investigation #2021014357 was conducted on [redacted] & [redacted]. Alura by Inspired Living had deficiencies at the time of the investigation.	A 000		
A 025 SS=G	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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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, facility report review, and interview, the facility failed to provide adequate supervision to prevent for 3 of 4 sampled residents (#1, 2 & 4), failed to maintain written documentation and updates for events and changes which required medical attention for 3 of 4 sampled residents (#1, 2 & 4), and failed follow a healthcare provider's order for a (#1). Findings: 1. Resident #1's record revealed an admission date of . The health assessment was dated and documented diagnoses	A 025		

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A 025	Continued From page 2 including . She was noted to be at risk for elopement, and at risk for . The facility report, dated at 6:50 PM, revealed the activity director informed the nurse on duty that resident #1 had a possible . The nurse assessed the resident who said the resident's hurt. The note documented the resident's healthcare provider and family were notified. The report submitted to the Agency for Health Care Adminsitration (AHCA) revealed the nurse heard a noise by the door of the memory care unit and found resident #1 on the ground holding her right arm. The nurse called emergency medical services ( ) and took resident #1 to the emergency room (ER) for care. , showed resident #1 had a right and , and the family was to take her for an orthopedic evaluation on . The facility noted they would continue to monitor the resident for , or symptoms. Resident #1's facility progress note, dated at 12:18 AM, reflected that and , results from the hospital documented to the right and , and that the resident had a soft in place. There were no notes found regarding resident #1's return from the hospital, any care to be provided and medication changes upon return from the hopsital. There were no notes found regarding any follow-up care and observation for , or symptoms. There were no notes found regarding the visit to the orthopedic physician. On at 1:10 PM, nurse A confirmed she was working when resident #1 . She confirmed she called . She stated resident #1 returned from the hospital with her family, but no paperwork was provided from the hospital. She	A 025		

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A 025	Continued From page 3 contacted the nursing director to inform her. Staff A said the family took resident #1 for outpatient surgery and she returned with a hard on her arm. She stated she did not know what was done and did not see any new orders for care for resident #1. On at 1:40 PM, staff D, a caregiver in memory care, stated resident #1 had a on her arm a few weeks ago and kept taking it off. A few days after that, resident #1 had surgery and returned with a hard . Staff D stated she is not permitted to create notes in the facility records and can only verbally report any incidents to the nurse on duty. On at 2:30 PM the nursing director confirmed the unlicensed staff cannot create notes in the electronic system. She stated they are to report to the nurse on duty who will enter notes when they have a chance. She confirmed she did not have any hospital notes or other notes regarding the surgery for resident #1. She confirmed there were no facility progress notes regarding care and follow-up for resident #1 following the instructions, or surgery to her right arm. 2. Resident #2's record revealed an admission date of . The health assessment was dated and documented diagnoses including , lower , and legal . He was noted to ambulate with a cane. The report submitted to AHCA revealed on at 8:45 AM, resident #2 was found on the bathroom floor in his room by a caregiver. He had to both elbows. First Aid was applied. The family and healthcare provider were notified. The resident refused to allow the facility to call . The resident's son took him to the	A 025		

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A 025	Continued From page 4 ER at approximately 11:30 AM. He returned the same day without any paperwork or orders. On [redacted], the nursing director was informed by resident #2's healthcare provider that resident #2 had a [redacted] of his left [redacted]. The facility progress notes revealed a note on [redacted] at 4:31 PM for a [redacted] with injury. He had [redacted] on both elbows. A note on [redacted] at 5:15 PM reflected that the nurse was alerted to resident #2 with [redacted] stabbing [redacted] on the left and right sides. Tea colored [redacted] was seen in a bottle in the resident's room. Resident #2 was taken by [redacted] to the hospital on stretcher. His son was notified. There were no additional notes in the record. On [redacted] at 11:10 AM, the nursing director stated when resident #2 returned from the ER on [redacted] with his son, he had steri-strips on both elbows and a soft [redacted] on his left [redacted] but there was no paperwork or orders from the hospital. She stated resident #2 continued to complain of [redacted]. She said on [redacted], resident #2's [redacted] was severe, and he was sent [redacted] to the ER. The resident's son notified the facility that resident #2 would not be returning and would be moving to another facility for a higher level of care. She confirmed there were no notes upon the return from the hospital on [redacted] about changes in care level, follow-up observations, and no documentation that any attempts were made to obtain records or orders from the hospital. 3. Resident #4's record revealed an admission date of [redacted]. The health assessment dated [redacted] included diagnoses of [redacted], and [redacted]. He required assistance with all activities of daily	A 025		

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A 025	Continued From page 5 living, except he only needed supervision with eating. He required assistance with self-administration of medications. He was at risk for . He resided in the facility's memory care unit. A facility report, dated at 1:35 PM, documented an unwitnessed . The report stated the nurse was notified by a caregiver that the resident was observed on the floor in his bedroom and required medical attention. The report reflected that hospice was notified and he was sent to the hospital. It read, "no injuries observed at time of incident" and "no injuries observed post incident." Facility progress notes for revealed an entry at 3:23 PM describing the resident's left thumb was and discolored. Hospice was called. Facility was to monitor for changes and hospice would visit the next day. Another note on at 9 PM noted resident #4's left thumb had increased and discoloration. Hospice was contacted again, and nurse would come to facility. On at 9:27 PM, a note reflected that an report revealed a of the right . Hospice was notified. On at 10:15 PM, the hospice nurse arrived and sent resident #4 "to the hospital via 911 for right , possible left thumb and possible right , ." On at 8:44 PM, a note in the record read, "Resident was observed on his floor in bedroom by care partner. Injuries: none seen." It was not documented to be a late entry note, but the resident was not present in the facility on . Photographic evidence was obtained. Resident #4's hospice record revealed he was admitted to hospice services on . On at 1:15 PM, an in person visit with	A 025		

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A 025	Continued From page 6 resident #4 was conducted after hospice was notified the resident had an unwitnessed . The resident complained of severe , , especially in the right . He had sustained multiple , scrapes and . The hospice provider ordered a stat (immediate) portable , . A hospice note on at 9:30 PM reflected a visit with the resident was conducted after the , confirmed a to the right . Resident #4 screamed in , with any movement. medication was not ordered. Deformity of the right , and left thumb were noted. was called to transport resident #4 to the hospital. The hospital record for resident #4 documented a moderately displaced right , a displaced right and , and of the , phalanx of the left thumb. The report also documented acute , "likely contributed to ". Photographic evidence was obtained. On at 1:20 PM, staff C, caregiver, stated on when she arrived for her 7AM-3PM shift, she found resident #4 on the floor next to his bed complaining of , , and she called the nurse on duty. She stated a mobile , company came during her shift, but the results were not received until after she left. She stated, "We tell the nurse on duty about any incidents we witness. The nurse is responsible for contacting the family, doctors and 911 when necessary. We keep an , on the residents, but the nurses are the only ones who do follow-up and can write notes in the record." On at 3:30 PM, the nursing director confirmed they had not notified AHCA electronically about resident #4's with	A 025		

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A 025	Continued From page 7 . . . . . She confirmed there were limited notes about his , who was contacted and when. Class II	A 025		
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , . . . , which is hereby incorporated by	CZ821		

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CZ821	Continued From page 8 reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

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CZ821	Continued From page 9 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident.	CZ821		

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CZ821	Continued From page 10 d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on resident record review, facility record review, and interview, the facility failed to electronically submit a report to the Agency for Health Care Adminsitration (AHCA) within 1 business day of a resident that resulted in multiple and required transfer to a facility for acute care due to the incident (#4), as required in F.S.429.23(2)(a). Findings: Resident #4's record revealed an admission date of . The health assessment, dated , included diagnoses of , , , and . He required assistance with all activities of daily living, except supervision with eating. He required assistance with self-administration of medications. He was at risk for . He resided	CZ821		

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CZ821	Continued From page 11 in the facility's memory care unit. The facility report, dated .. .... at 1:35 PM, reflected an unwitnessed . The report stated the nurse was notified by a caregiver that the resident was observed on the floor in his bedroom and required medical attention. The report reflected that hospice was notified and the resident was sent to the hospital. It read, "No injuries observed at time of incident....no injuries observed post incident." The facility progress notes for .. .... revealed an entry at 3:23 PM describing the resident's left thumb as ..... and discolored. Hospice was called. The facility was to monitor for changes and hospice would visit the next day. Another note on at 9 PM noted resident #4's left thumb had increased .... and discoloration. Hospice was contacted again, and the nurse would come to facility. On .. .... at 9:27 PM, a note documented an , report was received indicating a ..... of the right ..... Hospice was notified. On at 10:15 PM, the hospice nurse arrived, called emergency medical services and the resident was sent to the hospital for a right ....., possible left thumb and possible right . On at 8:44 PM, a note in the resident's record read, "Resident was observed on his floor in bedroom by care partner. Injuries: none seen." It was not documented to be a late entry note, however the resident was not present in the facility on . Photographic evidence was obtained. Resident #4's hospital record, dated .. .... , reflected a moderately displaced right ... . , a displaced right ... and , and a of the	CZ821		

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CZ821	Continued From page 12 phalanx of the left thumb. The report also documented acute , "likely contributed to ". Photographic evidence was obtained. On at 3:30 PM, the nursing director confirmed they had not submitted an electronic report to the AHCA about resident #4's with . Unclassified	CZ821		