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 _____	05/26/2022

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 Investigations #2022002702 & #2022005886 were conducted on . . . . . and . Alura by Inspired Living had deficiencies at the time of the survey.	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 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 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 observations, record reviews, and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to 2 of 4 sampled residents who eloped from the facility (#1 & #3), and failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for . . and injuries for 1 of 4 sampled residents who experienced repeated . . with injuries (#2). Findings:	A 025		

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A 025	Continued From page 2 1. Resident #1's record revealed a facility admission date of . Documentation in the record indicated the resident's diagnoses were D deficiency, , transient , and . An 1823 health assessment form, dated , indicated the resident was not at risk for elopement. A facility elopement risk assessment, dated , indicated the resident was at minimal risk for elopement. A facility note, dated at 2:18 p.m., indicated the resident was found walking around the first floor without her walker and required direction and assistance to the second-floor activity room. The note revealed that the resident was very as to where she was, what to do, and that she "may need to up level of care". A facility note, dated at 10:45 p.m., indicated the resident was extremely earlier in that shift. The nurse spoke with the resident's family regarding the resident's constant calling. Caregivers were in to see the resident several times without any actual requests from the resident. Review of a facility incident report revealed the report indicated that on at approximately 7:15 p.m., law enforcement returned resident #1 to the facility after the resident was found walking on a 4-lane road that was located approximately one mile from the facility. The incident report indicated the facility's analysis of the incident was that due to the resident's decline, the resident did not remember to sign out of the facility and, it was believed the resident followed a visitor out of the facility. The report indicated the resident was last seen in the facility at approximately 6 p.m. The incident report indicated the facility's corrective	A 025		

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A 025	Continued From page 3	A 025		

action following the elopement was to move the resident to the facility's locked memory care unit. The note indicated the resident was seen walking in the road and law enforcement was called to assist. The resident said she had to leave and that she was afraid. She was returned to the facility, assisted to her apartment, and her family was notified. A facility note, dated at 10:50 p.m., indicated the resident was and pushed her call pendant several times within a short period of time asking staff to stay with her.

A facility elopement risk assessment, dated , indicated the resident was at minimal risk for elopement.

A facility note, dated at 10:48 a.m., indicated the resident was now living in the secured memory care unit.

An 1823 assessment form, dated , indicated the resident had , cognition, short-term memory loss, and was at risk for both and elopement.

On at 3:26 p.m., Nurse C said that on she became aware of a commotion that involved resident #1. The nurse responded to where the resident was reported to have been found, which was approximately one-half mile from the facility and on the opposite side of the two-lane road that ran in front of the facility. The nurse said when she arrived, there were two police officers, and the nurse understood that a citizen first saw the resident and contacted law enforcement. The nurse said that although the resident used a walker, she did not have it with her at the time. The nurse said the resident was fully clothed with shoes on, and when the nurse

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A 025	Continued From page 4 asked the resident why she left the facility, the resident responded that she needed to get a hold of her family member. The nurse said she did not see any visible injuries on the resident. The nurse said she and the police officers walked with the resident to the facility. The nurse then assisted the resident to her apartment, retrieved some of the resident's belongings, then assisted the resident to the memory care unit. On . . . . . at 4:47 p.m., Nurse H said that on , resident #1 lived at the facility for only two days and "was already acting weird". The nurse then said, "I knew something was gonna happen with her and it did." She then said regarding the resident's elopement, "it was in the 30's (temperature) outside at that time and she did not have on a coat." On at 1:57 p.m., the administrator said when resident #1 eloped, "she was only going for a walk" and said none of the staff knew the resident went for a walk". 2. Resident #3's record revealed that he was admitted to the secured memory care unit on . . . . . The record revealed diagnoses including . . . . . An 1823 assessment form, dated . . . . . , indicated the resident was not at risk for elopement and no other safety precautions were noted. Facility elopement risk assessments dated and , both indicated the resident's risk for elopement was minimal. A facility note, dated at 2:15 p.m., indicated the resident was moving furniture in the hallway. He pushed through some visitors, then ran out of the memory care unit and onto the front porch of the facility. He hit and kicked the staff who tried to re-direct him into the memory	A 025		

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A 025	Continued From page 5 care unit. A facility note, dated at 11:42 p.m., indicated the resident was seen exit-seeking several times and staff redirected him. A facility note, dated at 1:49 p.m., indicated the resident was very aggressive while trying to exit seek. He swung his arms at staff and other residents, walked at a rapid pace around the unit, and went in and out of rooms. A facility note, dated at 1:49 p.m., indicated the resident spit on other residents' clean laundry. He walked up and down the hallways, attempted to open windows in resident rooms, and attempted to exit through all of the egress doors. A facility note, dated at 7:30 a.m., indicated a resident was heard screaming. A nurse observed this resident outside of another resident's room and the two of them were struggling with each other over a plastic elephant. The other resident said resident #3 entered the room, took the elephant, then tried to exit the room through the window. The nurse instructed resident #3 to return the elephant, but he proceeded to enter the room then tried to exit through the window. The nurse redirected him from the room. A facility note, dated at 11:05 a.m., indicated that a staff member saw the resident in the parking lot, ran out to get him, and was able to get the resident to follow her inside. The resident's family member was notified, and they picked the resident up to take him to their house for the holiday.	A 025		

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A 025	Continued From page 6 A facility note, dated at 4:31 p.m., indicated the resident returned to the facility from the family's home. A one-on-one sitter was not available, but one would be provided by a home health agency on at 7 a.m. Facility staff would continue to conduct safety checks. A facility note, dated at 6 p.m., indicated the resident had increased exit-seeking behavior and tried to exit through all the doors. He twisted a nurse's and was verbally redirected, which was ineffective. His family was notified. A facility elopement risk assessment, dated , indicated the resident was at risk. A facility note, dated at 1:45 p.m., indicated the resident was seen climbing onto a chair then falling off. He sustained an on the of his and under his . A facility note, dated at 7:39 p.m., indicated the resident was aimlessly around. He pulled and yanked on locked doors, demanded that staff open them, demanded that staff sit on the floor, and kicked doors. A one-on-one sitter was present with the resident. A facility note, dated at 7 p.m., indicated the resident had increased exit-seeking and aggressive behaviors. He attempted to exit the memory care unit when a visitor was leaving. A facility note, dated at 11:40 a.m., indicated the resident made repeated attempts to leave. A facility note, dated at 5 p.m., indicated the resident was sent to the hospital due to a change in mental status and aggressive behavior.	A 025		

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A 025	Continued From page 7 A facility note, dated at 9 a.m., indicated the resident's family moved his belongings out of the facility. On at 3:55 p.m., Caregiver E said when resident #3 exhibited and exit-seeking behavior, she redirected him. On at 4:05 p.m., Activities staff G said it was she who saw resident #3 in the parking lot on . She said that prior to that, she went into another resident's room and saw that one of the windows in the room was open wide, the screen was on the ground outside, and the window blinds were on the room floor in front of the window. It was at that time she realized she had not recently seen resident #3. She immediately exited the unit through doors that led to the outside of the right side of the facility. She proceeded to walk around to the front of the building, where she saw resident #3 walking towards her and coming from the direction of the left side of the facility. She met up with the resident, then instructed him to follow her into the facility, which he did. Staff G showed the window she referred to. A screw was seen partially sticking out of the inside of the bottom frame of the window, which prevented the window from being opened. On at 10:25 a.m., Caregiver I said that on she saw resident #3 at breakfast then last saw him pacing around the unit at a time that she could not remember. She said when the resident exhibited and exit-seeking behavior, she tried to calm him down and to busy him with something else. However, she said the resident's aggressive behavior escalated to the point in which she just gave him space.	A 025		

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A 025	Continued From page 8	A 025		

On at 12:23 p.m., Caregiver J said that on , she last saw resident #3 on a hallway but she could not remember an exact time.

On at 1:44 p.m., the Maintenance Director said that prior to resident #3's elopement, each memory care window had a vinyl/composite material in the inside of the bottom frame to prevent the window from opening. The Maintenance Director said he believed resident #3 forced the window open enough to where it lifted up and over the vinyl/composite material, which then allowed the window to be fully open and the resident to exit the unit. He said that after the elopement, he put a screw in the bottom of each window frame to prevent the ability to open the windows. He said each egress door alarm was checked every Friday. He said the facility had a camera at each memory care unit egress door and although he viewed the footage from each one, he did not see resident #3 exit the unit that way.

3. Resident #2's record revealed a facility admission date of . The resident's diagnoses included . She had tremors and right-sided . The resident lived in the facility's secured memory care unit.

Facility risk assessments, dated and , both indicated the resident's risk was minimal.

A facility note, dated at 11:18 p.m., indicated the resident was found in a supine position on the floor in front of her bed. She was covered with a blanket and thought she was in bed. Staff were instructed to provide constant safety monitoring.

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A 025	Continued From page 9 A facility note, dated at 9:25 p.m., indicated the resident was found on the floor, on her with her up. A facility note, dated at 11:08 p.m., indicated the resident was found on her on the floor in front of her toilet. An assistive bar was on the floor in front of her. A facility note, dated at 8:03 a.m., indicated the resident was found on the floor near her armchair. came from her . Emergency Medical Services ( ) was called, and the resident was taken to the hospital. Emergency Room discharge instructions, dated , indicated the resident was seen for a minor closed injury, and were placed. A facility note, dated at 6:10 p.m., indicated the resident returned to the facility from the hospital. She had stitches on her left forehead, an with discoloration on her lower right , , and an on the top of her , . A runner rug, bunched up near her chair, was removed. Facility risk assessments, dated and , both indicated the resident was at risk for . A facility note, dated at 3:13 p.m., indicated the resident was found sitting on the floor next to her bed. A facility note, dated at 10:50 p.m., indicated the resident was found on the floor on her . A was seen on the of her , was called and she was taken to the hospital. Emergency Room discharge instructions, dated , indicated	A 025		

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A 025	Continued From page 10 the resident was seen for a superficial . . . . . to the , , and staples were placed. A facility note, dated . . . . . , indicated the resident returned to the facility from the hospital. A facility note, dated at 11 a.m., indicated the resident in her bathroom while trying to remove wet clothing. She lost her balance and onto her . . . . . . A facility risk assessment, dated . . . . . , indicated the resident's risk for was minimal. A facility note, dated at 2:43 p.m., indicated the resident was found on her right side on the floor near the entrance of the memory care unit and the water cooler. Her walker was not with her. She sustained a on the right side of her . . . . . was called and she was taken to the hospital. A hospital health care provider's note, dated . . . . . , indicated the resident was there with a injury following a ; the resident sustained a . . . . . . A facility note, dated at 10:29 p.m., indicated the resident returned from the hospital. She had dark purple discoloration around both , an . . . . on her forehead, and dark purple discoloration on her left cheek. A , , . , ( ) evaluation was completed on . . . . . . A facility note, dated . . . . . at 10:10 a.m., indicated the resident's shoe slipped off and she . . . . onto the floor. A discharge note, dated . . . . . , indicated the resident was discharged secondary to reaching her maximum physical rehabilitation potential at that time due to her poor rehab potential and	A 025		

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A 025	Continued From page 11 , . . . cognition. Her goals were not met and at the time of the discharge, she required supervision with transfers, activities of daily living, and mobility for safety due to her , cognition. A facility note, dated . . . . . at 7:20 a.m., indicated the resident was found on her on the dining room floor. . . . . came from the . . . of her . Her walker was against the wall, her chair was pulled away from the table, and she was barefoot. was called and she was taken to the hospital. A facility note, dated . . . . . at 3:30 p.m., indicated that a follow-up call was made to the hospital, and it was learned the resident had five staples placed in the of her . . . . At the time of the survey, the resident had not returned from that hospital visit. On at 3:26 p.m., Nurse C said she did not recall resident #2 being at risk for . . She said resident #2 ambulated with a walker, which she oftentimes did not use. She said the resident was aphasic, pleasant, and , . On at 3:45 p.m., Nurse D said to prevent resident #2 from falling, the nurse gave the resident her walker when the nurse saw the resident not using it, and she assisted the resident to and from meals. The nurse said the resident did use her pendant to call for assistance with toileting and getting ready for bed. On at 3:55 p.m., Caregiver E said to prevent resident #2 from falling, she always made sure the resident had her walker. The caregiver said the resident stumbled at times, so the caregiver helped the resident to regain her	A 025		

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A 025	Continued From page 12 balance. On . . . . . at 12:23 p.m., Caregiver J said resident #2 was unsteady on her and oftentimes did not use her walker. To prevent the resident from falling, the caregiver provided the resident with reminders. On . . . . . at 1:57 p.m., the Administrator said, "We really can't control someone from falling." She said the facility's _ interventions for resident #2 included , , , , evaluation, a walker, and resident reminders. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make,	A 032		

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A 032	Continued From page 13 at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.	A 032		

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 _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 032	Continued From page 14 This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow its resident elopement policy when 2 of 4 sampled residents eloped from the facility (#1 & #3). Findings: Resident #1's record revealed documentation that the resident eloped from the facility on . Resident #3's record revealed documentation that indicated the resident eloped from the facility on . The facility's resident Elopement policies and procedures, modified on ..... , read in step 2 that "The health and wellness director (HWD) complete appropriate documentation in the resident's record including: date and time resident was discovered missing, when resident was last seen, resident's condition prior to elopement, status upon finding resident, family and health care provider notification, and orders received." Both resident #1's and #3's record did not contain the documentation that was outlined in step 2 of that portion of the policy. A request was made of the Administrator on ..... at 10:15 a.m. to provide that documentation. At 12:55 p.m., the Administrator said the requested documentation was never completed because the person who was the HWD at the time of both resident's elopement was new to the position and, since both elopements occurred on a weekend, the HWD was not present in the facility. However, when	A 032		

Agency for Health Care Administration

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A 032	Continued From page 15 asked whether the HWD worked the week following the elopements, the administrator said "yes". Class III	A 032		