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 _____	08/03/2022

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 Investigation #2022009683 and a Generator Monitoring were conducted on . Alura by Inspired Living had a deficiency 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 1 of 4 sampled residents who eloped from the facility (#4). Findings: Review of resident #4's record revealed a facility admission date of . An 1823 health assessment, dated , indicated the resident's diagnosis was . The form also indicated the resident was "alert & oriented x 1", required supervision with	A 025		

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A 025	Continued From page 2 ambulation, and was not considered an elopement risk. Review of the facility's "Elopement, , Missing Resident" policy, dated and modified on , indicated the following: "Definition of elopement: an incident in which a resident leaves the community without community employees' knowledge. This applies especially when a resident has , decision-making abilities and is unaware of his/her own safety and needs . . . Residents have a right to live at ease, in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce the risk of elopement by residents. The community will identify residents at risk for elopement to minimize resident's safety risks . . . residents who score greater than 9 on the elopement risk management form are considered at risk for elopement." Review of resident #4's Elopement Risk Management forms revealed the following Elopement Risk scores: . . . . . = 9; . . . = 11; = 15. Review of a health care provider's visit note, dated . . . . . , revealed the resident had advanced . A facility note dated at 6:24 AM indicated the resident attempted leave the memory care exit door, which set off the door alarm. The resident was redirected from the door and taken to the common area. The resident then returned to the . . . door, exited the building, and walked around to the facility's main front door. The resident was brought . . . inside.	A 025		

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A 025	Continued From page 3 A facility report, dated . . . . . , indicated that on at 6:24 A.M., Caregiver A reported to the Director of Nursing (DON) that resident #4 set off an exit door alarm in the Memory Care unit at approximately 6:01 AM, and was then redirected to the common area by Caregiver E. After staff completed morning rounds, they went to the common area to check on resident #4 but she was not there. A caregiver immediately alerted all care staff via radio to begin a search for the resident in all apartments and common areas in the Memory Care unit. Caregiver E went outside of the community and found the resident at the front door of the community. The resident was brought . . . into the Memory Care unit where Caregiver A looked at the resident and determined the resident had no apparent injuries. The facility's analysis of the incident was that the resident got up early and did not realize that she was going out of the egress doors. She normally went out to the enclosed courtyard. The resident attempted to go out of the egress doors, the alarm sounded, and she was redirected. The exit door was not properly reset by a new employee. The resident again went out of the exit door and went outside. The facility's corrective action was that staff were given an in-service on . . . . . and on . and elopement. Staff were in-serviced on how to properly latch and reset the exit door. Elopement drills would continue to be performed monthly on all shifts. A facility note dated . . . . . at 3:10 PM indicated the resident was seen pushing on the exit door, which set off the door alarm. The resident was easily redirected away from the door. During an interview with Caregiver A on at 1:40 PM, the caregiver said that on . . . . . she worked the 11 PM - 7 AM shift on the	A 025		

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A 025	Continued From page 4	A 025		

assisted living side of the facility. She said that on the morning of , she received an alert on her phone that indicated a Memory Care unit door had been opened. She called over the radio and learned that resident #4 opened the door. Afterward, Caregiver A was not sure of the time, she went to Memory Care unit because the door alert was still showing on her phone. When she arrived on the Memory Care unit, she saw both Caregivers C and E looking for resident #4. Caregiver A said she called for staff working on the assisted living side to join in the search. Caregiver A said she looked outside but did not see the resident.

On at 2:52 PM, Caregiver E said that on the morning of , he assisted resident #4 out of bed and placed her in the common area. He was in another resident's room providing morning care when he heard a door alarm sound. He responded to the alarm and found resident #4 there, whom he redirected to the common area. After completing the other residents' care, he went to the common area to check on resident #4 but she was not there, and he could not find her elsewhere on the unit. Caregiver E said that when he first redirected resident #4 away from the door, he closed it and heard it latch, which he believed would automatically reset the audible alarm. He said an audible alarm did not sound when the resident exited the door the second time. He said he later learned that to reset the alarm, he had to do so through a phone application, which he said he did not receive training. He said following the resident's elopement, he received elopement training, participated in an elopement drill, and was taught how to reset the alarm.

On at 3:15 PM, staff showed that to exit the Memory Care unit, resident #4 had to go

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A 025	Continued From page 5 through two doors, the first of which had an audible alarm and the second had an alarm that was only sent to the staff's phones. The DON said that prior to the resident's elopement, the resident did not exhibit exit-seeking behavior. The DON said that Caregiver E did not have his phone with him when the resident eloped and therefore, would not have been alerted when the resident exited through the second door. The DON said that despite Caregiver E saying the first door latched when he closed it, that could not have been true because had it latched, the audible alarm would have automatically reset. At that time, a camera was seen mounted over the inside of the first door. The DON said the facility was unable to obtain footage of the resident's elopement. On . . . . . at 3:54 PM, the Administrator said the application for the door alarms could be accessed by staff on either their phone or on a computer that was located on the unit. She said new staff were given a username and password for the application (app) during orientation and the Maintenance Director provided the training on its use. The Administrator said the training was not documented. She said the facility's cameras were not working on the day resident #4 eloped. The DON said that Caregiver E was trained on the use of the app, but Caregiver E did not have his phone with him when the resident eloped. On . . . . . at 4:26 PM, the Maintenance Director said that during new staff orientation, he brings up the topic of the alarm app, but other administrative staff gave training on its use. Class II	A 025		