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 _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALURA SENIOR 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 #2022013612 and #2022015431 were conducted on [redacted]. Alura Senior Living had deficiencies identified at the time of 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 [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 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		

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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 interviews and record reviews, the facility failed to provide adequate supervision and provide care and services appropriate to meet the needs of residents by failing to ensure safety through proactive measures to minimize the potential for . . and injuries for 2 of 4 sampled residents who experienced with injuries (#2 & #5). Findings: 1. Resident #2's record revealed she was admitted on to the memory care unit. Her record contained a Resident Health Assessment form (1823) dated . Her	A 025		

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A 025	Continued From page 2 diagnoses included a history of [redacted] of right [redacted], skin [redacted] to the [redacted], short term memory [redacted], and [redacted]. She required supervision for eating and grooming. She needed assistance with ambulating, transferring, bathing, and [redacted]. Her record contained a physician's order to wear a helmet at all times due to [redacted] of the [redacted] and [redacted], check every shift. Her record contained facility notes as follows: On [redacted] at 10:19 AM, the resident was found sitting on the floor. On [redacted] at 7:20 PM, the resident was found on the floor sitting against the couch. On [redacted] at 3 AM, the resident was found sitting on the floor with her [redacted] against her mattress. On [redacted] at 5 AM, the resident's pendant call bell was answered by a caregiver. The resident was found sitting on the floor next to her bed. Family and the director of nursing (DON) to be notified by [redacted] shift. On [redacted] at 6 AM, the resident was found on the floor between the 2 beds. She hit her [redacted] on the end table and sustained a 5-inch [redacted] to her right [redacted] area. She was transferred via ambulance to the hospital. Facility intervention documented a pressure [redacted] was applied to the [redacted] to prevent further [redacted]. On [redacted] at 12:23 PM, the resident was found on the floor on her [redacted] in her room. She was transferred to the hospital via ambulance with a hematoma to her right forehead and right [redacted]. Resident #2 had not returned to the facility at the time of survey. The resident's record did not contain an incident report. "A hematoma . . . is a localized [redacted] outside of	A 025		

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A 025	Continued From page 3 , due to either or ." (wikipedia.org). On at 3:47 PM, the DON documented she spoke to the resident's Power of Attorney. Resident #2 remained in a rehabilitation facility due to a possible or side effect of a . On at 4 PM, the Administrator and the DON said the resident continuously refused to wear a helmet. They confirmed resident #2 had multiple even with increased safety checks. They confirmed resident #2 remained out of the facility after a on which resulted in a injury requiring her to be transferred to the hospital for treatment. There was no documentation other than safety checks of measures to minimize the potential for and injuries. 2. Resident #5's record revealed she was admitted on into the memory care unit. Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included risk, , tremor, , and hard of hearing. She was awake, alert, and oriented x1 to self. She required assistance with ambulation, transferring, bathing, , and grooming Her record contained facility notes as follows: On at 4:56 pm, the resident was sitting on the floor with her against the bed. There was on the floor and her clothes from a to the of her . She was transferred via ambulance to the hospital. She received 8 staples to the and returned to the facility at 10:09 PM. Facility intervention was documented as increased safety	A 025		

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A 025	Continued From page 4 checks. There were no time frames documented. On , the resident's son, a physician, removed the staples from resident's . On at 9:40 AM, the resident was observed on the floor on her on the side of the bed. No apparent injuries were noted. On at 2:51 PM, the resident was observed sitting on the floor in the common area. On at 3:19 PM, the resident was found on the floor in the dining room. She was transferred via ambulance to the hospital due to a bump on the of her . She returned to the facility with a diagnosis of nondisplaced , . The facility intervention was documented as "sent to hospital via 911". On at 4:30 PM, the resident slipped out of the wheelchair while a staff member was wheeling her. She landed on her . No injuries were identified. On at 4 PM, the Administrator and the DON confirmed resident #5 had multiple even with increased safety checks. Other than safety checks, there was no other documentation of other measures put in place to reduce the resident's . 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.,	CZ821		

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CZ821	Continued From page 5 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 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	CZ821		

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CZ821	Continued From page 6 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. 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.	CZ821		

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CZ821	Continued From page 7 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. 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	CZ821		

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CZ821	Continued From page 8 assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit an adverse incident report for 1 of 4 sampled residents (#2). Findings: Resident #2's record revealed she was admitted on to the memory care unit. Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included a history of of right , skin to , short term memory , and . She required supervision for eating and grooming. She needed assistance with ambulating, transferring, bathing, and . Her record contained a physician's order to wear a helmet at all times due of the , and , check every shift. Her record contained facility notes as follows: On at 3:47 PM, the Director of Nursing (DON) documented she spoke to the resident's Power of Attorney. Resident #2 remained in a rehab facility due to a possible or side effect of . On at 12:23 PM, the resident was found on the floor on her in her room. She was transferred to the hospital via ambulance with a hematoma to her right forehead and right . Resident #2 had not returned to the facility at the time of survey. Residents record did not contain an Incident Report.	CZ821		

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CZ821	Continued From page 9 On ... . at 4 PM, the Administrator and the DON confirmed there was no Adverse Incident Report submitted for resident #2. They said they did not report the incident because they did not think it was adverse because the resident did not have a . They explained that the resident continuously refused to wear a helmet. They confirmed resident #2 had multiple . . The facility's policy on Adverse Incident reporting was requested. They were unable to provide one. Unclassified	CZ821		