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 _____	02/01/2023

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 Investigation #2023000647 was conducted on , and . Additional information was obtained on . Alura Senior Living had deficiencies identified at the time of the survey.	A 000		
A 025 SS=J	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	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 resident diets in accordance with Rule 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 observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and monitor the general health, safety, and physical wellbeing of 2 of 7 sampled residents who sustained . . . . . and . . injuries to which the facility could not provide an explanation as to the cause (#1 & #4). Findings: 1. Resident #1's record revealed she was admitted on to the memory care unit. Her	A 025		

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A 025	Continued From page 2 Resident Health Assessment form (1823) was dated . She required assistance with all activities of daily living including assistance with self-administration of medications. She was oriented times only to self. She was under Hospice care and was a risk. Her diagnoses included with behavioral disturbance, , , , and elevated , without a diagnosis of , . Review of facility notes revealed resident #1 had multiple since admission. A facility incident report indicated that on at approximately 11 AM resident #1 was in her room. Her daughter arrived and stated that she observed her mother sitting in her wheelchair with injuries. The daughter came out of the room with her mother, pushing her in the wheelchair. She got Nurse A's attention and showed her the condition of her mother. Nurse A stated she noticed her entire forehead was discolored, she had two scratches on the right side of her forehead, her lower , was split, and . Her upper , was , and her was discolored. She also had scratches on both sides of her forehead, and on the sides of her . On at 9:55 AM, the Executive Director said Caregiver E was the only caregiver in the memory care unit on because of staff calling out. There were 20 residents in the memory care unit that day. The Executive Director said Nurse A was the nurse assigned to memory care and assisted Caregiver E and passed medication. She said there was an ongoing criminal investigation with the Rockledge Police Department involving this incident. She said she reported the incident to the DCF, but they did not accept it. She said Caregiver C was	A 025		

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terminated on . . . . . because he did not come to the facility to give a statement to the police. Caregiver E resigned on . . . . . because he was alone in the memory care unit again. The Executive Director said on . . . . . at approximately 11 AM, resident #1 was brought to the nurses' station by her daughter. Resident #1 had above her right and left , and on her . . . . She had a cut on her , with dried . . . and on her . The daughter asked Nurse A and Caregiver E what had happened. They responded that they did not know, and they were not aware of any . . or incidents involving resident #1. The resident's daughter transported her to a local hospital where she was diagnosed with hematomas.

On at 12 PM, the DCF investigator said there was an ongoing case, but the Rockledge police officer asked him not to go to the facility until she completed her investigation.

On . . . . at 1:15 PM, Nurse A said she worked in the memory care unit on . She said she gave resident #1 her medication crushed in applesauce between 8 AM and 9 AM. She did not notice any injuries at that time. She said the resident was asleep and she did not think she had breakfast. Nurse A said she did not dress her or put her in the wheelchair. Between 10:30 AM and 11 AM, the daughter of resident #1 arrived at the facility and brought her mother to the common area in a wheelchair. Resident #1 was dressed and ready to go out. The daughter questioned Nurse A about her mother's injuries. Nurse A said resident #1 had discoloration to her forehead, a split , with dry . . . . , a . . . . on her , and scratches on both . Resident #1 was visibly upset and crying. Because of her , resident #1 was unable to verbalize

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A 025	Continued From page 4 what happened. Resident #1's daughter transported resident #1 to a local hospital in her car. Nurse A said she did not hear any residents screaming or fighting that day. Resident #1 would not have been able to get up off the floor if she had without assistance. On at 1:20 PM, Caregiver B said he worked on the assisted living side of the facility on . He said the main nurse's office is in the memory care unit and he had been in the office that day. He would have been able to hear if someone was screaming or yelling. He said Nurse A called him to come to the memory care unit because she needed help. He said resident #1 looked like "someone beat the . . . out of her." He took a picture of her and sent it to the Assistant Director of Nursing (ADON). He said Nurse A and Caregiver E did not know what happened to resident #1. Resident #1's daughter took her to the hospital in her car. He said resident #1 would not have been able to get herself up off the floor if she . . On . . . . . at 2 PM, the Rockledge Police Officer said she was conducting a criminal investigation involving resident #1 and Alura Senior Living staff. On . . . . . at 3:40 PM, the Executive Director, she said she "had no idea" what happened to resident #1 and they may never know. The cameras were working in real time but were not working to recall. She could not review any footage of incident. Based on all the staff statements, she said they did not know how resident #1 was injured. On , the facility policy procedure related to injuries of unknown origin was requested. At 4 PM, the Executive Director said she was unable	A 025		

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A 025	Continued From page 5 to provide a policy for injuries of unknown origin. On at 4:10 PM, the ADON, she said she received a call from Caregiver B on . He sent her a picture of resident #1 via text. The caregiver could not explain how the injuries occurred. The photo of resident #1 provided by the Assistant Director of Nursing (ADON) revealed on the resident's forehead above the right and left , a cut on her lower , with dry , and a on her . She said the staff on duty gave her their statements. Caregiver E gave 2 statements. In the first statement, he said he got resident #1 ready for the day. In the second statement, he documented that he only changed her brief in the morning. He wrote that the resident did not have breakfast because she was asleep. The ADON said she feels the memory care unit is safer now that Caregiver E is not there. She said she could not explain what happened to resident #1. The ADON said the Director of Nursing (DON) and the Executive Director took over the investigation and interviews. On at 4:35 PM via telephone, Caregiver E said he worked in the memory care unit on . He was the only caregiver for 20 residents. He said he had no contact with resident #1. He said he only peeked in the door to make sure she was in her bed asleep. He said he provided no care to resident #1. She slept through breakfast. He said he was very busy with other residents. He saw resident #1 when her daughter brought her to the common area in her wheelchair. He said he did not know how resident #1 was injured. Resident #1's hospital records revealed she was admitted to the hospital on with a	A 025		

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A 025	Continued From page 6 diagnosis of [redacted], and acute right hematoma. She was admitted to the Progressive Care Unit (PCU) with a diagnoses of major closed [redacted] injury, right sided [redacted] hematoma, [redacted], hematuria, and [redacted]. A repeat [redacted] on [redacted] revealed a left sided [redacted] hematoma. On [redacted] at 10:07 AM, resident #1's daughters said her sister went to the facility on [redacted] to pick their mother up for Christmas. She got a call from her sister who said their mother had been injured. She met her sister at the emergency room at the hospital. She said her mother was covered in [redacted] on her [redacted], [redacted], arms, and [redacted]. The [redacted] got worse by the next day. [redacted] on her [redacted] and arms got darker and worse. She said her sister was out of town at the time of survey and she would relay a message to call the surveyor. On [redacted] at 10:40 AM, the Nurse Practitioner for resident #1 said at the hospital, resident #1 had very dark [redacted] on her [redacted] that appeared to be [redacted] marks, and a right and left hematoma. She said, "They even did a [redacted] kit", but that was 3 days after admission. On [redacted] at 11:23 AM, Caregiver J said she was not sure if resident #1 could get herself off the floor if she [redacted]. There was only one time that she knew of her getting herself out of bed and that was a time when her husband put her to bed in an uncomfortable position, so she got out of bed and [redacted]. She was aware of resident #1's history of [redacted] and her [redacted] interventions were to: "go in and get her dressed, tell her what you are about to do, let her help. If she is sitting too long in the wheelchair in the TV room, she will try to get up."	A 025		

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A 025	Continued From page 7 She said she never witnessed staff being aggressive or . On at 11:55 AM, the Executive Director was requested to provide the following: All incident reports for all the sampled residents; All point of care (caregiver) documentation; Any additional documentation of facility investigations regarding resident #1. She said, "the police took everything and told her not to speak with any staff about the resident's incident." Camera footage was requested. The Executive Director said the cameras are not working to recall any footage. They only work in real time. On at 12:57 PM, the ADON said it had never been reported to her that staff were to residents. She said she heard that there were issues with Caregiver E, at other facilities where he worked. She said after the incident involving resident #1, the facility implemented frequent resident monitoring but did not set specific times for the monitoring to be done and they were not documented. On at 1:37 PM, the DON said a previous incident involving Caregiver E was "a while ". Caregiver F, who was no longer employed at the facility, reported that Caregiver E was rough with residents, and he pinched a resident on her . Caregiver F reported it to the nurse, who is no longer employed at the facility, who then emailed it to the DON. She said she no longer had access to that email; she forwarded the email to the Executive Director. The DON said a meeting was held with both Caregiver E and Caregiver F. During this meeting, Caregiver F said that she did not see Caregiver E pinch the resident but thought his approach with residents could be better. Another Nurse, no longer employed at the	A 025		

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A 025	Continued From page 8	A 025		

facility, reported that Caregiver E was "not good with residents". She said she heard a smacking sound coming from the dining room, and when she went to see what happened, Caregiver E was there and said he was cleaning food off a resident's . The DON said other incidents regarding Caregiver E were reported to DCF. She said following the recent incidents: 1. A second person was hired for memory care to only provide additional oversight from 8 AM-6 PM; 2. Dedicated activities staff were assigned to memory care. 3. Staff rounds were to be done every two hours; 4. Bring the residents out of their rooms; 5. Engage them in activities; 6. Nurses were told to not close the door to the nurses' station; and 7. The DON's office was moved to memory care. She said interventions for resident #1 were hospice, rounds every two hours, a new wheelchair, and a hospital bed. She confirmed resident #1 would not be able to get herself off the floor if she .

On at 2:07 PM, the Business Office Manager said Caregiver E and a kitchen employee previously had words and said Caregiver E cursed at her and swung a knife around. She said an investigation into the incident found no evidence to support her claims. She said Caregiver G and Caregiver E previously had words regarding Caregiver E's mother, who also worked at the facility, but nothing came out of the investigation. Caregiver F once said Caregiver E pinched a resident but then later recanted her statement.

On at 2:20 PM, the Executive Director said there were "two previous occasions where the facility filed a report with DCF that involved [Caregiver E's name]. She said she worked with Caregiver E at another Assisted Living Facility.

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She said Caregiver E was a snitch, so people did not like him. At a previous facility where she and Caregiver E worked, an employee came to work late, Caregiver E reported her, and the Executive Director fired her. That employee came to this facility through hospice and reported to a hospice nurse that Caregiver E was mean to resident #7. An investigation into the incident found nothing. Shortly thereafter, the memory care staff began picking on Caregiver E and bullying him because he was a snitch. Caregiver F told a nurse that he was talking roughly to a resident, was not being nice and was stern. Caregiver F said a resident was being combative and Caregiver E said, "Stop. Stop". Caregiver F said Caregiver E could have been nicer to the resident. The Executive Director said she did not recall an incident where Caregiver E was accused of pinching a resident. She then said the Caregiver F's allegation was reported to DCF, but the report was not accepted by them. When asked for all documents related to investigations and allegations made about Caregiver E, she said the Business Office Manager had the documents but "the police may have taken them when they were here". She denied knowing anything about a nurse making an allegation against Caregiver E. She then said, "I'm the Executive Director. I'm not the one who writes people up. It would be the DON who writes them up. There's a huge race problem. Our two nursing administrators are black, and they found reasons to get rid of white people. A lot of bullying between black and white. I never got involved with disciplinary action with [Caregiver E's name]. I told the Business Office Manager to handle it with the Director of Nursing. No one's telling me the truth (regarding [resident #1's name]). My first thought was it was the daughter . . . I wasn't here on the 24th and 25th. I came in on the 26th. The staff said someone would have had to pick her

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A 025	Continued From page 10 up. The investigators alluded to [Caregiver E's name]." She said the detective told her this on . She said, "He's always outstanding and won awards." She said, "She believed the whole entire nursing staff was not telling her the truth. Then I thought it was another resident because it was reported that he was agitated overnight." Regarding interventions following incident with resident #1 and #4 she said: 1. In-services, keep resident's rooms closed to prevent residents from in; 2. Another staff member hired to work from 10 AM-6 PM to assist with watching residents; 3. Keep the nurses' station room door open; 4. Moved DON's office to memory care. She said, "I feel like the nursing department is not being run properly. The detective told me not to suspend [Caregiver E's name], do not change anything, do not say a word to him, do not move him and do not do anything. The detective said, 'If you decide to suspend him then you'll have to suspend everyone'." The Executive Director said this is the reason Caregiver E was not removed from the staffing schedule. On , a review of the point of care documentation revealed Caregiver E signed that he gave resident #1 a shower on at 7:48 AM. Review of Caregiver E's time sheets revealed he was permitted to work on , 12/127, , , , and . On at 8:40 AM, resident #1's daughter said she arrived at the facility around 10:45 AM on Nurse A and Caregiver B were exiting the memory care unit. She had to call Nurse A to unlock the door. When she entered the memory care unit, she did not see	A 025		

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A 025	Continued From page 11 her mother in the common area where she should have been. She then went to her mother's room and found resident #1 up and dressed in her wheelchair. She was sitting in her room in the dark. When she turned the light on, she noticed the injuries to her mother's and immediately took her to Nurse A. She said Nurse A, Caregiver B, and Caregiver E were unable to explain how her mother was injured. 2. Resident #4's record revealed he was admitted on to the memory care unit. His Resident Health Assessment form (1823) was dated . His diagnoses included , , and . He was a high risk for . He required assistance with ambulation, bathing, and toileting and supervision for , eating, grooming, and transfer. He required assistance with self-administration of medication. Review of the staff schedules revealed Nurse A, Caregiver F and Caregiver G were scheduled in the memory care unit on . A facility report was completed by the ADON. It reflected that on , resident #4 was in his bedroom. It is believed that resident #3 him. Resident #4 was found lying in his bed with a large hematoma to the right side of his . 911 was called and paramedics and police responded. Resident #4 was transported to the hospital. On at 11:30 AM, the ADON said there were no witnesses who saw resident #4 being by resident #3. The staff assumed that was the case because resident #3 had been in an altercation with resident #2 earlier that day. She confirmed resident #4 had been transferred to the	A 025		

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A 025	Continued From page 12 hospital due to a . . . injury. On . . . . . at 1:35 PM via telephone, resident #4's spouse said she had not seen her husband and did not know how he was doing. She did not know how her husband could have been involved in an altercation with another resident. She did know he was in the hospital with a injury. She knew he had a . . . . . hematoma. On . . . . at 2:45 PM, the DON said she had received many different stories and some stories were changing regarding the incident with resident #4. He was found in his bed but there was . . . . on the floor by the . . . of the bed. She was unable to confirm if resident #4 went to breakfast or if he got up that morning. She said Caregiver F found a model airplane wing that belonged to resident #4 in the hallway. Caregiver F discovered resident #4 with injuries when she went to return the airplane wing. The same day, both residents #2 and #3 were discharged home for the safety of the other residents. She confirmed no staff witnessed an altercation between resident #4 and another resident. On at 4 PM, Nurse A said resident #4 was found by Caregiver F who alerted her of his injuries. When she arrived at resident #4's room, she found him in bed with his . . . on the pillow. He had a large hematoma on the left side of his forehead. There was . . . . on the floor at the . . . of his bed. Nurse A left the room to call 911. Nurse A said resident #4 probably could have gotten himself up off the floor. She did not see any other residents around or in his room. Resident #4 was unable to give an accurate account of what happened.	A 025		

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	AL11969870	A. BUILDING: _____ B. WING _____	02/01/2023

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A 025	Continued From page 13 On [redacted] at 4:10 PM, Caregiver B said he entered resident #4's room and saw he had a "goose egg" on his [redacted]. There was [redacted] on the floor. He said he sent someone, not sure who, to get the Executive Director. He said they suspected resident #3 resident #4 because resident #3 had some of resident #4 belongings earlier in the day. Those belongings were found by Caregiver F in the hallway. [redacted] at 10:10 AM, Caregiver H said resident #2 "always did this", then moved both of her [redacted] in a rapid boxing motion. She said he often talked about fighting crime. She said resident #2 and resident #5 did not like resident #3. She said she never saw anything physical occur between resident #2 and any other residents, including resident #3. She said resident #3 "wanted to talk to everybody and liked attention". She said resident #4 "was so sweet. He did not come out of his room much, but he enjoyed activities when he did." On at 10:16 AM, resident #5 said, "A man came in and grabbed me hard on my arm and [resident #2's name] was sitting right there (pointing to a chair in her room) and he got up to help me then he and the man began wrestling on the floor". She did not know the man's name. She said staff were nice to her and never harmed her. On at 11:23 AM, Caregiver J said resident #2 did not exhibit aggressive behavior; he only . She said resident #3 displayed aggressive behavior toward staff but no other residents. On at 11:32 AM, Caregiver G said Caregiver F found resident #4, and said when she entered his room, "There was a lot of	A 025		

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A 025	Continued From page 14 on the floor and a big knot on his . . . ." She said there were no other residents in the room when she entered, and she did not see anyone enter his room on that morning. On at 11:55 AM, the Executive Director said regarding the incident on . . . . involving resident #4, "I gave directive to my ADON and DON to obtain written statements from the staff because I was busy, and I've not received anything . . . from my nursing department yet." Class I	A 025		
A 030 SS=D	59A-36.007(5) FAC; 429.28(. .) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the	A 030		

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A 030	Continued From page 15 Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the	A 030		

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A 030	Continued From page 16 resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from	A 030		

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A 030	Continued From page 17 community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . . . for health care services, the provision of or arrangement of transportation to health care . . . . . , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated	A 030		

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A 030	Continued From page 18 mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State	A 030		

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A 030	Continued From page 19 Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide proper notice of discharge	A 030		

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A 030	Continued From page 20 to 2 of 2 residents sampled (#2 & #3). Findings: 1. Resident #2's record revealed he was admitted on to the memory care unit. His record contained a Resident Health Assessment form (1823) dated . His diagnoses included , and . He was oriented to person only. He required precautions and supervision for bathing, was independent with all other activities of daily living, and needed assistance with self-administration of medication. A facility note dated at 9:53 PM revealed resident #2 was found with his around resident #3's . A facility note revealed that on at 9:07 PM, resident #2 had another altercation with resident #3. Resident #2 was standing in the doorway of the nurses' station. Resident #3 tried to push his way through the doorway of the nurse's station. Resident #2 defended himself by grabbing the resident #3 by the collar and one arm. The nurse was able to intervene. A facility note revealed that on at 11:42 AM resident #2 was observed fighting with resident #3. Both were lying on the hallway floor. Resident #2 had his arm around resident #3's . There was no documentation either resident sustained an injury during this altercation. The resident was discharged from the facility on	A 030		

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A 030	Continued From page 21 to family home. 2. Resident #3's record revealed he was admitted on to the memory care unit. His Resident Health Assessment form (1823), dated , included diagnoses of 's, , and . He required assistance with bathing, , grooming, toileting and supervision for ambulation and eating, was independent with transfer, needed reassuring and redirection, and needed assistance with self-administration of medication. A facility note dated at 12:28 PM by Nurse A revealed she heard someone calling for help in the hallway in the memory care unit. She observed resident #3 fighting with resident #2. Both were lying on the floor. Resident #2 had his arm around resident #3's . The nurse was able to get him to release resident #3. A facility note dated at 5:50 PM revealed that resident #3 pushed his way past resident #2 who was standing in the doorway. The nurse was able to get the 2 men apart immediately and take resident #3 to his room. A facility note as a late entry on at 5:40 AM revealed that resident #3 was involved in an aggressive altercation with resident #2. The nurse took resident #3 to his room. A letter addressed to both resident #2's and #3's family indicated "we are sending you this letter as our official termination notice from Alura Senior Living for . . . (resident name) because . . . (resident name) behavior has presented a danger to the well-being of other residents and associates. He has been physically aggressive towards care associates. This termination is in	A 030		

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A 030	Continued From page 22 accordance with the terms and provisions of Mr. (resident name) residency agreement. This discharge is immediately. You are required to provide a 24-hour private duty companion at your expense while . . . (resident name) remains at the community. If at any time a 24-hour private duty companion is not provide, we reserve the right to contract with a caregiver at your expense. You will need to vacate the residence and remove all belongings. We are available to assist you with arrangements to help make this a smooth transition." Resident name was exactly how it was documented on the notices. The specific resident name was not on the notice. Neither letter contained the required language that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and did not include the statewide toll-free telephone number of the program. The facility's undated policy on , neglect and , read, "Resident on resident contact: in an incident involves resident on resident contact, both residents should be separated and evaluated for a change of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and interventions should be developed to address the behaviors." On at 12:30 PM, the spouse of resident #2 said she was given 24 hours to move her husband out of Alura's memory care unit. She said on she and her daughter were at the facility. They were talking with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), who offered to move her husband's room if she agreed to provide a 24-hour sitter. She said she was going to agree	A 030		

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A 030	Continued From page 23 with the 24-hour sitter, when the administrator interrupted their conversation and said they had to move him. Resident #2 is currently residing at home with his spouse and is now under hospice care. Class III	A 030		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

Agency for Health Care Administration

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A 077	Continued From page 24 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the	A 077		

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A 077	Continued From page 25 individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which	A 077		

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	AL11969870	A. BUILDING: _____ B. WING _____	02/01/2023

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A 077	Continued From page 26 is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility's administrator failed to supervise and maintain the facility including the management of all staff and the provision of appropriate care to all residents by failing to ensure appropriate care and services was provided to meet the needs of residents and to provide adequate supervision and monitor the general health, safety, and physical wellbeing of 2 of 7 sampled residents who sustained [redacted] and [redacted] injuries (#1 & #4), ensure 2 of 7 sampled residents was issued a proper discharge notice that contained all of the required language (#2 & #3), and to ensure the facility had enough qualified staff to provide resident supervision and awareness of the general health, safety, and physical and emotional well-being of 2 of 7 sampled residents who sustained and [redacted] injuries of unknown origin (#1 & #4). Findings: 1. A facility report indicated that on [redacted] at approximately 11 AM, resident #1 was seen by her family member and facility staff to have [redacted] above her right and left [redacted] and both [redacted] and a cut with dried [redacted] on her [redacted]. Record reviews and staff interviews revealed the facility had no documentation to indicate how the resident sustained the injuries and all staff interviewed said they could not explain the cause of the injuries either.	A 077		

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A 077	Continued From page 27 On at 9:55 AM, the Executive Director said Caregiver E was the only caregiver in the memory care unit on because of "staff call outs" and that there were 20 residents in the memory care unit at the time. Nurse A was assigned to memory care; she assisted Caregiver E and passed medication. 2. Record reviews and staff interviews revealed residents #2 and #3 were involved in physical altercations with each other on , and . . . . . A . . . . notice for an immediate facility discharge for both residents indicated the reason for the discharge was their "behavior has presented a danger to the well-being of other residents and associates." Review of the Brevard County clerk of courts public records revealed the administrator was charged with "alter destroy conceal etc evd in proc invest", "false info to LEO re missing pers or fel investing", and subsequently . . . . . on in relation to the incident involving resident #1. Review of the facility's employee background roster on at 10:35 AM revealed the administrator's employment end date was . The administrator is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Chapter 408 Part II, Chapter 429 Part I, Florida Statues, and 59A-35 Florida Administrative Code. This administrator has a history of noncompliance with 429.26(7) FS; 59A-36.007(1) FAC dating	A 077		

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A 077	Continued From page 28 . . . to . . . . Class I	A 077		
A 079 SS=G	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 . 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left	A 079		

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A 079	Continued From page 29 solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making	A 079		

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A 079	Continued From page 30 decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter	A 079		

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A 079	Continued From page 31 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to have enough qualified staff to provide resident supervision and awareness of the general health, safety, and physical and emotional well-being of 2 of 7 sampled residents who sustained and injuries of unknown origin (#1 & #4).	A 079		

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A 079	Continued From page 32 Findings: 1. Resident #1's record revealed she was admitted on to the memory care unit. Her Resident Health Assessment form (1823), dated , reflected that she required assistance with all activities of daily living including assistance with self-administration of medications. She was oriented only to self. She received Hospice care and was a risk. Her diagnoses included with behavioral disturbance, , , , and elevated without a diagnosis of , . Facility notes revealed resident #1 had multiple since admission. A facility report indicated that on at approximately 11 AM, resident #1 was in her room. Her daughter arrived and stated that she observed her mother sitting in her wheelchair with injuries. The daughter came out of the room with her mother, pushing her in the wheelchair. She got Nurse A's attention and showed her the condition of her mother. Nurse A stated she noticed her entire forehead was discolored, she had two scratches on the right side of her forehead, her lower , was split, and . Her upper , was , and her was discolored. She also had scratches on both sides of her forehead, and on the sides of her . The report indicated the facility's analysis of the incident was that resident #1 was found to have a . No . Due to the possible circumstances of the cause of resident's injuries, the amount of information divulged to Alura Senior Living is very limited. Resident #1 is not able to explain her account of the incident or how her injuries occurred due to	A 079		

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A 079	Continued From page 33 her . . . . . . Based on the information we have received from the investigator involved in the case, the resident is still in critical condition, fighting for her life. It is unknown the causes of the incident or why it occurred. The incident is still under investigation by the Rockledge Police department. On at 9:55 AM, the Executive Director said Caregiver E was the only caregiver in the memory care unit on because of staff call outs. There were 20 residents in the memory care unit. Nurse A was assigned to memory care, and she assisted Caregiver E and passed medication. She said there was an ongoing criminal investigation with the Rockledge Police Department involving resident #1. She said she reported the incident to the Department of Children and Families (DCF), but they did not accept it. She said Caregiver C was terminated on because he did not come to the facility to give a statement to the police. Caregiver E resigned on because he was alone in the memory care unit. The Executive Director said on at approximately 11 AM, resident #1 was brought to the nurses' station by her daughter. Resident #1 had above her right and left , . . , on her . , a cut on her , with dried , and on her . The daughter asked Nurse A and Caregiver E what had happened. They said they did not know and were not aware of any . . or incidents. The resident's daughter transported her to a local hospital where she was diagnosed with . . . . hematomas. The Executive Director said she "did not know what happened" to resident #1 and they "may never know". On at 1:15 PM, Nurse A said she was	A 079		

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A 079	Continued From page 34 working in the memory care unit on . She said she gave resident #1 her medication crushed in applesauce between 8 AM and 9 AM. She did not notice any injuries at that time. She said the resident was asleep and did not think she had breakfast. Nurse A said she did not dress her or put her in the wheelchair. On between 10:30 AM and 11 AM, resident #1's daughter brought the resident to the common area in a wheelchair. Resident #1 was dressed and ready to go out. The daughter questioned Nurse A about her mother's injuries. Nurse A said resident #1 had discoloration to her forehead, a split , with dry , a on her , and scratches on both . Resident #1 was visibly upset and crying. Resident #1 was unable to verbalize what happened. Resident #1's daughter transported resident #1 to a local hospital in her car. Nurse A said she did not hear any residents screaming or fighting that day. She said resident #1 would not have been able to get up off the floor if she had without assistance. On at 1:20 PM, Caregiver B said he was working on the assisted living side of the facility on . He said the main nurse's office is in the memory care unit and he had been in the office that day. He would have been able to hear if someone was screaming or yelling. He said Nurse A called him to come to the memory care unit because she needed help. He said resident #1 looked like "someone beat . . . her." He took a picture of her and sent it to the Assistant Director of Nursing (ADON). He said Nurse A and Caregiver E did not know what happened to resident #1. Resident #1's daughter took her to the hospital in her car. He said resident #1 would not have been able to get herself up off the floor if she . .	A 079		

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A 079	Continued From page 35 On . . . . . at 3:40 PM, the Executive Director said she "had no idea" what happened to resident #1 and they may never know. The cameras were working in real time but were not working to recall. She could not review any footage of incident. She said all the staff statements revealed they did not know how resident #1 was injured. On at 4:10 PM, the ADON said she received a call from Caregiver B on . . . . He sent her a picture of resident #1 via text. The staff could not explain how the injuries occurred. The photo of resident #1 was provided by the ADON. It revealed that resident #1 had . . . . on her forehead above the right and left , . . , a cut on her lower , with dry . . . , and a . . . on her . She said the staff on duty gave her their statements. Caregiver E gave 2 statements. In the first statement, he said he got resident #1 ready for the day. In the second statement. He indicated that he only changed her brief in the morning. He said the resident did not have breakfast because she was asleep. The ADON said she feels the memory care unit is safer now that Caregiver E is not there. She said she could not explain what happened to resident #1. She said the Director of Nursing (DON) and the Executive Director took over the investigation and interviews. On at 4:35 PM via telephone, Caregiver E said he worked in the memory care unit on . He was the only caregiver for 20 residents. He said he had no contact with resident #1. He only peeked in the door to make sure she was in her bed asleep. He said he provided no care to resident #1. She slept through breakfast. He said he was very busy with other residents. He saw resident #1 when her	A 079		

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A 079	Continued From page 36 daughter brought her to the common area in her wheelchair. He did not know how resident #1 was injured. This statement contradicts the 2 written stamens he provided to the facility. On , resident #1's hospital records revealed she was admitted to the hospital on with a diagnosis of , , acute right hematoma. She was admitted to the progressive care unit (PCU) with a diagnoses of major closed injury, right sided hematoma, , hematuria, and . A repeat on revealed a left sided hematoma. On at 10:07 AM, the daughter of resident #1 said her sister went to the facility on to pick their mother up for Christmas. She got a call from her sister who said their mother had been injured. She met her sister at the emergency room at the hospital. She said her mother was covered in on her , , arms, and . The got worse by the next day. The on her and arms got darker and worse. She said her sister was out of town at the time of survey. On at 10:40 AM, the Nurse Practitioner for resident #1 said at the hospital, resident #1 had very dark on her that appeared to be marks. She also had a right and left hematoma. She said, "They even did a kit" but that was 3 days after admission. On at 11:23 AM, Caregiver J said she was not sure if resident #1could get herself off the floor if she . There was only one time that she knew of her getting herself out of bed and that was a time when her husband put her to bed in	A 079		

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A 079	Continued From page 37 an uncomfortable position, so she got out of bed and . She was aware of resident #1 had a history of and her interventions were to "go in and get her dressed, tell her what you are about to do, let her help. If she is sitting too long in the wheelchair in the TV room, she will try to get up." She said she never witnessed staff being aggressive or . On at 11:55 AM, the Executive Director was asked for the following: All incident reports for all the sampled residents; all point of care (caregiver) documentation; and any additional documentation of facility investigations regarding resident #1. She said, "The police took everything and told her not to speak with any staff about the resident #1 incident." She said the cameras are not working to recall any footage, "they only work in real time". On at 12:57 PM, the ADON said it had never been reported to her that staff were to residents. She said she heard that there were issues with Caregiver E, at other facilities where he worked. She said after the incidents involving resident #1, the facility implemented frequent resident monitoring but did not set specific times for the monitoring to be done and they were not documented. On at 1:37 PM, the DON said following the recent incidents: a second person was hired for memory care to only provide additional oversight from 8 AM-6 PM, dedicated activities staff were assigned to memory care, staff rounds were to be done every two hours, staff are to bring the residents out of their rooms, staff were to engage them in activities, nurses told to not close the door to the nurses' station, and the DON's office was moved to memory care. She	A 079		

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A 079	Continued From page 38 said interventions for resident #1 were hospice, rounds every two hours, a new wheelchair, and a hospital bed. She confirmed resident #1 would not be able to get herself off the floor if she . On at 2:20 PM, the Executive Director said regarding interventions following the incident with resident #1 and #4, that they did "in-services, keep residents' rooms closed to prevent residents from in, another staff member was hired to work from 10 AM-6 PM to assist with watching residents, keep the nurses' station room door open, moved the DON's office to memory care. On at 8:40 AM, resident #1's daughter said she arrived at the facility around 10:45 AM. Nurse A and Caregiver B were exiting the memory care unit. She had to call Nurse A to unlock the door. When she entered the memory care unit, she did not see her mother in the common area where she should have been. She then went to her mother's room and found resident #1 up and dressed in her wheelchair, sitting in her room in the dark. When she turned the light on, she noticed the injuries to her mother's and immediately took her to Nurse A. She said Nurse A, Caregiver B, and Caregiver E were unable to explain how her mother was injured. 2. Resident #4's record revealed he was admitted on to the memory care unit. His Resident Health Assessment form (1823), dated , included diagnoses of , , , , , , and . He was a high risk for . He required assistance with ambulation, bathing, and toileting and supervision for , eating,	A 079		

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 _____	02/01/2023

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

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A 079	Continued From page 39 grooming, and transfer, and assistance with self-administration of medication. Review of the staff schedules revealed Nurse A, Caregiver F and Caregiver G were scheduled in the memory care unit on . A facility report, completed by the ADON, reflected that on , resident #4 was in his bedroom. It read, "It is believed that resident #3 him. [Resident #4's name] was found lying in his bed with a large hematoma to the right side of his . 911 was called and paramedics and police responded. [Resident #4's name] was transported to the Hospital." On at 11:30 AM, the ADON said there were no witnesses who saw resident #4 being by resident #3. The staff assumed that was the case because resident #3 had been in an altercation with resident #2 earlier that day. She confirmed resident #4 had been transferred from the hospital due to a injury. On at 1:35 PM via telephone, resident #4's spouse said she had not seen her husband and she did not know how he was doing. She did not know how her husband could have been involved in an altercation with another resident. She did know he was in the hospital with a injury. She knew he had a hematoma. On at 2:45 PM, the DON said she had received many different stories and some stories were changing regarding the incident with resident #4. He was found in his bed but there was on the floor by the of the bed. She was unable to confirm if resident #4 went to breakfast or if he got up that morning. She said Caregiver F found a model airplane wing that	A 079		

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A 079	Continued From page 40	A 079		

belonged to resident #4 in the hallway. Caregiver F discovered resident #4 with injuries when she went to return the airplane wing.

On . . . at 4 PM, Nurse A said resident #4 was found by Caregiver F who alerted her of his injuries. When she arrived at resident #4 room, she found him in bed with his on the pillow. He had a large hematoma on the left side of his forehead. There was on the floor at the of his bed. Nurse A left the room to call 911. She said resident #4 probably could have gotten himself up off the floor. She did not see any other residents around or in his room. Resident #4 was unable to give an accurate account of what happened.

On at 4:10 PM, Caregiver B said he entered resident #4 room and saw he had a "goose egg" on his . There was on the floor. He said he sent someone, not sure who, to get the Executive Director. He said they suspected resident #3 . . . . . resident #4 because resident #3 had some of resident #4 belongings earlier in the day. Those belongings were found by Caregiver F in the hallway.

On at 11:32 AM, Caregiver G said Caregiver F was the one who found resident #4 and when she entered his room, "there was a lot of . . . on the floor and a big knot on his . . . ". She said there were no other residents in the room when she entered, and she did not see any enter his room on that morning.

On at 11:55 AM, the Executive Director said regarding resident #4, "I gave directive to my ADON and DON to obtain written statements from the staff because I was busy, and I've not received anything from my nursing

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A 079	Continued From page 41 department yet." The facility did not have sufficient staff to meet the needs of the residents to provide adequate supervision. According to the above statements, there was one staff who was left alone in the memory care unit to care of 20 residents alone. This resulted in a resident #1 having to be transported to higher level of care to due to injuries sustain that no one could explain. On [redacted], another resident sustained a injury that required him to be transferred to a higher level of care and to date, no one knows what happened to resident #4. Resident #4 remains in the hospital. Class II	A 079		