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 _____	R 04/18/2023

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 Revisit to Complaint Investigations #2022013612 and #2022015431 was conducted on 4/17/2023 and 4/18/2023. Alura Senior Living Assisted Living had a deficiency uncorrected at the time of the visit.	{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	{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: DEFICIENCY REMAINED UNCORRECTED Based on observations, record reviews and interviews, the facility failed to provide adequate supervision to 1 of 14 sampled residents who eloped from the facility's secured memory care unit (#28), failed to 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 1 of 14 sampled residents (#8), and failed to document a significant change for 1 of 14 sampled resident's record when the resident was admitted on Hospice care (#27).	{A 025}		

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{A 025}	Continued From page 2 Findings: 1. Review of resident #26's record revealed a facility admission date of . . . . . An 1823 health assessment form dated indicated her diagnosis was . . . . . and that she was not considered an elopement risk at that time. A and a resident evaluation form indicated the resident did not exhibit elopement risk behaviors at that time. A facility report (documented erroneously under another resident's name) indicated that nurse D was in another resident's room when she was told that someone found resident #28 outside of the facility near the neighborhoods. She then went out the front door and saw an unknown family helping the resident cross the street onto the facility's property. The resident had no apparent injuries. The resident's daughter was notified. The daughter said she was on the phone with the resident when she was away from the facility and that the resident read a sign that read Liberty. It was unknown how the resident exited the facility or how long she'd been gone. The last time the nurse saw her was when she gave her meds at approximately 5:40 pm and was notified of her elopement at approximately 6:20 pm. One on one supervision was placed with her, and all doors were checked to ensure the alarms were working. On . . . . . at 2:15 PM, nurse D said regarding the resident's elopement "it was during dinner time. I put it in my documentation when she got out. I was in a room with another resident. I ran out the front door and I got her. She was right in the front of the building. A guy and a girl were with	{A 025}		

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{A 025}	Continued From page 3	{A 025}		

her. I remember giving her dinner and I gave her medicine. Two residents and I was in the room with one of them. As I was coming out to get the , cuff to take care of the , nurse A said the resident was outside. The last time I saw her, I gave her evening meds. Twenty minutes later a happened. I did not hear a door alarm. I don't really know what happened. She got out, I did not hear the door alarm. I've never seen her push on doors, and she never said she wanted to leave. We have a very large alarm on the door that is now very loud." When asked if she received training after the incident she replied, "I can't remember . . . a new protocol that if a resident is exit seeking, we will put them on a system where we check them every 15 minutes then every 30 minutes then every hour til we know the resident is no longer trying to exit seek."

On at 2:48 PM, nurse A said regarding the elopement, "I was working on the assisted living side. I went down to memory care and then I got a call from the concierge saying there was a resident outside and so I let (nurse B's name) know. I went outside and I saw her walking with a man, woman, and dog who were bringing her . She doesn't know exactly how far she got. We got her to memory care. She was not injured. She was fine. I believe she tried to exit seek sometimes. She had sundowning so in the later part of the afternoon she'd stand by the front desk saying she wanted to go home. That was a cue for us to keep an on her cause she wanted to go. We had elopement drills. We had an in-service about elopements."

On at 2:57 PM, nurse B said regarding the elopement, "I was doing med pass in assisted living. A call came over the radio that the resident

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{A 025}	Continued From page 4 was outside. By the time I got downstairs she was already inside. She would say she wanted to go see family but was easily redirected." The nurse said he did receive elopement training. On at 3:17 PM, concierge C said regarding the elopement, "We had the companion box that alerts when a pendant is going off and when a door is open that should not be. Memory care 172 door showed up. I didn't know which door it was so I contacted someone in plant ops, who said it was a door in memory care that could lead outside. I locked the front sliding doors and ran to memory care. I didn't hear an alarm. I searched the common areas and hallways and did not see any staff either. I returned to the front desk and got a call from her son, who said the resident called him saying she was out in the street. I went out the front sliding doors and saw two people walking with her. I called a staff member who came and brought the resident inside." She said she attended a meeting after the incident where resident elopement was discussed. On at 4:13 PM, caregiver K said regarding the elopement, "I don't remember too much of that because I was in a room helping a resident. She never tried to exit before but did say she wanted to go home. We did an elopement drill. I didn't hear the alarm on the door. They have new alarms now that are way more louder." On at 4:15 PM, the camera footage from the time of the elopement was reviewed. It revealed that on at 5:06 PM the resident approached the door with her walker. She pushed on the door then turned and walked away. At 5:35 PM, she returned to the door, pushed it and the door opened without a delay. She went through	{A 025}		

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{A 025}	Continued From page 5	{A 025}		

the door then turned around and pulled her walker through. At 5:43 PM, concierge C was seen walking by the camera. At 6:15 PM, nurse A was seen bringing the resident into her room, which was and right next to the door she left through.

On at 9:35 AM, the maintenance director said a new screamer alarm was placed on the door following the elopement. In addition, two new cameras were mounted in each memory care corridor and two at the door used by the resident to elope.

Documentation revealed elopement drills were conducted on and .

On at 10:45 AM, a request was made of the Director of Nursing (DON) to provide additional drills and training conducted following the elopement.

On at 11:05 AM, the DON returned and said she was unable to provide more drills or training.

The facility's undated elopement policy indicated a resident elopement drill will be conducted every month for memory care. It also indicated that following an elopement the executive director along with the DON will provide direction to caregiving staff via documented training.

2. Resident #27's record review revealed an admission date of . The last 1823 Health Assessment dated listed diagnoses of , , and abnormal gait. She needed supervision with bathing and . Independent with ambulation,

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{A 025}	Continued From page 6 transferring, eating, grooming and toileting. She needed assistance with self-administration of medications. Resident #27 was admitted to Hospice care on as documented on the interdisciplinary care plan. There were no facility notes documenting the significant change of resident #27 being admitted to Hospice care. Photographic evidence was obtained. On at 2:30 PM, an interview with the DON confirmed the finding. 3. A review of resident #8's record revealed he was admitted on . His diagnoses included , , , and . His record contained a Resident Health Assessment form (1823) dated . He required assistance with ambulation, bathing, and toileting. He was at high risk for . A review of resident #8's facility notes revealed the following: On - "Returned to the facility. Climbed out of bed within 10 minutes of admit." On - "Resident found on the floor during morning rounds - No apparent injury." On - "Resident was found on the floor while caregivers were making rounds. He was transported to the hospital for a medical evaluation. He was , from the side of his . He was admitted to the hospital with a diagnosis of hematoma." On at 1:50 PM, the DON confirmed there were no updates to resident #8's service plan. There were no interventions put in place after he returned from the hospital on . Class II	{A 025}		

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