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
	AL11969314	A. BUILDING: _____ B. WING _____	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO WINTER PARK	2701 HOWELL BRANCH RD WINTER PARK, FL 32792

(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
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., 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.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 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 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	CZ821		

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CZ821	Continued From page 2 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. 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	CZ821		

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CZ821	Continued From page 3 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 assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to electronically submit a day 1 adverse incident report to the agency and a 15-day adverse incident report for 1 of 2 sampled residents (#1) within the specified timeframes as required. Findings: In a review of resident#1's health assessment dated confirmed a medical history of , , history of , , unsteady gait, , , increased memory loss, forgetfulness, , supervision with ambulation and transferring, and assistance with medication self-administration The resident required assistance with daily living to include ambulation, bathing, , eating, self-care, toileting, and transferring, The resident was designated as a risk. There was no care plan in the record to prevent . In a review of the facility notes it revealed the following: Resident had unwitnessed as she was straightening her bed while she was bending	CZ821		

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CZ821	Continued From page 4 forward her were slipping farther apart until she . 911 was called Resident sustained a In a review of the facility incident report dated . The resident while straightening sheets on her bed, The resident was wearing socks on her , while bending forward her began slowly sliding apart and the resident . Displaced , left , . The resident was sent to hospital. In a review of the facility's policy documented to maintain focus on resident care. As part of the program, associates are to report, track and investigate and document the outcome of residents who have . Residents will be assessed quarterly and on a needed basis for risk. When occur the nearest care staff must respond to the resident, if an injury is noted or suspected 911 is called. Once a resident is determined to be a risk every effort to provide each resident with adequate supervision and assistive devices are used to minimize the risk of accidents. This would also be the case for residents who may develop a potential after moving into the community. Every time a resident an incident report, and a investigation form must be completed. In an interview on at 1pm with the administrator, she stated the memory care does not have call buttons. She stated there are videos in the residents' rooms that will alert staff when the resident is a few inches from the floor. She stated resident#1 was prone to . She stated she incurred a on her , due to the incident and was sent to the hospital and then went to rehab. She stated the resident did not have a prevention plan documented. She	CZ821		

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CZ821	Continued From page 5 confirmed the above statements about the and staff being delayed due to a in the video equipment. She stated the equipment has been repaired since then. She stated she did not think that the incident qualified for an adverse incident report even though the resident incurred a , therefore no adverse incidnet report was submitted. Photographic evidence obtained Unclassified	CZ821		
A 000	Initial Comments A complaint (#2025001397) and a generator monitoring was conducted on at Allegro Winter Park. Deficiencies were found 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	A 025		

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A 025	Continued From page 6 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 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:	A 025		

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A 025	Continued From page 7 Based on resident record review, observation and interviews, the facility failed to provide appropriate supervision that resulted in a and injury for 1 of 2 sampled residents. Findings: In a review of resident#1's health assessment dated confirmed a medical history of , , history of , , unsteady gait, , , , increased memory loss, forgetfulness, , supervision with ambulation and transferring, and assistance with medication self-administration The resident required assistance with daily living to include ambulation, bathing, , eating, self-care, toileting, and transferring, The resident was designated as a risk. There was no care plan in the record to prevent from occurring. In a review of the facility notes it revealed the following: 3:35am resident had unwitnessed was observed on her with her on her walker next to the of the bed. The resident had made an attempt to get up on her own. Body check done no apparent . X rays were taken with no . 715 pm Resident had unwitnessed in her room she was observed laying on on the floor due to resident opening door in resident room to the bathroom. No redness or . 10:10pm resident had an unwitnessed . The resident denied hitting her . The resident when entering the bathroom in her room. The resident to the left side after losing balance. 3:08am resident had an unwitnessed . The resident was found flat on her with on the floor next to her bed with a large	A 025		

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A 025	Continued From page 8 . X rays taken of her right arm. Resident had ,, to right cheek and covered to right arm Resident had unwitnessed as she was straightening her bed while she was bending forward her were slipping farther apart until she . 911 was called. The resident sustained a , . In a review of the facility incident report dated , the resident while straightening sheets on her bed. The resident was wearing socks on her , while bending forward her began slowly sliding apart and the resident . Displaced , left , , . The resident was sent to hospital. In a review of the facility's policy revealed to maintain focus on resident care. As part of the program, associates are to report, track and investigate and document the outcome of residents who have . Residents will be assessed quarterly and on a needed basis for risk. When occur the nearest care staff must respond to the resident, if an injury is noted or suspected 911 is called. Once a resident is determined to be a risk every effort to provide each resident with adequate supervision and assistive devices are used to minimize the risk of accidents. This would also be the case for residents who may develop a potential after moving into the community. Every time a resident an incident report, and a investigation form must be completed. Observed facility video from incident dated - 7:45am resident #1 was fixing her bed and against the bed and then to the floor. At 8:04 am staff came into the room to investigate and left to get med tech. The Med Tech entered	A 025		

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A 025	Continued From page 9 the room at 8:06am then left to call emergency services ( ). arrived at 8;30am. In an interview on at 2:30pm with the family member and power of attorney for resident#1, she stated the morning of the incident her mother waited on the floor for 20 minutes after she till someone attended to her. She stated they do not have call buttons in the memory care they have video cameras that record if a resident gets too close to the ground. She stated she never said anything about a call button as they do not use them in memory care. She stated she was told by staff there was a delay with the video and that is why it took so long for her mother to receive assistance. She stated her mother was trying to make the bed when she . She stated her mother was to get care services that are supposed to take care of her, and she should not have been making the bed. She stated her mother ended up with a left , and was admitted to the hospital. She stated she then went to a rehab and 20 days later. She stated the certificate states the cause of was complications with . In an interview on at 11:30am with Staff A, she stated she came into the room to assist the other staff. She stated resident#1 would when she didn't use her walker. She stated the caregiver looked in on her a few minutes before it happened, but she was sleeping so she went to the next resident. She stated the resident right after that and when we saw it on the video the staff went into the residence to assist and call emergency services. She further stated she is not aware of any care plan or prevention plans in place for resident#1. She stated the resident was very active and tried to be	A 025		

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A 025	Continued From page 10	A 025		

independent when walking and transferring even though we would remind her to use her walker or call staff for assistance. She stated she has had multiple before this incident because of her not asking for assistance.

In an interview on at 11:00am with the memory care resident assistant director, stated she was not present during the incident she was off that day. She stated they always have 2 caregivers and med tech on each shift. She stated the capacity was full at the time of the incident. She stated her understanding of the incident and relayed to the family that the resident , the video camera had a delay of 2 minutes, but the staff was there within 5 minutes. She stated a nurse was not available and the staff cannot and are not allowed to move the resident off the floor. She stated emergency services were then called. She stated resident#1 had had a few , but she was continuously reminded to use her walker to prevent the . She stated the residents are checked on every 1 to 2 hours depending on the need of assistance. She stated the memory care does not use call buttons to alert staff. She stated there are video cameras in each room which will go off if the resident is about 4 inches from the floor. She stated apparently there was a video glitch that day of the incident.

In an interview on at 1pm with the administrator, she stated the memory care does not have call buttons. She stated there are videos in the residents' rooms that will alert staff when the resident is a few inches from the floor. She stated resident#1 was prone to . She stated she incurred a on her , due to the incident and was sent to the hospital and then went to rehab. She stated the resident did not have a prevention plan documented. She

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A 025	Continued From page 11 confirmed the above statements about the and staff being delayed due to a in the video equipment. She stated the equipment has been repaired since then. She stated she did not think that the incident qualified for an adverse incident report even though the resident incurred a , therefore no adverse incident report was submitted. Photographic evidence obtained Class II	A 025		