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
	AL11970342	A. BUILDING: _____ B. WING _____	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRO	1290 FEDERAL HWY FORT LAUDERDALE, FL 33304

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A 000	Initial Comments An uannounced Relicensure, Generator Monitoring and Bed Capacity Increase survey was conducted at Allegro on 11/05/2025. Deficiencies were identified related to the Relicensure at the time of survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a) ensure a resident's Health Assessment (AHCA form 1823) was accurate and reflective of the resident's current care needs and diagnosis, for 2 of 2 sampled residents (Resident#4 and 11). b) ensure a resident was reassessed for continued residency after the resident exhibited a signficant health change (including changes in diagnosis and ADLs) and the findings documented on a new AHCA form 1823, for 2 of 2 sampled residents (Resident#4 and 11). The findings included: 1) An observation made during Medication Pass (Med Pass) on between 8:15 AM and 8:35 AM revealed that Staff E (Medication Technician) crushed medication for Resident #4. Further observation revealed Resident #4 is , (resides in the memory care unit), she was observed being assisted and guided to the dining room, so she can be assisted with her breakfast. During an interview with Staff E on 11/05/2025 at 8:27 AM, she was asked why Resident #4 is having her medication crush. Staff E stated Resident #4 has difficulty swallowing her medication, therefore her medications gets crushed. During an interview with the Staff G (Resident Care Director) on at approximately 11:30 AM, she was informed to provide Resident#4's file containing the most updated Health Assessment and Physician's order for	A 010		

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A 010	Continued From page 5 medication crush. A review of Resident #4's file documented that she was admitted on . Further review revealed a Health Assessment signed by a Medical Doctor (MD) with an examination date of documented as follows: a) Diagnoses: , b) Status: c) Activities of Daily Living (ADLs) as: Independent for ambulation, , eating, toileting and transfer. Supervision: bathing and grooming. Review of Resident #4's file revealed no documentation for a Physician's order indicating medication crush. Further review of resident's file revealed the facility progress notes did not document resident was having problems with swallowing medication and /or Physician was notified. During an interview on at approximately 11:30 AM with Staff G, she confirmed Resident #4's did not have a Physician's order for medication crush in her file and an updated -to- health assessment examination from a health care provider documenting change in condition at this time. She acknowledged the findings. No additional documentation was provided during survey. 2) A review of Resident #11's facility files and documents revealed a Resident Health Assessment (AHA Form 1823) dated documented the Resident's diagnosis to include: , retention. It also documented the Resident had , Catherer and required Nursing services for , Catherer.	A 010		

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A 010	Continued From page 6 A review of the Resident's progress notes indicated the following, a) On at 10:10 PM, the facility placed a call to Local Hospital the resident was admitted to local Hospital due to Retention/ of . b) On at 10:09 PM, Resident #11 returned to Facility, alert pleasant and verbally responsive. No distress. No complaints voiced. Verbalized, she was very tired from her hospital stay. Resident was noted with a , Cather in place/ bag. Per Local Hospital case manager stated , to be managed by Community Home Health service. Call placed to community Health spoke who informed writer that someone would come out to see resident tomorrow resident made aware. 1823 and hospital d/c paperwork sent over to guardian. Call placed to Guardian pharmacy who stated medications will be sent out tomorrow. Needs , and attended to via staff. bag removed and bedside drainage bag applied. c) On at 4:18 PM, Resident #11 returned to Facility from Primary Care Physician (PCP) and urologist , , removed at , , No signs of , or discomfort. PCP signed updated Medication List. In an Interview with the Resident Care Director, Staff G, on at 1:20 PM, she stated the resident was admitted to the hospital on due to rention/inflamation of baldder, stated she came into the facility with a , in place, which was placed temporary and it was only in place for 3 days in the facility.	A 010		

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A 010	Continued From page 7 On at 1:20 PM, an updated Health Assessment form (form AHCA 1823) was requested from the Resident Care Director, Staff G, in which she informed, there was not an updated Resident Health Assessment (AHA Form 1823) that reflects the change in condition (, Cathered removed) and due to the recent hospital admission. On at 1:38 PM, the surveyor requested discharge paperwork for , . The Resident Care Director stated she did not have discharged paperwork for , was provided by Primary Care Physician (PCP). No additional information was provided during the interview. Class III	A 010		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no	A 056		

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A 056	Continued From page 8 individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who	A 056		

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A 056	Continued From page 9 receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to provide Physician's order for crush pills for 1 of 5 sampled residents (Resident #4). The findings included: An observation during Medication Pass (Med Pass) on between 8:15 AM and 8:35 AM, Staff E (Medication Technician) was	A 056		

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A 056	Continued From page 10 observed to assist with self-administration of medication to Resident#4. Residetn#4, medication a) , 20 mg capsule, take one capsule by once daily, 7:00 AM. b) , 5mg tablet, take one tablet by once daily, 7:00 AM. c) 10,000mcg tablet, take one tablet by once daily, 7:00 AM. d) Carb 600 mg tablet, take one tablet by once daily, 7:00 AM. e) DOC SOD 100 mg capsule, take one capsule by twice daily, 9:00 AM and 8:00 PM. f) 20 mg tablet, take one tablet by once daily, 9:00 AM. g) , 20 mg tablet, take one tablet by once daily, 9:00 AM. Further observation revealed Staff E used a pill crusher device to crush the resident's pills. After the medication was crushed she proceeded to put medication inside a medication cup with released contents from a softgel capsule mixed with yogurt. During an interview with Staff E at approximately 8:21 AM she was asked why Resident #4 gets her medication crushed. At this time, she stated Resident #4 has difficulty swallowing the medication. During an interview on at approximately 11:30 AM with Staff G (Resident Care Director) she was informed to provide a Physician's order for crush pills and/or any documentation from a health care provider to support Resident #4 can get her medication crushed. At this time, she stated the facility does not have documentation from a health care	A 056		

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A 056	Continued From page 11 provider to support Resident #4's has an order for medication crush. She acknowledged the findings. No additional documentation was provided during survey. During an interview on at approximately 3:30 PM with Staff G and the Administrator they were both informed of the findings and concerns mentioned above. They acknowledged the findings. Class III	A 056		