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 _____	03/11/2026

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 unannounced Complaint investigation, complaint number 2026002648, was conducted at Allegro on - . Deficiencies were identified at the time of survey.	A 000		
A 025	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		

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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 the resident. This was evidenced by the failure to ensure the physical and , , , well-being of 1 of 1 sampled residents, (Resident #1) with and a known history of requiring supervision for safety and prevention. The findings include: Resident #1 was admitted to the facility on	A 025		

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A 025	Continued From page 2	A 025		

and resided in the facility's memory care unit. The resident was enrolled in hospice services on admission.

Review of the Resident Health Assessment Form 1823 dated indicated diagnosis' including , Non- and Collapse, , and . The form further indicated the resident's needs included assistance with ambulation and Activities of Daily Living (ADL). The resident was assessed to be alert with at times. The resident was identified as a risk. Her ADL needs included: Independent with eating, requiring a mechanical soft diet and independent with transferring. Resident#1 required assistance with ambulation, bathing, , toileting and supervision with self-care.

Review of the facility's electronic progress notes for Resident #1 dated indicated staff found the resident asleep lying on the floor in her room. Resident#1 was unable to describe if she and denied any , . The family was notified.

Review of the facility's "Resident Incident Report" dated at 2:15AM staff found Resident #1 on the floor by her bed, denies , . Resident #1 is placed to bed, and unable to describe . The family is notified by phone at 8:15AM.

During an interview conducted with Resident #1's family on starting at 2:33PM she stated that a private video camera was installed in

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the resident's room. She stated she reviewed the video from and observed 2 caregivers, names unknown, place the resident in bed. She stated that she had not been notified by the facility of the incident.

Review of the facility's electronic progress notes for Resident #1 dated at 8:30PM indicated the resident was agitated, yelling, screaming, kicking and attempting to get out of her wheelchair. The note indicates staff redirected the resident and a call was placed to her family in an attempt to calm the resident.

Review of the facility's electronic progress notes for Resident #1 dated at 11:30AM indicated Resident #1 was agitated, screaming out "get away, get away" and kicking. The resident is documented as sliding to the floor from her wheelchair and staff assisting her into her wheelchair. The resident had no apparent injury and the family is notified. Further review revealed no Incident Report was available for review.

Review of the facility's "Resident Incident Report" dated 10:44 PM indicated facility's "SafelyYou" video system was activated and video reviewed. The video revealed the resident was found on her bedroom floor, she denied any , or injury. The family is phoned at 11PM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented - none.

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A 025	Continued From page 4 Review of the facility's "Resident Incident Report" dated at 6:45 PM revealed Resident#1 was attempting to ambulating without assistance and in the activity room. The resident was alert to name and verbally responsive. On assessment, a bump was noted on the of her , Ice was applied and 911 called. The family was notified by phone at 6:55PM. Further review of the report indicated family member was informed of and pending transfer to the hospital for evaluation, the family member is documented as becoming upset and verbally to staff and 911 personnel and refusing transfer of Resident#1. Emergency Medical Service ( ) personnel are documented as arrival at 6:55PM, an assessment was made of the resident and determination of transfer was required. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions noted on report: walker to be left within arm distance, lock wheelchair at all times. During an interview conducted with Resident#1's family on starting at 2:33PM family member left the facility at approximately 6:15 PM on and then received a call that Resident#1 and hit her . The family member stated she requested that personnel wait until she returned to the facility to transfer Resident#1 since the resident had and would not understand what was happening to her. The family member stated that she was only 10 minutes away, but the facility and refused her request.	A 025		

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A 025	Continued From page 5 Review of the facility's electronic progress notes for Resident #1 dated revealed that the resident returned to facility on at 12:30AM. Review of the facility's "Resident Incident Report" dated at 8:00AM the "SafelyYou" video System is activated. The resident is observed on the floor at her room entrance. No injury is noted and the resident denied any . The report indicates that the physician and family are notified at 8:15 AM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. During an interview conducted with Resident#1's family on starting at 2:33PM, the family stated the room video was reviewed and Resident#1 was observed on at 8:05 AM falling her wheelchair which was not locked. Review of the facility's electronic progress notes for Resident #1 dated 12:59PM revealed care staff reported during transfer to her wheelchair Resident#1's left lower sustained injury. The Assistant Resident Service Director (ARSD) is notified and first aid is administered. The family is notified. No incident report is available for review of the injury. During an interview conducted with Resident #1's family on starting at 2:33PM family member stated that a call is received from the	A 025		

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A 025	Continued From page 6 nurse notifying her that that an injury to Resident#1 lower left ⌄ as occurred. The family member stated that an "aide in training" banged Resident#1's ⌄ with the wheelchair ⌄ rest creating a "nasty " which then turned into an . The family stated that the resident was forced to stay in her wheelchair by facility staff. Review of the facility's "Resident Incident Report" dated 5:50AM revealed staff performing rounds and found Resident#1 on the floor outside her apartment. Resident#1 denied , . The family is phoned at 10:30AM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. Comments: Walker within reach, wheelchair, pendant device given to the resident. No further documentation is noted. Review of the facility's electronic progress notes for Resident #1 dated on indicated Resident#1 is seen by the hospice nurse for care and ⌄ changed. Review of the facility's "Resident Incident Report" dated on 2PM revealed Resident#1 was found sitting on the floor in the living room area. The resident stood up from the wheelchair unassisted and , hitting her on the bookshelf. The resident denies , , and no ⌄ is noted. 911 is called at 2:11PM and arrives at 2:17 PM. Family is notified by phone at 2:14 PM and refuses transfer. Hospice is notified.	A 025		

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A 025	Continued From page 7 Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted. Review of the facility's electronic progress notes for Resident #1 revealed no progress note for the on . During an interview conducted with Resident#1's family on starting at 2:33PM family stated that on at approximately 12pm facility staff wheel Resident#1 from the dining room after lunch to the activity area and left her there alone, where the resident from her wheelchair. The family member stated that the facility didn't report to family until after 2:15pm. Review of the facility's electronic progress notes for Resident #1 on 7:25PM revealed Resident#1 was picking at her left lower and removing the . The note indicated that the open appears with yellow drainage and the resident is complaining of extreme . The hospice nurse is notified. The note indicates that Resident#1 is on , medication and for . Review of the facility's electronic progress notes for Resident #1 on revealed a over her entire body and the hospice nurse is notified. The prescribed medications: and are discontinued, and is ordered for 2 days.	A 025		

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A 025	Continued From page 8 Review of the facility's electronic progress notes for Resident #1 on revealed the resident is removing the left ◡ ◡ and the is . care is being performed by the hospice nurse. Review of the facility's electronic progress notes for Resident #1 on reveals care order changes. The left lower ◡ is to be left open to air and Cream applied to the by hospice nurse. Review of the facility's electronic progress notes for Resident #1 on reveals the resident has removed the left ◡ ◡, and the hospice nurse is notified. Review of the facility's "Resident Incident Report" dated on 4:30AM indicated the "SafelyYou" video system is activated. Resident #1 is observed scooting on her from the bathroom to her bed, which is soiled with feces. Care staff are observed in attendance, assisting and returned Resident #1 to bed. The report indicated that the family is phoned at 5:30 AM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. During an interview conducted with Resident#1's family on starting at 2:33PM stated she observes the in-room camera, Resident #1 is yelling out at 4:36AM on . The family states notification was at 6:48 AM.	A 025		

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A 025	Continued From page 9 Review of the facility's "Resident Incident Report" dated on 2:32 AM "SafelyYou" video system is activated. Resident #1 is seen attempting to stand from the recliner, with her hanging over the chair armrest. Resident is seen holding on to the walker and ambulates to her bed. Her pants become undone and . Resident #1 attempts to kick them off and loses her balance, grabbing the wheelchair then lands on her with her against the bed. Resident #1 has no apparent injuries, and video did not show that she hit her . Family is notified at 3PM via phone. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted. Review of the facility's "Resident Incident Report" dated on 3:20PM revealed Resident #1 was in the unit's medication room, along with three care staff. Resident #1 was sitting in her wheelchair, positioned against the wall when she attempted to stand up from the chair and on her right side. Resident #1 did not hit her per staff. The Resident Service Director ( ) assessed the resident, and a bump is noted on Resident #1's right side of . The is unsure if the bump is from a previous . Hospice is notified and the family is called at 3:24 PM. The report indicated that the family refused evaluation. Review of the facility's "Resident Incident Report"	A 025		

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dated on 2PM indicated Resident #1 is in the activity room and attempts to stand unassisted, lost her balance, , but did not hit her . No injury is noted. The report indicates the family is called at 3:55 PM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. Review of the facility electronic progress notes revealed no note indicating a .

Review of the facility's "Resident Incident Report" dated on 11:37PM indicated "SafelyYOU" video system is activated. Resident #1 is observed moving around in her recliner, she places a on top of the wheelchair then slides to the floor. Resident #1 is assessed to have a to her right lower extremity. The family is notified via text message on at 2AM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted.

Review of the facility's "Resident Incident Report" dated on 1;30AM indicated care staff are performing rounds and find Resident #1 sitting on the bathroom floor. Resident #1 denies , but has an on her left . Family is notified at 8:15 AM, a voice message is left. Further review of the incident report indicated

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A 025	Continued From page 11 incident investigation section with questions/answers including: Previous history of this type of incident? No Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted. Review of the facility's electronic progress notes for Resident #1 on 3:59PM indicates the hospice nurse visits and evaluates the resident. Video is provided by Resident #1's family and reviewed by the facility and hospice showing Resident #1 hitting her when she in the bathroom on at 1:30AM. The family agrees to send Resident #1 via 911 to hospital for evaluation. During an interview conducted with R#1's family on starting at 2:33PM states the room camera video shows Resident #1 getting out of bed on at 12:20AM, her pants are falling down, and the bandage on her left lower is hanging loose. The resident and hits her . The family states the room video shows the resident calling out and at 1:30AM when a care staff enters the room and scolds the resident about getting out of bed unassisted. The aide assists the resident to bed. The family states the room video shows no checks on Resident #1 until 6:08AM, when a care staff enters the room. The family states the facility notified her at 8:15 AM. Hospice is called at 1:30PM and Resident #1 is transferred to the hospital. The family states that a "small is found on evaluation" at the hospital. No video evidence of the incident was available for surveyor review.	A 025		

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A 025	Continued From page 12 Review of the facility's electronic progress notes for Resident #1 on 7:34PM indicates Resident #1 returns to the facility under Hospice 24-Hour Crisis Care. Review of the hospice orders for Resident #1 on 4PM, medication order for , 1mg, give 1 tab by every 4 hours as needed for , / agitation/ sleep. Review of the facility's electronic progress notes for Resident #1 on 7PM indicates the resident is discharged from hospice 24-Hour Crisis Care. The note indicates that hospice nurse administered the last dose of , 1mg on at 3:10PM. Review of the hospice orders for Resident #1 on at 2PM, 24 -hour Crisis Care to end on at 7PM. Resident#1 to continue all routine medications and PRN meds. Review of the facility's electronic progress notes for Resident #1 on 7:40PM The resident was given , 1mg at 3:55PM for agitation. Vital signs were measured: , is , . Hospice was notified of resident's . A PDA was scheduled to begin shift at 11PM- 8AM. During an interview conducted with R#1's family on starting at 2:33PM the family member states she had requested on Resident #1's readmission to the facility on that no , be given to the resident due to . The family stated that the hospice nurse had changed the order, yet facility staff didn't follow order change and administered the	A 025		

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A 025	Continued From page 13 medication. Review of Resident #1's Medication Observation Record (MOR) revealed the resident had prescribed order for , 0.25mg twice a day as needed for , since . Further review of MOR revealed the medication was administered six times in : at 4:28pm; at 2:39pm; at 10:19am and 6:20PM; at 10:30am and at 1:23 PM. Review of the facility's "Resident Incident Report" dated on 2PM, Resident#1 slid out of her wheelchair to her while in common area. No injury was noted. The family is notified by phone at 2:15 PM. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted. Review of the facility's electronic progress notes for Resident #1 on 2:30PM the ARSD observes Resident#1 to be drowsy, nodding off in her wheelchair, and easily aroused. No injuries are noted from incident. Review of the facility's "Resident Incident Report" dated on 3PM Resident#1 slid out of her wheelchair and is observed lying on her right side on the floor in hallway of common area. Her wheelchair is at her . The resident is alert to name and has no visible injuries. Resident #1 did not hit her per care staff. The family is	A 025		

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	AL11970342	A. BUILDING: _____ B. WING _____	03/11/2026

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notified by phone at 3PM. Hospice is notified. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted.

Review of the facility's electronic progress notes for Resident #1 on 3:32PM Rsident#1 is observed by ARSD to be very drowsy, sleepy, bending forward in her wheelchair. Vital signs measured: , . The hospice nurse is notified.

Review of hospice medication orders for Resident #1 on at 7:09 PM, Hold , 1mg by every 4 hours as needed for 48 hours. Discontinue , ◡ and .

In an interview with the ARSD on at approximately12:45PM she stated that on , overnight shift, 11p-7a, there was no PDA on duty. Resident #1's family member was planning on staying with the resident but did not.

Review of the facility's "Resident Incident Report" dated on 7:12 AM indicated the "SafelyU" video system activates. Resident #1 is observed to be removing a soiled brief while in bed, with her ◡ dangling over edge of bed. The resident sits upright and pulls at the bed sheets while standing next to bed. The resident loses her balance and backward. Care staff are observed entered room, provided , and assisted her to the recliner. The family is notified

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A 025	Continued From page 15	A 025		

by phone at 7:45 AM and hospice was notified. Further review of the incident report indicated incident investigation section with questions/answers including: Previous history of this type of incident? No. Was a reduction plan in place? No. Contribution Factors - / Risk. Follow up and Prevention: Reduction Interventions Implemented- none. No further documentation is noted.

Review of the facility's electronic progress notes for Resident #1 on 5:17PM orders received from hospice to transfer Resident#1 to hospice Inpatient Unit due to and safety concerns. Resident#1 does not return to the facility.

In an interview with the ARSD on at approximately12:45PM she stated the facility had recommended that the resident's family hire a private duty aide (PDA) for additional 1:1 monitoring/ support and care when Resident #1 was discharged from 24-hour hospice crisis care. The ARSD stated the family hired a PDA for a few days, then stopped the PDA care. The ARSD stated that Resident #1 would become agitated and was a high risk and had numerous . The ARSD stated that Resident #1 required additional monitoring/supervision since she would frequently attempt to stand unassisted from her wheelchair and . The resident was unable to propel herself in the wheelchair. She was asked about what interventions had been implemented for Resident#1 due to numerous , she stated that staff were instructed to monitor the Resident #1 more aggressively and frequently, nightly checks were changed from every 2 hours to every 1 hour after she returned from hospital and was coming

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A 025	Continued From page 16 off hospice 24-hour crisis care. She stated the facility policy included care staff will check residents every 2 hours for wellness/ safety/ toileting. She stated that care staff would keep Resident #1 in the common areas for monitoring, never leaving her in her room during the day and the resident needed constant monitoring by staff in an attempt to reduce / injury. She stated that there is no documentation that care staff performed these tasks. When asked how the facility could determine if care staff enter a resident room to check on a resident, she stated that the Executive Director (ED) could review hallway cameras, but it would be very long difficult process. There was no electronic medical charting system for care staff, only for nurses. Any care concerns are communicated on the 24-hour log shared by staff on each shift. She stated that she could not recall any discussion with management about Resident #1 appropriateness and discharge due to increased need for supervision care and numerous . In an interview with the Acting Executive Director on at approximately 10AM she stated that the facility has a video camera monitoring system, "SafelyYou" in each resident room. The system is running all the time, but when the resident has a sudden change in position /breaks a 90-degree plane, the video (no audio sound) will record and retain for 10 minutes before and 10 minutes after the . The facility will get notified of a potential and the nurse or care staff in charge. The video can be reviewed but is saved by the outside vendor and not for extensive periods of time. She stated that the position of the camera doesn't capture the resident in the bathroom, only the living space. She stated that Resident#1's	A 025		

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family had installed a private video camera which captured the entrance to the resident's bathroom. She acknowledged that the facility has video cameras in each hallway which the video can be reviewed but it is extremely time consuming due to volume of recordings.

Review of Resident #1's hospice record revealed the resident was receiving care from another hospice provider and switched to the current provider on .

Review of the initial nursing assessment dated indicated Resident #1 was identified as a risk. She had an unsteady gait, and previously ambulated with a walker. The resident can no longer safely walk without the walker, can get up and take few steps but needs to be in a wheelchair. The resident has severe difficulty with self-care, bathing, , , , and toileting. The resident's attention span/ concentration is , , with disorientation, , changes, and , . Further review of hospice notes indicated on approximately the resident sustains a on her left lower , and care is ordered. Further record review indicated Resident #1 has ongoing lengthy care treatments including , , along with care.

In an interview with the hospice nurse on at 9:10AM she stated that she had cared for Resident#1 extensively. She stated that Resident#1 had , was pleasant, but would become agitated very quickly, exhibiting aggressive verbal and physical behaviors towards staff, other residents and her family. The nurse

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stated that she would offer emotional support during her visits and had encouraged the resident's family to hire a PDA to provide the additional emotional and physical support to the resident. She stated that the agitation was not safe for Resident #1. The Nurse stated the resident was alone at night and would attempt to get up and . She stated the staff could not watch the resident every second, and the resident needed more supervision. The nurse stated she believed a PDA would offer the resident emotional support, monitor for risk and would prevent the resident from removing her . The nurse stated that the healing process of the on Resident #1's left lower was lengthened due to the resident removing the and picking at/ touching the . The nurse stated that she was unaware if the facility had discussed hiring a 1:1 PDA with the family. She stated she had discussed the PDA option numerous times with the family, who denied the need. The nurse stated the resident was discharged from the facility and moved to an inpatient hospice unit after sustaining a , the transfer was due to and safety concerns.

Review of the facility Risk Policy, " Minimizing Risk Policy" revealed that " a Investigation form will be completed and approved by the and ED. The form will outline the findings and steps that need to be taken to attempt to proactively decrease the resident potential". The will take the lead in evaluation and take steps to contact family, caregivers, and health care providers in developing a plan to decrease potential of the resident. Further review revealed "when all the interventions and approaches are exhausted and the resident continues to be a

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A 025	Continued From page 19 risk, then it is appropriate for the and ED to meet with the resident, family and appropriate healthcare providers to determine the next steps in the resident's needs. Summary of Resident#1's Incident Reports and progress notes from admission until discharge revealed the resident or slide from her wheelchair 15 times. Further record review revealed the resident had , hitting her 5 times, , , , and	A 025		