STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968814	05/30/2018
NAME OF PROVIDER OR SUPPLIER **THE ALLEGRO AT BOYNTON BEACH, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **11450 HAGEN RANCH ROAD** **BOYNTON BEACH, FL 33437**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR # 2018003199, was conducted on at The Allegro at Boynton Beach, LLC, License # 12706. The facility had deficiencies at the time of the investigation.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on interview and record review, the facility failed to offer personal supervision as appropriate for residents identified as an elopement risk due to memory , , 1 of 3 sampled Residents (Resident # 1).

The findings included:

On a review of the records reveal Resident # 1 is a female suffering from the following diagnosis: Chronic ( ), Stomach pain, ( ), and .

On , a review of the record for Resident # 1 was conducted. The Nurses progress note dated (late entry) documented ; Resident tried to leave the building several times during the evening shift, she was observed outside walking near the (Ensemble) Memory Care parking lot. An associate saw the resident, and walked her back inside the building. The resident was checked and no indications of injury noted, Care staff notified Supervisor of the situation. Resident monitored throughout the evening, Husband was notified on of situation.

On at 01:30 PM, an interview was conducted with Staff A. She stated Resident # 1 was wandering all the time. She stated in , the girls say they were looking for her and could not find her and they found her in the parking lot looking for her husband. She stated the resident was . They found her right away. She went on to state that in , Resident # 1 was leaving from the Memory Care door. Resident # 1 was able to go out the door and look like a normal person.

On at 01:32 PM, an interview was conducted with the Administrator. She stated she was not aware that Resident # 1 had eloped in . She stated she was out of town during that time with her daughter. She says she was made aware by someone on staff (Name she could not recall). She states there was an incident that took place on when the resident was found at the entrance of the facility near Hagen Ranch Road. She states she completed the 1 and 15 day reports to Agency for Health Care Administration (AHCA) regarding the Adverse Incident. She stated she took

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statements. She says she did not look at the cameras in the common area on the memory care unit to determine how the resident left the facility. She says she was told that the resident possibly walked out with other family member. She stated she is not sure what took place.

On at 01:36 PM, an interview was conducted with Resident # 1. She stated she did not have a husband. The medical chart indicates her husband is her emergency contact. She was not oriented to person, place or time. She answered yes to every question. She was unable to provide appropriate responses during the interview.

A review of a statement written by a staff member (Staff B) who was present on the day of 's incident revealed the following. Staff B says at 4:45 PM. The Aide went to the TV look for her and she was not there. She says she took her car to Woolbroght Road and found her. The letter was dated .

A review of a statement written by Staff C dated revealed the following. She stated the night of , right after dining I saw her sit down in the medication . I went to put one of the Resident's to bed. When I got back, I looked for her to put her in the . I can't find her. It was 6:45 PM , we were looking everywhere in the building. She was not there until Staff B drove her car to Woolbright. She found her.

A review of a statement written by Staff D, present during the incident on . Staff D stated she was working that night when Staff B came and told her that Resident #1 was missing. She stated she went with Staff B to check all of the in the memory care unit, but she wasn't there. She says she left the building to go look outside for her. She says she didn't see her. She says she went back inside to get her keys so she could drive around to look for her. She says that when she got a call from Staff B saying that she had found Resident # 1.

A review of a statement from Staff E, revealed the following: She stated during the morning shift Resident # 1 was agitated and slapping staff. She says she got her to calm down. She stated the Resident started again. She stated the resident was also pushing the staff members out of the way, so she could run out of the door. She goes on to state in the evening she noticed the resident outside the main porch. She stated she continued to pass med's. She stated one of the other staff members asked if she had seen Resident # 1. She stated they didn't hear any doors sound with the alarm, nor did we see her leave. I suggested Staff B and Staff D to take their car and look for her. After 7 minutes, Staff D called me and stated , she found her on Woolbright, heading East.

A review of the facility Incident report reveals the Resident was noted missing from 5:23 PM - 06:45 PM.

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An interview was conducted with the Maintenance Director of the facility. He stated he was never interviewed regarding the elopements. He stated there are cameras in the hallways of all of the common areas. He stated he reviewed the tapes of the dates of the elopements. He stated there are cameras at the exit door in the memory care unit. He says he did not recognize the resident leaving the facility.

On [redacted] at 02:31 PM, an interview was conducted with the facility Administrator. She stated she did not determine how the resident eloped from the facility. She stated she recommended 24-hour one-on-one supervision to be provided by the family. The Administrator was also unable to provide documentation of steps and procedures implemented when the resident exhibited increased exit seeking tendencies and elopements from the building. The Administrator was also unable to demonstrate the facility implementing increased supervision in the memory care unit to address the need of increased supervision for the Resident #1 and other residents. Specifically, since they were unable to determine the breach of safety in the unit, resulting in easy access for memory [redacted] residents to elope.

Refer to A 0032 for additional supportive findings.
Class II

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on interview and record review, the facility failed to assess a resident for elopement risk and implement the facility elopement protocols upon elopement of a resident , for 1 of 3 sampled residents (Resident # 1). The facility also failed to conduct and document resident elopement drills on an annual basis to ensure all staff were properly trained in the facility protocols.

The findings included:

A review of the Health Assessment form (form 1823) for Resident # 1 was conducted. Resident # 1 is a [redacted] female who was admitted into the facility in [redacted]. She suffers from the following diagnosis: Chronic [redacted], Chronic Obstruction [redacted], Stomach Pain, [redacted], and [redacted]. The section on the form which addresses whether Resident # 1 is an elopement risk is blank. The Resident requires supervision with ambulation, dressing, and eating. Resident # 1 requires assistance with dressing, self-care [redacted] and toileting. The section on the 1823 form regarding the Resident's ability is blank.

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A review of the policy for elopement includes the following: Proceed with a thorough search for the resident for one hour. Notify the community Director, Notify the Regional Director, Notify the family/Responsible party, Notify the Police Department.
The Attending Physician, The State and Local Agencies, Identifying News Media, ... Safe Return,
The facility policy states the following steps should be taken:

1. The preliminary search efforts should last no longer than 1 hour from the time that the resident was reported missing.
2. The Staff are to document in the resident's record:
   a. Observation/condition of resident prior to incident.
   b. Time resident was discovered missing
   c. Last placard resident was seen
   d. Description of search effort
   e. Time/place resident was found
   f. Findings of the Resident Services Coordinator and other sources regarding the resident's physical and mental condition upon return
3. Complete an incident report
4. The resident's record should be revised to reflect the elopement and consideration given to preparation of a plan for elopement management and or re-evaluation of the Resident's suitability for the community.

On at 12:42 PM, an interview was conducted with the facility Maintenance Director. He stated there are cameras above every door in the memory care. He says when Resident # 1 eloped in , he was not interviewed by anyone, but he did review all of the tapes. He says he did not see the resident exit. He stated he also checked every door to make sure that they were secure.

On . . . . . at 01:36 PM, an interview was conducted with Resident # 1. She was dressed in Capri pants, top and a jacket. She was well- . She was neat and clean. She was in a cheerful mood. The Resident stated she was not married and did not have any kids. She stated she does not recall going into the parking lot at all. She stated she doesn't recall leaving the facility and walking to the entrances. She was not oriented to person, place or time. The medical record demographic form indicated the resident has a husband and a daughter. The Resident was unable to provide her last name. She did not know that she lived in the facility. She provided inappropriate answers to all interview questions. She failed to make a sentence. She answered yes to every question. She was observed ambulating without any adaptive equipment. The Resident was not observed wearing an identification bracelet. An observation of the Ensemble Memory Care unit, revealed a key , on every

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entrance and exit door. The unit is secure. The cameras are above the doors.

A review of the progress note for Resident # 1 dated (late entry) documents: Resident tried to leave the building several times during the evening shift She was observed outside walking near the Memory Care (Ensemble) parking lot. An associate (Unknown) saw resident and walked her back inside the building. The resident was checked and no indications of injury noted, Care staff notified Supervisor (Unknown(of the Situation. Resident monitored throughout the evening Husband was notified on of situation. The note does not include the time of the incident, which staff located the resident, time of incident, who made the notifications to husband. The physician was not notified. The incident was not logged on the incident log as an elopement.
The facility did not conduct an internal investigation, Law Enforcement was not notified. It is unknown how long the resident had been missing from the facility. The note was entered by an outside Nursing Consultant of the facility, a day after the incident took place. She is no longer employed in the facility.

A request was made for the facility elopement drills for the past 2 years at 10:22 a.m., The final request was made at 02:31 p.m. The DON was unable to locate any the requested drills.

On at 01:36 PM, an interview was conducted with the Administrator. She stated she was not aware that Resident # 1 had eloped in , She stated she was out of town . She stated she was made aware by someone on staff (Name she could not recall). She stated there was an incident that took place on , when the resident was found at the entrance of the facility near Hagen Ranch road. She stated, she completed the 1 and 15 day reports to AHCA regarding that Adverse Incident; took statements. She stated she did not look at the cameras in the common area on the memory care unit to determine how the resident left the facility each time. She stated she was told that the resident possibly walked out with other family member. She stated they always have adequate staffing in the memory care unit because they have a Medication technician (Med Tech) and 3 Certified Nursing Assistants (CNA's) on duty in the evening and the overnight shift. She stated they did have a Nurse who was terminated. She further stated that the regulations state they are not required to have a Nurse overnight. She stated the staff were advised to call the Nurse Consultant regarding incidents and she would log the entry in the progress notes. She confirmed that the notes and reports may be entered several days later.

A review of the Adverse Incident report for the elopement which occurred on , was not reported to AHCA until . The 1-day Adverse Incident report should have been submitted to the Agency on . A further review of the the 15-day Adverse Incident report was submitted on . The 15-day report was due /

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On at 02:30 PM, an interview was conducted with the Administrator. She stated they are in the process of replacing the Nurse Consultant. She agreed that the facility should have conducted the proper investigation for the elopement discovered on . She stated she was sure that the staff had completed elopement drills, but could not find the documents.

Refer to A 0025 for additional supportive findings.
Class II

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on interview and record review, the facility failed to complete an adverse incident report regarding an elopement of resident that placed the resident at risk for harm due to the resident's diagnosis and mental limitations, for 1 of 3 sampled residents (Residents # 1).

The findings included:

A review of the medical record for Resident # 1 was conducted. Resident # 1 was admitted in . The following information was revealed from the Florida Health Assessment form (form 1823). The Resident suffers from the following diagnosis: Chronic ( ), Stomach pain, (, and . She requires assistance with bathing, self care , and toileting. She has a regular diet. The section of the Health Assessment section for elopement risk is left blank.

A review of the progress note written by the facility Nurse Consultant for Resident # 1 dated (late entry)documented the following. Resident tried to leave the building several time during the evening shift. She was observed outside walking near the Memory Care (Ensemble Unit) parking lot. An associate saw resident and walked her back inside the building. The resident was checked and no indications of injury noted, Care staff notified Supervisor (Unknown) of the Situation. Resident monitored throughout the evening, husband was notified on of situation. The note does not include time of incident, which staff located the resident, time of incident, who made the notifications to husband. The physician was not notified. The incident was not logged on the incident log as an elopement. The facility did not conduct an internal investigation. The facility failed to complete an Agency for Health Care Administration (AHCA) Adverse Incident form for the elopement. .

On at 01:36 PM, an interview was conducted with the Administrator of the facility. She stated at the time of the incident she was out of town. She stated unfortunately, Staff E, the Licensed

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Practical Nurse on duty failed to document the time of the event and the staff who were present at the time the incident occurred. She stated she was never made aware. Therefore, she never conducted an investigation or completed an Adverse Incident report (1 day and 15 day report) to AHCA for the incident. She went on to state that she did complete the Adverse Incident report for the elopement on for Resident # 1. She acknowledged the findings.

Refer to A 0025 and A 0032 for additional supportive findings.

Class III