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 _____	08/12/2026

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 (#2026005796) and Generator Monitoring survey was conducted at Allegro on . Deficiencies related to the Complaint were identified at the time of survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure elopement risk residents were identified, that their photos were made available to staff, that a daily effort was made to ensure they were wearing identification, and that a standardized policy on elopement was crafted by the facility and implemented by facility staff, for 2 out of 2 sampled residents (Resident #1 and #2).	A 032		

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A 032	Continued From page 2 The findings included: On in an entrance conference at approximately 9:10am, Staff A (Administrator) and Staff B (Resident Service Director, LPN) both identified that they conduct a weekly Risk Meeting for case consultations in which any concerns or changes in Residents' care needs were discussed. In the same interview, Staff B outlined the events of the elopement that occurred . She identified that Staff E (Med Tech/Care Staff) checked outside of the alarmed door 1 min after the alarm went off, but Resident #1 was already on the elevator by that time (2:16am) so she did not see him. Staff E then returned to the unit, saw another resident pacing and assumed that resident had pushed the door alarm. Staff E then reset the alarm and returned to care provision. Staff B advised that Staff E was later written up for not completing a headcount as is policy. Review of elopement in-service training from conducted by Staff B listed topics: Check all egress doors in a timely manner. Reset alarms. count all residents to make sure all residents are accounted for. Review of policy from Allegro Management Company, Policy and Procedures Manual titled Category: Assisted Living Policy: Missing Resident (Elopement) Policy - FL addresses only what to do once a resident is determined to be missing. It does not address how to respond to door alarms or other potential indicators of elopement. "When Community associates determined that a resident of the Community cannot be accounted for or immediately located,	A 032		

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A 032	Continued From page 3 they are "missing." In advance of need, each Community will complete a Missing Resident Search Assignment Form with information specific to that Community's layout and surroundings. Missing Resident In-Service Training - A designated trainer will conduct missing resident in-service trainings as part of the Community orientation program for all new associates to review the Elopement 1 and Elopement 2 policies. As part of annual training, all associates must attend Elopement 1 & 2 policy review. Additional general elopement training will be completed by each associate in the online learning management systems as part of orientation and annually." Review of elopement trainings 1 & 2 completed in Relias as well as the complete Elopement Risk Evaluation policy did not reveal how to respond to indicators of possible elopement, such as a triggered door alarm, or state to conduct an immediate headcount. On in an interview at approximately 11:00am with both Staff A and Staff B, both reported that the elopement risk assessment is completed upon resident admission. Additionally, both identified the only elopement risk resident is Resident #1. This surveyor inquired if Resident #1's risk was identified upon admission or not until after his attempted elopement. Staff B advised it was post-elopement. This Surveyor inquired if any other residents were at risk, Staff B denied. Surveyor inquired if there was a book of elopement risk residents on site. Staff B reported she would check the memory care unit and return with it. At approximately 11:15am, Staff B returned with Elopement Risk binder. Included was a facesheet	A 032		

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A 032	Continued From page 4 including a half-body (waist up) photograph for Resident #1 and a copy of his care plan. No other residents were included in the binder. On at approximately 11:20am Staff A was asked whether there were a training and policy on identifying potential indicators of elopement as only item this was the single in-service done by Staff B in response to Resident #1's elopement. Surveyor also inquired about Elopement 1 & 2 policy review. Staff A was unable to provide an answer. On at approximately 1:10pm on a tour of the Memory Care Unit with Staff A, approximately 18 residents were observed in the open common area eating lunch or watching television. Multiple care staff were observed in the area as well as private duty aides providing activities of daily living care to residents. Staff A introduced Staff C (Program Director for Ensemble Memory Care) to this surveyor. Staff C was asked to identify elopement risk residents. Staff C stated there were several but identified Resident #2 as actively exit seeking. When asked if an elopement risk assessment had been completed for Resident #2, she stated she wouldn't know - she oversees the program but does not have anything to do with clinical care provision. Staff C identified that Resident #2's behavior had shifted over the last month and stated that she reported this information to the clinical team, specifically to Staff B. Staff A disputed this and stated she had not been informed. Surveyor inquired if any of the Memory Care Unit staff are represented at the At-Risk meeting Staff A and Staff B had described - Staff A and Staff C stated that no, they were not. This writer, Staff A and Staff C checked Resident	A 032		

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A	Continued From page 5 #1 and Resident #2 for identification. Neither were wearing any. When asked, Staff C stated at one point all Residents wore identification bracelets, but she could not recall when this had changed. On at 1:17pm Surveyor, Staff A and Staff B walked to furthest exit door and triggered door alarm to evaluate Staff response. Alarm sounded loudly, but there was no immediate response from staff. After a full 3-minute delay at 1:20pm 3 staff responded to the door. A review of the record for Resident #1 (Date of admission) revealed the following: Resident Health Assessment (AHCA form 1823) dated that listed: Medical History and Diagnoses: , (,), HLD (, ,), Physical or Sensory Limitations: None; no driving or Behavioral Status: Short term memory loss, language/communication difficulties, executive functioning , lability Nursing/Treatment/ , Service Requirements: Memory care secure facility Rated Resident #1 as Yes for elopement risk. No Elopement Risk Evaluation was completed upon admission as was stated was the policy/protocol for new admissions. A review of the record for Resident #2 (Date of admission) revealed the following: Resident Health Assessment (AHCA form 1823) dated that listed:	A 032		

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A 032	Continued From page 6 Medical History and Diagnoses: Physical or Sensory Limitations: Left blank or Behavioral Status: moderate to severe . Disoriented to time, person and space. Moments of agitation. Nursing/Treatment/ Service Requirements: Left blank Special Precautions: Left blank Rated Resident #2 as Yes for elopement risk. Elopement Risk Evaluation Form dated and included the following summary/conclusion/recommendation: Resident is on secured memory care neighborhood, does throughout the neighborhood but does not exit seek. On at approximately 2:30pm, in an interview, Staff B explained that a change to the facility's assessments occurred when they migrated to a new electronic medical record in approximately and the Functional Needs Assessment, they previously used was adjusted to cover only activities of daily living and no longer included elopement. Staff B stated the facility only became aware of this gap in assessment after the elopement . Staff B stated that she has not received any information from the memory care unit about Resident #2 exit seeking or exhibiting a change in behavior. On at approximately 3:00pm, in an exit conference with Staff A and Staff B concerns regarding elopement were identified and discussed. No additional information was provided.	A 032		

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