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
	AL11968576	A. BUILDING: _____ B. WING _____	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT SARASOTA	1900 PHILLIPPI SHORES SARASOTA, FL 34231

(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
A 000	Initial Comments An unannounced focused control and complaint survey for #2021001975 was conducted on at Inspired Living of Sarasota, an assisted living facility in Sarasota, Florida. Complaint #2021001975 was substantiated at A0030. The following is description of the deficiencies.	A 000		
A 030 SS=G	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 2 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other	A 030		

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A 030	Continued From page 3 similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is	A 030		

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A 030	Continued From page 4 harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where	A 030		

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A 030	Continued From page 5 complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and staff, family, and DCF staff interviews, the facility failed to ensure	A 030		

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A 030	Continued From page 6 residents lived in a safe, decent living environment free from and neglect for 1 (Resident #1) of 1 resident reviewed who had been reported as a potential situation to the Department of Children and Families and Law Enforcement. The findings included: On at 12:12 p.m., the Executive Director (ED) said there had been a reported allegation of involving Resident #1. The ED said Resident Aid Staff B had been a new employee training with Resident Aide Staff A. The ED said Staff B reported that on she had assisted Staff A with Resident #1 to bed. Staff B said Staff A was using foul language and when Resident #1 asked why were you doing this to me, Staff A slapped Resident #1's . Staff B reported it the next day. The ED said they went to see Resident #1 and her arms looked like there could be some marks and she reported the incident to the Department of Children and Families (DCF). The ED said when DCF came, they felt they had something, and they called in the police. The ED said the Law Enforcement officer came to the facility and said since they had , they would go forward with it. The ED said Staff A was suspended that day as she was under facility and DCF investigation. The ED said Staff A returned to work about a week later after doing an training and safe transferring training. The ED said Staff A returned to work prior to DCF and Law enforcement had completed their investigations. The ED said the deputy came to the facility twice and DCF did a follow up and subsequently DCF found enough evidence to go forward with the allegations and as far as she knew the police found enough evidence to go forward with it also. The ED said following this	A 030		

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A 030	Continued From page 7 incident they didn't do any further retraining with staff as they really hadn't been having any problems at all that warranted the need to do and neglect training. She said they had never had problems like this before or since. The ED said Staff B resigned after reporting the allegation as she said she was getting phone calls at home and harassed, and she didn't feel safe. On at 12:55 p.m., Resident #1's daughter said she had initially been informed of the incident by the facility but never heard anything further from the facility about it. Resident #1's daughter said she had been informed by DCF that the alleged , , (Staff A) was working at the facility. She said that did not make her happy and she had told the Administration that. Resident #1's daughter said she had visited her mother a few days prior to survey and all she could do was look at all the staff and wonder if they were the one. She said it made her uncomfortable, but during the pandemic, it would not easy to move her mother to another facility. On at 1:05 p.m., the DCF investigator said she had verified her case and forwarded it to the Office of the Inspector General Office. She said she notified the facility of this. DCF Investigator said she had talked Resident #1's daughter and had told the daughter the , , (Staff A) was working at the facility. She said the daughter flipped out and said her mother had a new on her arm. DCF Investigator said she had learned Staff A was working at the facility from the police. The Investigator said this was a resident that lacked capacity, had , on her arms that no one had seen day before and there was a written statement from a witness, yet no one at the facility called law enforcement.	A 030		

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A 030	Continued From page 8 DCF investigator said she was the one who called in Law Enforcement. DCF Investigator said it was her impression the facility was waiting for the DCF and police investigations before returning the alleged , . . , ... to work. DCF Investigator said she was told by the facility they did their own investigation and with retraining that was enough to let Staff A come . DCF Investigator said she was told by law enforcement they had enough for battery on person 65 & older and they were sending the case with probable cause to the state attorney and that her DCF report would also go with it. On . . . . . at 1:38 p.m., the Operations . , ... said Staff A had been suspended on and had returned to work on . . . . . after a 4-day training. The Operations . , said Staff A had returned to work on the . shift as a caregiver and worked all throughout the building with all residents. The Operations . , ... said it was a memory care facility and for the most part the residents would not be cognizant enough to really be interviewed about specific events. On at 2:06 p.m., the ED agreed Staff A had been brought to work prior to receiving result of DCF or law enforcement investigations. She said the police and DCF investigations were considered separate from the facility investigation. She said she was advised by Human Resources that they based it on their own internal investigation. ED said she did not conduct the investigation and did not have any documentation of the internal investigation as it was conducted by the regional people. On at 2:09 p.m., in a telephone call, Human Resources Staff C said she, the Health & Wellness Director, and Director of Human	A 030		

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A 030	Continued From page 9	A 030		

Resources did the investigation. Staff C said they gathered statements from Staff A and Staff B who had said she witnessed Staff A put her [redacted] on Resident #1. Staff C said they did not have camera footage because it was a resident room. Staff C said they called DCF and DCF and the police did their own investigation. Staff C said the facility investigation involved talking to Staff A&B and doing a skin assessment. Staff C said Resident #1 was not able to be interviewed because of her advanced [redacted]. Staff C said where Staff B said she saw Staff A put her [redacted], there was no [redacted]. Staff C said they did see [redacted] on Resident #1's upper arms. Staff C said the [redacted] were in multiple stages of healing, so they couldn't be sure how she got them, when she got them, and couldn't prove that was put there from Staff A. Staff C said they had no evidence to terminate Staff A from employment. Staff C admitted they brought Staff A [redacted] to employment prior to DCF and the police completing their investigations. Staff C said DCF and police investigations could take months and the employee would be going without a paycheck all that time. Staff C said anyone could say someone did something to someone but if they had nothing to prove that, they weren't saying it didn't happen, but without having evidence or concrete proof they just didn't have the grounds to terminate her. Staff C said before Staff A was brought [redacted], she did [redacted] & neglect training and signed off on that. Staff C said Staff A was put on a final warning because the skin assessment did show some [redacted]. Staff C said DCF and police hadn't shared anything with them yet and last they heard it was still an open investigation and it could go on for months. Staff C said she did not know why Staff A was eventually terminated and would have to look that up.

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A 030	Continued From page 10 On at 2:17 p.m., the ED was in the room during the time of phone call with Staff C. The ED said Staff A had been terminated on after bringing a resident out into the lobby and leaving them unattended. ED said she had had contact with DCF who had told her they felt they had enough information to move forward with the case. She was not sure when this had been and thought it might have been . On at 3:00 p.m., the ED provided a copy of the training Staff A had received prior to returning to work on . It consisted of the company's 4-page /Neglect policy dated 2014, modified . Staff A had signed the last page on . No other documentation of any other training was provided. On at approximately 4:00 p.m., the ED agreed the safety of the patients should be the priority. Class II	A 030		
A 165 SS=D	429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

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A 165	Continued From page 11 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results	A 165		

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A 165	Continued From page 12 of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section.	A 165		

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INSPIRED LIVING AT SARASOTA	1900 PHILLIPPI SHORES SARASOTA, FL 34231

(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
A 165	Continued From page 13 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to provide within 1 business day after the occurrence of an adverse incident a preliminary report and within 15 days a full report to the agency on all adverse incidents including the results of the facilities investigation into the adverse incident for 1 of 1 incident reported to law enforcement. The findings included: On . . . . . at 12:12 p.m., the Executive Director (ED) said there had been a reported allegation of . . . . . involving Resident #1. The ED said she reported the incident to the Department of Children and Families (DCF) on . . . . . The ED said when DCF came they felt they had something, and they called in the police in. The ED said the Law Enforcement officer came to the facility twice for this incident. On at 12:46 p.m., the ED said she did not file an adverse incident for police being on site	A 165		

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
	AL11968576	A. BUILDING: _____ B. WING _____	02/09/2021

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A 165	Continued From page 14 because she was told the Regional Nurse they didn't have to file one, because the facility hadn't called the police in, they had been called in by DCF. Class III	A 165		