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
	AL11969074	A. BUILDING: _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

(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 Complaint Investigation #2022008619 was conducted from ..... to and . Inspired Living had defciencies found at the time of the visit.	A 000		
A 030 SS=J	59A-36.007(5) FAC; 429.28(..) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) 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 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.	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 (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 standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (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 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.	A 030		

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A 030	Continued From page 2 429.28 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 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.	A 030		

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A 030	Continued From page 3 (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 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	A 030		

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A 030	Continued From page 4	A 030		

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 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

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A 030	Continued From page 5 call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], 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 [illegible] or [illegible] 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 interviews, the facility failed to ensure the residents living in a safe environment free from [illegible] (95 resident), allowed five staff involved in a physical take of an aggressive resident with [illegible] to remain employed at the facility (Staff G, I, K, and J) based on Agency review of the work schedule and employee interviews. Findings:	A 030		

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A 030	Continued From page 6 Review of a facility report filed with the Agency for Health Care Administration (AHCA) electronic reporting system reviewed that on ....., Resident #2's behavior became more aggressive, and was alleged to have slapped another resident and hit a staff member. Law Enforcement was called to the facility to attempt to deescalate the resident's behavior. The report indicated that the full episode occurred on ....., but the facility's narrative showed the episode indicated that the episode occurred on ....., but the facility's narrative showed the episode happened on Friday, ..., Resident #2's progress notes reflected that he was transported to a local hospital on ..... Resident #2's AHCA 1823 health assessment was signed by a doctor but not dated. It showed diagnoses of late onset 's ....., with behavioral disturbances, , hearing loss, ..., major , , and type II. The AHCA health assessment reflected that , care required the resident to be monitored for safety, medication management, to explain all tasks prior to performing them and provide reinforcement. On ....., Resident #2's progress notes, completed by the Wellness Director, indicated that the incident of involved Resident #2, a Memory Care resident, transported to a local hospital based on his aggressive behavior was on , not . On at 10:12 AM, the Wellness Director stated on ....., Resident #2 became aggressive with staff. She stated the facility attempted to have him by calling local law enforcement, but they refused. Instead,	A 030		

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A 030	Continued From page 7 they had Resident #2 transported to a local medical facility to help control his behavior. "The Florida Mental Health Act of 1971 (Florida Statute 394.451-394.47891 [1] [2009 rev.], commonly known as the " ," allows the involuntary institutionalization and examination of an individual." (Retrieved from Wikipedia.org). On at 11:14 AM, the family of Resident #2, in an independent telephone interview, confirmed Resident #2 suffers from 's and can be aggressive. The family confirmed that were call the facility to assist Resident 32's behavior on . They were concerned that they found three staff members lying on top of Resident #2, pinning him to the ground. The family stated Resident #2 had on his upper arms after that incident No photos were taken because the resident was sent out of the country by the family following this incident. On at 12:10 PM, the Administrator stated Medication Technician (Med Tech) G, who was called to the Memory Care Unit on , performed a "take down" of Resident #2 by putting her on Resident #2 and putting him on the ground. The Administrator confirmed neither Med Tech G not any other staff at the facility were trained to physically restrain a resident. On at 1:19 PM, the Administrator and Assistant Administrator confirmed the facility did an internal investigation which resulted in an, "Memo of Conversation" with Med Tech G. They stated Med Tech G was not taken off the schedule while the investigation was completed but was restricted to working on the Assistant	A 030		

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A 030	Continued From page 8 Living portion of the building and not allowed access to the Memory Care unit. Med Tech G was allowed to work from [redacted] until [redacted] when she was terminated upon returning to work from vacation. The Assistant Administrator stated as part of the internal investigation they had written statements from two of the staff involved in the incident. The statement was from Med Tech G and Caregiver K. On [redacted] at 1:19 PM, the Administrator stated the incident involving Resident #2 had been caught on video. A copy of the video was requested but the Administrator stated she would need to contact their corporate office. On [redacted] at 4:30 PM, the Administrator stated the facility would not be able to provide a copy of the video. She explained she did not think it existed anymore, a violation of the company policy to save all videos which result in resident [redacted]. On [redacted] at 9:05 AM, another request of the Administrator to view the video if the incident was made. The Administrator stated she did not take any of the staff off the schedule because she would have been shorthanded. She stated she immediately held an all-staff in-service training on [redacted] which reviewed resident [redacted]. On [redacted] at 11:07 AM, the Vice President (VP) of the corporation stated she is working with the Information [redacted] (IT) folks to obtain a copy, but she was sure the full incident with Resident #2 was not captured because the cameras were not reset from day light saving time. She stated the Administrator had been informed to contact the Florida [redacted] Hotline but	A 030		

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A 030	Continued From page 9 did not complete that task until . . . . Review of the State-Wide System revealed that an . . . . . report was called in on . . . . . , during the survey. The Administrator stated she did not call in the report until after the surveyor's entrance. She stated the Administrator had been informed to contact the Florida . . . . . Hotline but did not complete that task until . Review of the State-Wide . . . . . System revealed that an . . . . . report was called in on . . . . . , during the survey. The Administrator stated she did not call in the report until after the surveyor's entrance. On at 11:17 AM, the Administrator showed the video from the Memory Care Unit involving Resident #2. It revealed that the resident was seen walking around the unit not interacting with anyone but staff. No aggressive behaviors were seen. At 12:00 PM, the Administrator said the video she had shown was from . . . . . , not . . . . . , the date of the incident regarding Resident #2. The Administrator stated . . . . . video was not available. On . . . . . , the "Memo of Conversation," dated , revealed that on , Med Tech G was called to the Memory Care Unit to help diffuse the situation and she forcibly lowered him to the ground. It was discussed with Med Tech G to not, "diffuse a situation physically but to keep everyone safe by getting them away to a safe location and preventing the resident of harm to himself or others preferably by redirection." On . . . . . , the written statement from Med Tech G, dated , read, "I, Med tech G and another staff, we were assisting 303 in the AL (assisted living area) and heard on the radio to	A 030		

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A 030	Continued From page 10	A 030		

come now all staff. So, we both ran down to the elevator to go across to the MC (memory care unit). When we got there and saw a staff member in the nurses' station with Resident #2 and some of the residents there. He was cursing at everybody there, so I tried to call him, and another staff member asked me to get her charger (cell phone charger) from him. I asked him kindly to give it to me and he said no. Then Caregiver J took the charger out of his . He (the resident) tried to hit Caregiver J and me three times. I backed away from him, he struck a resident who was walking by, he slapped her on the left side of the , went to the and hold him and told him he was getting violent. Med Tech I, we both lowered him down on the floor and then called the police."

Caregiver K's written statement, dated , read, "The MC med tech called for everyone to go to MC because the resident was being aggressive. When I got there, I saw the resident in the med tech's , and I couldn't make out what he was saying. He had a charger that belonged to one of the staff and Med Tech G tried to get it out of his . He attempted to hit her, so I held one while she blocked the other to get the charger. After she got it, I let his go. The Med Tech called his son. After letting the son in, I saw the resident on the ground with the staff holding him down and then the son helped him up. After the Wellness Director came in, I went to the front desk to let in the police, fire department and ambulances."

On at 1:55 PM, Caregiver K said she remembered the incident with Resident #2. She was working on the assisted living side and heard an "all call". When she arrived in the Memory Care unit, the resident was being aggressive to

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A 030	Continued From page 11 staff, hit one staff and took her cell telephone charger. She stated she is not sure who took Resident #2 to the ground because she left to open the door for the Wellness Director. When she returned, he was on the ground. She said she did hold his arm until the son arrived. at 8:50 AM, Med Tech G stated she was called to the Memory Care unit because a resident was out of control. She stated she observed Resident #2 pushing other residents and staff, yelling. She said she could not understand what he was saying. She stated to prevent the resident from hurting any other residents, the caregivers held the resident down on the floor. She stated she was not taken off the schedule, but she did attend an in-service training a few days after the incident. Med Tech G confirmed the in- service training was related to resident . On at 9:30 AM, in an interview with Caregiver J, she denied witnessing the incident with Resident #2. She stated she was outside opening the door for the family and law enforcement. Stated she did attend and neglect training on . On at 1:09 PM, in an interview with Med Tech I, she stated she no longer works at facility, she left to go out of state with her family. Stated she observed Resident #2 being out of control. Stated she was not sure who put him on the ground. She denied laying on the resident, just holding him down. Documentation of the in-service training, including and neglect, revealed the training was held on , after the incident on . Training on covered	A 030		

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A 030	Continued From page 12 . . . . . behavior and . . . . . and neglect. Staff in attendance included Med Tech I, Med Tech G and Caregiver K. Caregiver J was not in attendance. There was a total of 32 staff present out of a total of 72 staff, 40 are caregivers/med techs. In-service on included and neglect. None of the staff involved in the incident attended. In-service training on included . . . . . and neglect along with Resident Rights, Caregiver J was in attendance, Med Tech G was on vacation, Caregiver K and Med Tech I had resigned. On at 9:05 AM, the Administrator stated they do not have a written policy on . . . . . since they do not allow staff to put their . . . . on residents. She further stated they cover this in both in-service training and when they are hired under . . . . . and neglect training. There was an additional in-service training conducted on . . . . . by the Vice President of clinical services. The topics included communicating and redirecting Memory (MC) residents, resident rights, and & neglect. On at 9:05 AM, the Administrator stated Med Tech G was terminated when she returned from her vacation on . She stated Med Tech I, recently quit. The Administrator stated she chose not to remove anyone from the schedule while she investigated so she would not be short staff. Review of the facility's policy on surveillance cameras, revealed that, "The administrator is responsible for video compliance . . . it is the administrator's duty to preserve video evidence . . . the administrator is responsible for ensuring camera video review after resident incidents, accidents, and resident elopement. Preservation of camera when video includes resident or associate incident, accidents,	A 030		

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(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 030	Continued From page 13 and investigation of resident . . . . . allegations. The administrator submits a preserve video form." Review of the Preservation Form sent to the Corporate Office from the Administrator showed the date of . . . ., not . . . ., the date of the incident. On , review of the termination letter to Med Tech G, written by the Vice President, read, "On . , . . , I reached out to you regarding an allegation that you had inappropriate physical contact with a resident when you took the resident to the ground. During that telephone discussion, you told me you wrapped your arms around the resident so he could not hit anyone. You said you gently placed the resident on the ground in a seated position, then laid the resident on the floor, and gently held him there so he could not get up to hurt anyone . . . Regardless of the circumstances, or how gentle you tried to be with the resident, the contact you had with the resident was not appropriate. This behavior runs contrary to our polices and protocol related to conduct and safety . . . I have a responsibility to ensure that disciplinary actions taken for serious incidents reflect the severity of the incident. I understand that you received a Memo of Conversation for his matter. This memo of conversation issued to you was not appropriate. Consequently, I have permanently removed the disciplinary action from your file . . . During my review of the matter, which includes your disciplinary history, I discovered that since the aforementioned Memo of Conversation, discipline has been issued to you on two additional occasions for serious safety related infractions that could have harmed our residents . . . You have demonstrated a pattern of unsafe behaviors	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969074	A. BUILDING: _____ B. WING _____	07/11/2022

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A 030	Continued From page 14 and decision making and we are unable to continue to put our community at risk." Review of additional incidents involving Med Tech G revealed that on ....., during a medication pass, she left a medication for one resident in another resident's room, and on , two medications were not properly charted by Med Tech G. On ..... at 9:30 AM, Caregiver J stated she has never been trained in . She stated she works in the memory care unit, and they were told to redirect the resident. Review of the facility's cell phone policy for staff revealed that, "To ensure proper care for our residents, the personal use of cell phones or mobile devices while working or in resident are areas is prohibited." Class I	A 030		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 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 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	A 165		

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A 165	Continued From page 15 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 of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and	A 165		

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A 165	Continued From page 16 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. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility placed the resident community (95 residents) at-risk by failing to properly file	A 165		

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A 165	Continued From page 17 electronic Agency for Health Care Administration (AHCA) reports in the required time frames for 2 sampled residents (#3 & #2). Findings: 1. On . . . . . , an electronically submitted report to AHCA revealed Resident #3 on . . . . . and was sent to the hospital for a higher level of care. The report, completed by the Administrator, was submitted to AHCA on , eight days after the event. On at 9:55 AM, the administrator stated she held the report on Resident #3 falling until she had all the medical information from the hospital. 2. On . . . . . , an electronically submitted report to AHCA revealed on , Resident #2, a Memory Care resident, had a change in behavior and became aggressive with staff. The facility contacted law enforcement. The resident was sent to a local hospital to monitor his behavior. The report was completed by the Administrator and submitted to AHCA on . . . . . On . . . . . , Resident #2's progress notes, completed by the Wellness Director, revealed that the resident was sent to the hospital because of his behavior on Friday , not Saturday . . . . . . On . . . . . at 9:55 AM, the Administrator stated the report was not filed timely on . . . . . , because it happened on the weekend. Class III	A 165		