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
	AL11968977	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT BONITA SPRINGS	27221 BAY LANDING DR BONITA SPRINGS, FL 34135

(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 survey for complaint #2022010664 was conducted through at Inspired Living at Bonita Springs, an assisted living facility in Bonita Springs, Florida. Complaint #2022010664 was substantiated at A0025. The following is description of the deficiency.	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.	A 025		

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A 025	Continued From page 1 (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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 record review, and interviews, the facility failed to provide the personal supervision and oversight required for each resident as to awareness of general health, safety, and well-being and maintaining a general awareness of the resident's whereabouts for 1 (Resident #1) of 52 residents in the memory care facility. This lack of oversight and awareness led to Resident #1's hospitalization after prolonged exposure to outside temperatures over 90 degrees Fahrenheit	A 025		

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A 025	Continued From page 2 (F) in the facility's courtyard and placed all 52 residents of the memory care facility at immediate risk of harm. The findings included: 1. Record review of Resident #1's chart revealed a progress note dated at 15:34 which indicated the following: Resident was found in the courtyard by a Care Partner (CP). CP radioed nurse for assistance with resident. Resident was found in the courtyard awake and responsive to stimuli. Resident shoes were not on and were lying next to her. Resident had a below her left . Resident was taken inside to her room; Hospice was called to be notified of injury and change in condition. (Emergency Medical Service) was activated due to behavior and concerns with . Resident was taken to (hospital) for evaluation. Husband called and made aware. 2. In an interview on at 1:00 p.m., Staff A (CP) said he found Resident #1 outside in the courtyard. Staff A said when he called her, she was difficult to respond, and when he said her name, she mumbled in response. Staff A said he had no idea how long she had been out there. Staff A said it was hot but was not sure what the temperature was. Staff A said he called Staff B Licensed Practical Nurse (LPN) who came out. 3. In an interview on at 1:35 p.m., Staff B (LPN) said when he went to Resident #1, she was sweating, her shoes weren't on, and she had on the bottom of her . He said they brought her to her room to cool down because it was hot outside and elevated her . Staff B said after a few minutes Resident #1 was still extremely hot, so he called Emergency Medical	A 025		

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A 025	Continued From page 3 Service ( ) to send her out. Staff B said when arrived, he had wet rags on her and took over from there. Staff B said he wasn't sure exactly how hot it was that day, maybe in the 90's. Staff B said he did not know how long Resident #1 had been outside. 4. Review of run sheet revealed arrived at the facility on at 3:08 p.m. The patient care record showed a primary impression of heat and . Secondary impression /Neglect suspected. Signs and symptoms: Somnolence - .| Injuries: Injury to . Injury: : Unspecified hot objects contact. Mechanism of injury: . at 3:10 p.m.: Unresponsive, temperature 102.8 degrees F. 3:12 p.m.: Unresponsive. Skin: Dry. Hot. to left . to top of right . Left : dorsal: - 1st: - 2nd: - 3rd: 5th: - - times 2 Upon arrival patient unresponsive seated in wheelchair with staff attending. Patient hot to touch and skin dry (not sweating). When staff questioned how long patient was outside, they advised they were not sure they last saw her at lunch. Patient has a to the bottom of her left with a that has , and is . 5. A review of accuweather.com for the facility's location, conducted on , revealed that the temperature on was 93 degrees F with a heat index of 100.4 degrees F.	A 025		

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A 025	Continued From page 4 Weather-Atlas.com states with a heat index value of 100.4 degrees F: "Take extra precautions, as heat cramps and heat exhaustion are possible. Note that heat index values are valued for light wind and location in the shade. Exposure to direct sunshine can increase the heat index value by up to 15 degrees F". 6. In an interview on at 2:03 p.m., Staff C (CP) said she is assigned as today's Courtyard Champion. Staff C said she checks the outside, front area, seeing if any residents have been out too long, if anything is going on outside, making sure everyone is safe. Staff C said, "I don't document it anywhere". When asked about the call check box at the courtyard door and at the gazebo in the courtyard, Staff C said, "They are there but I don't know if they work or not". She said she gets on her radio to tell the nurse it is done. 7. On at 2:11 p.m., Resident #1's spouse said the incident happened . Spouse said on he got a call about 4:00 p.m. telling him Resident #1 had cut her and was sent to the hospital. Spouse said when he went to the hospital, the story was different. Her were . He said when he visited her on he saw her and they were horrible. Spouse explained the top of her right was almost a dark brown the size of your fist if you put it on your and the left had all the skin on the heel and ball off. Spouse said she had a few other problems while at the hospital and eventually went to Hospice house where she on . Spouse said he received a copy of Resident #1's certificate which said the cause of was complications resulting from prolonged heat exposure.	A 025		

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A 025	Continued From page 5 On . . . . . Resident #1's spouse provided a photograph of the certificate dated : Cause of . . . . shows manner of . . . . as accident and cause of as complications resulting from prolonged heat exposure. 8. On . . . . at 2:28 p.m., the Administrator said Resident #1 was outside on , . . , for 1 hour and 15 minutes. He said he knew that from the cameras in the community. The Administrator explained they had a program called Courtyard Champion in which each day a staff member is assigned the duty of monitoring the courtyard, how long residents are outside and bringing them in if necessary. The Administrator said the day of the incident was a holiday with a lot going on. They did not have their daily meeting and inadvertently missed assigning a courtyard champion that day. All independently mobile residents, either walking or by wheelchair, have access to the courtyard and may enter and exit without supervision. The administrator explained that according to policy a staff member designated on a daily basis as the Courtyard Champion is to check the courtyard at least every two hours and monitor the residents in the courtyard. There is no requirement to document the residents in the courtyard at each two hour check nor keep track of how long a resident has been outside. The Administrator said the staff member is supposed to verify the checking of the courtyard by pressing an alert button at the gazebo. He said this call box system is not being monitored to ensure the courtyard check was done, but a log can be printed. The Administrator said since this incident we have implemented a protocol that the concierge is checking the camera screen every 15 minutes. He said they have not implemented anything specific so far as monitoring if it is being done. The Administrator	A 025		

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A 025	Continued From page 6 said we have a monthly staff meeting the first Thursday of every month. At our next staff meeting we will do an in-service on the importance of safety in heat. 9. On at 1:45 p.m., with the Administrator, observed a surveillance video from . The angle of the video watched was from a camera near the central lobby area. The video showed the following: At 1:28:44 p.m., Resident #1 is observed exiting the Northeast hallway onto the sidewalk in her wheelchair. She goes approximately 15-20 out from the doorway and stopped on the concrete driveway. Resident #1 was in direct sunlight. Resident #1 did not get out of chair but can be seen wiggling, fidgeting, and bending over at times, but chair remains in the same spot. At 2:15 p.m., the resident uses her to push herself a few but remains in the sunlight. At 2:19 p.m., she is still in sunlight approximately 10 from doorway and continues moving bit by bit backwards but remains in sunlight. At 2:34 p.m., Resident #1 is at the entrance of the patio still in direct sunlight. At 2:52 p.m., staff member finds the resident (per Administrator this was Staff A). At 2:53 p.m., another resident is seen picking up shoes a few from Resident #1. At 2:54 p.m., Staff B is seen approaching Resident #1. At 2:55 p.m., Resident #1 was brought inside. 10. On at 3:12 p.m., the Administrator said the incident with Resident #1 was a terrible accident. The Administrator said the Courtyard Champion Policy is a corporate policy that indicated checks every 2 hours, but in their morning meetings they are telling them every hour when the task is assigned. The Administrator said but in this heat that was not	A 025		

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A 025	Continued From page 7 enough and they were trying to do checks every 30 minutes. Administrator said he was working with corporate on changing the policy but needs their approval before it can be officially changed as it is a corporate policy. Class I	A 025		