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
	AL11968310	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT IVY RIDGE	7179 40TH AVE N SAINT PETERSBURG, FL 33709

(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 A complaint investigation (#2023004180) in conjunction with a generator monitoring survey was conducted at Inspired Living at Ivy Ridge on [redacted]. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	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 [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 [redacted] 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. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 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 observation, record review, and interview, the facility failed to notify 2 (Resident #1 and Resident #2) of the 2 sampled residents' representatives or family members of a change in resident condition related to an . . . . . event. Findings included: During an observation of the facility's video camera footage time stamped for at 10:12PM to 10:16PM, conducted on . . . . . at 11:50AM, it was seen that Resident #1 was pushing Resident #2's wheelchair down a hallway as Staff B, Med Tech followed behind and Staff	A 025		

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A 025	Continued From page 2 C, Care Partner approached shortly behind them. Resident #1 stopped in front of another resident room putting himself between Resident #2 and the staff members. Staff B was seen grabbing her lanyard and proceeded to hit Resident #1 with the lanyard several times on the arm. Staff C is then seen pushing Resident #1 forward and both staff then away slightly before Staff B reapproaches to hit Resident #1 with her lanyard again on his arm. Staff C is then seen grabbing and pulling Resident #1 backward when Resident #1 began to attempt to push staff away from himself and Resident #2. Staff B and Staff C are then seen pulling Resident #1's body down the hall and then to the floor together , Resident #1 was still holding Resident #2's wheelchair as he was dragged down the hall and on to the floor. The altercation led to Resident #2 being poured into the floor. Staff B and Staff C are then seen running away as both Resident #1 and Resident #2 are seen on the floor. (Video Evidence Obtained) During an interview with the Administrator, conducted on at 12:01PM, the Administrator stated that she only checked the camera's because she was planning to have a meeting with Resident #2's family about the and she wanted to give a better description. That is when she became aware of the incident. During a record review of Resident #1's health record and progress notes, conducted on it was revealed that Resident #1 had a Power of Attorney (POA) in place as their responsible party. The progress notes revealed no evidence that the facility had contacted the responsible party on or . During an interview with Resident #1's	A 025		

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A 025	Continued From page 3 responsible party conducted on . . . . . at 11:27AM, the responsible party revealed that she was not informed of any incident until she visited the facility the following day on to see Resident #1. She stated that at that time one of the involved staff members gave her an incorrect version of the incident and was there on . She stated that she found out what truly happened on . . . . . after the police had contacted the family and gave an accurate account of the events. During a record review of Resident #2's health record and progress notes, conducted on . . . . . , it was revealed that Resident #2 had a POA in place as their responsible party. The progress notes revealed no evidence that the facility had contacted the responsible party regarding the incident. During an interview with Resident #2's responsible party, conducted on at 12:39PM, the responsible party revealed that the facility never contacted her to talk about the staff's behavior. She stated that she was informed that two staff members were trying to direct Resident #1 away from Resident #2's wheelchair when Resident #2 out of the chair. The responsible party went on to say that she learned about the staff's behavior from an article that was posted about it. During an interview with the Administrator, conducted on at 12:04PM, the Administrator stated that Resident #1's family had informed her that no one had called her when Resident #1 initially went out to the hospital from the incident. During a further interview with the Administrator, conducted on . . at 2:14PM, the	A 025		

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A 025	Continued From page 4 Administrator was in agreement that the facility's documentation was not adequate. Class III	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's . . or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying . , medications. (e) Returning the medication container to proper storage.	A 052		

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A 052	Continued From page 5 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052		

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A 052	Continued From page 6 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	A 052		

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A 052	Continued From page 7 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure proper assistance with self-administration of medications (meds) according to the required steps in 429.256 Florida Statutes for 5 (Residents # 11,10,6,9,8) of 5 residents sampled that required assistance with self-administration of medications.	A 052		

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A 052	Continued From page 8 Finding included: An observation conducted on at 9:53 a.m Staff D, medication technician was observed to served medication in medication cup and place in the medication cart drawer. An observation conducted on .. .. at 9:55 a.m. Staff D medication technician was observed to served medication in medication cup and place in the medication cup drawer. An observation conducted on at 10:05 a.m. Staff D, medication technician moved away from medication cart, leaving the cart open, medication cart drawer was observed to have 3 unlabeled medication cups with pre-served with medication. An observation conducted on .. .. at 10:06 a.m. with the Administrator she confirmed with Staff C that medication cart #1 had 4 unlabeled medication cups with pre-served medication for residents # 11, #10, #6 in the drawer. An interview conducted on .. .. at 10:11 a.m. with the administrator she stated I made the health and wellness director aware of the incident. A record review conducted on of Health assessment 1823 dated .. .. for Resident # 11 revealed resident needs assistance with self-administration of medication. A record review conducted on .. .. of Health assessment 1823 dated for Resident # 10 revealed resident needs assistance with self-administration of medication.	A 052		

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A 052	Continued From page 9 A record review conducted on of Health assessment 1823 dated for Resident # 6 revealed resident needs assistance with self-administration of medication. An interview conducted on at 10:27 a.m. Health and wellness director (HWD) she stated she had not spoken to Staff D regarding pre-served medication. An observation conducted on at 10:42 a.m with Health and wellness Director (HWD) of medication cart #2, she confirmed the cart had two medication cups with preserved medications for residnets #9 and #8.(Photographic evidence) A record review conducted on of Health assessment 1823 dated for Resident # 8 revealed resident needs assistance with self-administration of medication. A record review conducted on of Health assessment 1823 dated for Resident # 9 revealed resident needs assistance with self-administration of medication. A record review conducted on of Facility assistance with Medication administration policy dated modified revealed: 1. Procedure responsibility health and wellness director or designee is reopenable for ensuring medication assistance services according to health provider orders. 10. One at a time: assist with medications and complete process with only one resident at a time. An interview conducted on at 2:51 p.m. with the health and wellness director she stated I have not spoken to the staff about the medication	A 052		

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A 052	Continued From page 10 errors. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

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A 054	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the Facility failed to maintain accurate and up to date Medication Observation Records (MORs) for three of five residents sampled (residents #6, #10 and #11). Findings included: During an observation conducted on at 10:06 a.m. with the Administrator she confirmed with Staff C that medication cart #1 had three unlabeled medication cups with pre-served medications for residents #6, #10 and #11 in the drawer. A record review conducted on of Resident # 6's MORs dated to revealed medications ordered for 9:00a.m had been signed out as given. A record review conducted on of Resident # 10's MORs dated to 3/31/2023 revealed medications ordered for 9:00a.m had been signed out as given, including a controlled ordered for 8:00a.m. A record review conducted on of Resident # 11's MORs dated to , revealed medications ordered for 9:00 a.m. had been signed out as given. During an interview conducted on at 2:51 p.m. with the Health and Wellness Director, she stated I have not spoken to the staff about the medication errors. Class III	A 054		

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A 056	Continued From page 12	A 056		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

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A 056	Continued From page 13 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968310	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT IVY RIDGE	7179 40TH AVE N SAINT PETERSBURG, FL 33709

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A 056	Continued From page 14 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to obtain a physician order issued and signed by the president's health care provider for any changes in directions for use of a medication that the facility is providing assistance with self-administration for 1 (resident #8) of five residents sampled. Findings included: An observation conducted on [redacted] at 10:42 a.m with Health and wellness Director (HWD) of medication cart #2, she confirmed the cart had a medication cup with preserved crushed medications in chocolate pudding. (Photographic evidence) A record review conducted on [redacted] of Health assessment 1823 dated [redacted] for Resident # 8 revealed resident needs assistance with self-administration of medication, regular diet, and a diagnosis of [redacted], aphasia. A medical record review conducted on [redacted] for Resident # 8 revealed there are no physician orders to crushed medication. An interview conducted on [redacted] at 11:49 a.m. with Health and wellness director she stated	A 056		

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A 056	Continued From page 15 I don't see a crushed order for medication in the Medication observation record(MOR) for Resident # 8. An interview conducted on . . . . . at 12:06 a.m. with staff C she stated I don't see and order to crush, but the resident told me to. The resident just won't take the pills, I informed the health and wellness director. An interview conducted on . . . . . at 12:13 a.m. with the Nurse practitioner she stated we do not have any documentation of Resident # 8 having issues with swallowing. An interview conducted on 12:46 p.m. with facility Pharmacist she stated resident #8 has , 81 mg, cannot be crushed, ... 100mg cannot be crushed and . . . . . cannot be crushed it can be made Slurry, but only by a Nurse that adds 10 cc of water. An interview conducted on at 2:51 p.m. with the health and wellness director she stated I have not spoken to the staff about the medication errors, I have not investigated what happened with medications this morning or if the medication crushed are supposed to be crushed. I review the health assessment 1823 when resident s are admitted and rely the information to the required departments. I have not sent the crush order to the pharmacy. Class III	A 056		