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 _____	05/31/2023

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 A complaint investigation #2023001871 was conducted at Inspired Living on . . . . . The facility had a deficiency at the time of the survey.	A 000		
A 025 SS=G	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. (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.	A 025		

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A 025	Continued From page 1 (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 observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 2 of 4 sampled residents (#3 and #6). Findings: 1. Review of resident #3's record revealed a facility admission date of . A 1823 health assessment form indicated her medical history included age related decline, minimal physical or sensory limitations and minimal or behavioral . She	A 025		

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A 025	Continued From page 2 was independent with bathing, [illegible], grooming, toileting, ambulation and transferring. A facility risk evaluation indicated she was a minimal [illegible] risk. A [illegible] service plan indicated she was a [illegible] risk due to [illegible]. Interventions were to use assistive device at all times, call for assist as needed, wear proper fitting footwear, keep walkways free of clutter, well-lit and safety checks for [illegible] each shift and observe location in the community each shift. On [illegible] at 9:03 am she appeared to be forgetful and somewhat [illegible] that morning. She was ambulating without her walker and tried to enter the main kitchen. A health care provider was notified. On [illegible] at 6:59 am she was seen around 2 am in the hallway without her pull up on. Staff changed her and redirected her to her room. "Please keep an [illegible] on her." On [illegible] at 2:48 am a pharmacy deliverer called from outside when dropping off meds to say the resident was outside at around 1 am. She said she went down the stairs and out the door. Staff on memory care were asked to take her in that unit for a little while and allow her to sit in the nursing station until she was ready to go to sleep. On [illegible] at 8:05 pm she went to the front desk and [illegible] on the floor next to the copy machine. The receptionist tried to redirect her without success. On [illegible] at 10:19 am she was sent to a hospital via 911. She went to the dining room and	A 025		

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A 025	Continued From page 3 said she several times in her apartment on the night before. An incident report submitted to the Agency indicated that at approximately 10:15 am she approached the concierge and said she a few times. She was holding the of her , which had a half-dollar sized area with dried . She was sent to a hospital. On at 2:20 pm she returned from the hospital. She was moved to the memory care unit upon her return. (No documented post-interventions) On at 6 am she was found on the floor in her room. She said she was okay. (No documented post- interventions) On at 7:54 pm she was found in another room on the floor under the bed. She had one shoe on and one off. (No documented post-interventions) On at 11:12 pm she had a and complained of lower , . (No documented post- interventions) On a health care provider ordered physical ( ) and occupational ( ) therapies. On at 6:14 am she was found on her bedroom floor. She denied , and no injuries were noted. (No documented post-interventions) On at 10:23 pm she was on the floor next to her bed laying on her with both on the bed. She complained of , while rubbing her cage. Emergency medical service ( )	A 025		

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A 025	Continued From page 4 was called but after their assessment and the resident's refusal to go, she was not taken to a hospital. (No documented post- interventions) A incident report submitted to the Agency indicated that at approximately 1:05 pm she was found lying on her in the grass near the rear of the property. Her were bent, and her were on her belly. Her pants had approximately 10 drops of on and around the area, 6 drops on the front of her shirt and 2 streaks of dried between her and upper . Her was blue and twice its normal size. She was taken to a hospital. (No documented post- interventions) A 1823 indicated her medical history included , of L3 , , oriented only to self and . She required assistance with bathing, , grooming, toileting, ambulating and transferring. On at 9:53 pm she was seen sitting on her approximately 10 away from the wall and facing the activity room mural. Her were loosely draped around her . She complained of in her . Her gait and balance were weakening despite receiving and . (No documented post- interventions) On at 6:22 pm she ambulated with a 4-wheeled walker with a seat. On a health care provider ordered a 2-wheeled walker. On at 12:16 pm she was supposed to ambulate with a 4-wheeled walker, but she was often seen without it. She was unsteady whether	A 025		

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A 025	Continued From page 5 she used it or not. Staff guided her around the community from one event to the next. She was discharged from and because she was not making progress with her ability to use her walker. The , said, "there is a window where you can teach a resident with 's to use a walker and it will stick as memory, we missed that window with this resident". On at 10:38 pm she was found in her room laying on her on the floor. She did not have shoes or slip resistant socks on. She ambulates with a walker but did not use it. It was by her closet. The intervention was to make sure she had on slip resistant socks when put to bed and walker beside the bed. On at 10:23 pm she was found in the activities room on the floor. She did have shoes on, but her wheelchair was not by her. The intervention was to continue to redirect her to use the wheelchair. She was very unstable and did not want to use it. When redirected by staff she gets very aggressive towards them. On at 7:03 pm she ambulated with a 4-wheeled walker and standby assistance. She also used a manual wheelchair with 1 person assistance. Her gait was , . 2. Review of resident #6's record revealed a facility admission date of . A 1823 indicated her medical history included , 's , Myelodysplastic , , and . She required supervision with bathing, , grooming, toileting. She was independent with ambulation and transferring.	A 025		

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A 025	Continued From page 6 A risk evaluation indicated she was a minimal risk. A service plan did not contain interventions. On a health care provider ordered and . start of care completed on . A incident report submitted to the Agency indicated that at approximately 2:20 am she was found lying on the floor in the hallway near the activity room. The was unwitnessed. She was alert to self and ambulated without assistance. A was seen on her right forehead. She was sent to a hospital. On at 8:50 am a report from the hospital revealed she her right . On at 10:29 am a request was made of the health care provider to order . Her plan was updated to safety checks every hour, encourage her to be involved with group activities so she will have visual monitoring and increased assistance due to increased . Staff to ensure proper footwear is in place with ambulation and gripper socks on at bedtime in case she gets up at night. On at 12 pm she returned from the hospital. She had a to her 4th and 5th on her right . On at 6:19 am she was found on the floor laying on her in her bedroom. She had a small bump on the left side of the of her . She had improper footwear on. (No	A 025		

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A 025	Continued From page 7 documented post- interventions) On at 4:22 pm hourly checks were completed on her. On at 10:43 am she ambulated with an unsteady gait and required 1-person assistance. She was alert, forgetful and oriented to herself, family and a few residents and staff. On at 3:38 am a loud boom was heard. She was on the floor in the hallway. She apparently hit her as she was on the top right side of her forehead. 911 was called and she was taken to a hospital. (No documented post- interventions) On at 8:44 am she was independent with ambulating. On at 5:10 pm she was found in the outside courtyard laying on her right side. She complained of , but was unable to state where. 911 was called and she was taken to a hospital. (No documented post- interventions) On at 8 pm she returned from the hospital. On at 6:10 pm she was seen laying on the dining room floor on her . Her , were cocked to the left with her left out straight and her right bent up pushing her right , off the floor. Her left socket was and turning blue in color. She had a linear on her left cheekbone that measured approximately 1 inch in length. She was holding both arms in the air and asking for assistance to get on her . Staff to do frequent checks over the weekend. (No documented post- interventions)	A 025		

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A 025	Continued From page 8 On at 5:49 pm she ambulated with an unsteady gait. Most often seen walking arm in arm with another resident to gain support. She received three times a week. On at 10:41 pm she ambulated without any assistance. She was at all times. On at 7:41 pm another resident informed staff that this resident was on the floor. She was found on the floor in the bathroom located by the nurse's station. She was assisted to a wheelchair and taken to the nurse's station for hourly checks. Within 10 minutes of the , she complained of , . Her right ankle was . She was wearing proper fitting shoes and a 15-minute check was done. 911 was called and she was taken to a hospital. (No documented post- interventions) On at 10:11 am the wellness director said she visited resident #6 at the hospital on and learned the resident had surgery for a right ankle on . The facility's protection policy read in part, a risk evaluation is completed by a licensed nurse or operations/clinical leader for residents upon admission, every six months, and upon a significant change of condition. The completed risk evaluation is maintained in the resident's record. Interventions to decrease the potential for resident and post resident are documented in resident's record and on resident's individualized service plan. On at 11:40 am, the administrator said the facility completed incident reports, but they were an internal document and not given for	A 025		

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A 025	Continued From page 9 review. A request was made of both the administrator and the wellness director for any additional documentation related to resident #3's and #6's . On at 1:14 pm, caregiver A said she'd been trained on the policy during some monthly meetings. She said resident #6 tended to hold onto people while she walked because she stumbled sometimes. She said resident #6 walked without an assistive device and for the most part stayed seated. She said residents at risk for had documentation in their record identifying them as such and the staff were trained on who they were. She said resident #3 now used a wheelchair but still gets up and has to be constantly redirected to sit down. She said she checked on the residents every two hours and if they were at risk for , she checked on them more frequently. She said residents were permitted to come in and out of the courtyard unrestricted. She said residents were checked on in the courtyard by one of the med techs and a call response box in one of the gazebos was pushed to show the check was done. On at 1:25 pm, caregiver B said courtyard checks were done every 1 hour or 30 minutes. An automatic alert goes to the staff's phone and the button in the gazebo had to be manually turned off. Regarding resident #6, she tried to walk with the resident. She said the resident tripped a lot and liked to hold . Regarding resident #3, the resident was now in a wheelchair but would not stay seated in it. She said she tried to keep a close , on the resident and that a staff member was always in the activity room.	A 025		

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A 025	Continued From page 10 On . . . . . at 1:35 pm, caregiver C said that on another resident told her that resident #6 was on the floor. When the caregiver responded to the bathroom, she saw the resident laying on her . . . . . on the floor. The resident did not respond when asked if she had , . The caregiver called 911. Regarding resident #3, the resident did not like to stay seated in her wheelchair. She said resident #3 required constant redirection and was difficult to communicate with due to the resident spoke French. Regarding the courtyard, she said when the door leading to the courtyard was pushed, an alert sounded on the staff's phone to prompt a courtyard check. She said there was not one person designated to do the checks. She said if no one responded to the alert the wellness director, who also received the alerts on her phone, called the facility to find out why. On . . . . . at 2:30 pm, the administrator said courtyard checks were done every hour. She said an alert went to the staff's phone automatically. She said a courtyard champion was assigned every day by the lead med tech or the staff decided among themselves who would do it. She said the check consisted of walking through the courtyard to make sure there were no residents in distress and that everything was okay and safe. She said the system was in place prior to and when resident #3 in the courtyard on . . . . . She said that after the , resident rooms were assigned to caregivers to give specific resident responsibility. She said the resident was not found in the courtyard as a result of an alert going to a staff's phone or during a courtyard check. She said the courtyard was meant for the residents to come and go frequently and that's what it was designated for.	A 025		

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A 025	Continued From page 11 Review of a sample of response times to courtyard check ins revealed the following: - 4 hours (hr.) 16 minutes (min), 1 hr. 50 min, 2 hr. 33 min, 1 hr. 17 min. - 3 hr. 10 min, 7 hr. 2 min, 1 hr. 14 min. - 1 hr. 46 min, 7 hr. 50 min. - 1 hr. 31 min, 2 hr. 29 min, 1 hr. 35 min, 3 hr. 45 min. - 1 hr. 7 min, 3 hr. 34 min, 16 hr. 11 min. - 1 hr. 3 min. On at 3:19 pm, the findings were discussed with the administrator and the wellness director. The administrator initially said the staff should respond to the alerts within a reasonable amount of time. She then said four hours was too long. The wellness director said one hour was too long and said she did not receive alerts on her own phone. On at 3:27 pm, the maintenance director said automatic hourly alerts go to staff's personal phone or a tablet on the unit 24 hours a day. The administrator said there was no process in place to monitor compliance. Class II	A 025		