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
	AL11968449	A. BUILDING: _____ B. WING _____	C 08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT HIDDEN LAKES	1200 54TH AVE W BRADENTON, FL 34207

(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 (#2023010590, #2023010905, and #2023012655) was conducted at Inspired Living at Hidden Lakes on . Deficiencies were identified at the time of the visit.	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	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 interviews, the facility failed to provide the personal supervision and oversight required for each resident to include awareness of safety, and well-being for five residents (Resident #1, Resident #3, Resident #4, Resident #8, and Resident #9) of five residents on the facility's memory care unit with resulting in significant injury. The lack of supervision and visibility of the memory care courtyard with hazards placed all residents at risk for injury. Findings Included:	A 025		

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A 025	Continued From page 2 In an observation conducted on at 9:15am the patio door had frosted glass and the window blinds next to the door on each side were not fully opened so only a faint outline of a resident was visible. When an attempt was made to open the patio door the alarm went off and the door was locked. Staff opened the door for surveyor to exit onto the patio. There were five residents sitting on the patio and no staff present. Surveyor attempted to re-enter the facility at approximately 9:23am and the door was still locked. Surveyor had to knock on the patio door and nearby window for staff to come to open the door. In an observation conducted on at 9:35am Resident #1 had reddish blue and purple on the right side of her and under her right , and a pink bulging knot on the right side of forehead along hairline, above the right temple. In an interview conducted on at 9:35am Resident #1 said that they had when asked how they were injured. A record review of a facility reported incident conducted on for Resident #1 dated revealed the resident in their room and sustained a right , and underwent surgery on . In a record review for Resident #1 there was an Agency for Health Care Administration Resident Health Assessment Form (AHCA Form 1823) dated with a diagnosis of right and history of , a hospital discharge report dated with a diagnosis of history of falling, and a facility risk assessment	A 025		

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A 025	Continued From page 3 dated . . . . . marked with "minimal risk". There was a progress note dated that Resident #1 was ambulating outside and was found on the ground with injuries and sent to the hospital. In an observation conducted on at 9:28am Resident #4 was lying on the common area loveseat with a large round sutured area with dried . . . . on his forehead. His wheelchair was pushed up against the wall by the patio door away from him. In an interview with Staff A conducted on at 9:30am they said that Resident #4 had . . . . on Wednesday (. . . . .) hitting his and went to the hospital. They also said Resident #1 had . . outside and gone to the hospital with a injury. In an interview with the family member of Resident #9 conducted on . . . . . at 9:55am she said that Resident #9 had gone to the hospital that Monday (. . . . .) because of a . She said she had hit her . . a few times and even had a small . . . . . due to . . . . She said she was now receiving , care. In a record review of an incident report conducted on for Resident #8 there was a on . . . . . in the courtyard resulting in the resident fracturing her right , . In an observation of the facility memory care courtyard conducted on . . . . . at 1:30pm there was a very large circular perimeter with a cement path around planter beds with shrubbery, that extended throughout the of the facility.	A 025		

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A 025	Continued From page 4 The cement walkway had drop offs between the sidewalk and planter beds and there were exposed irrigation pipes and sprinkler hoses laying on the walkway in several places. No staff were present. In an observation of Resident #3 ambulating with a rolling walker in the courtyard conducted on . . . . . at 1:42pm his rolling walker went off the side of the cement walkway several times due to the uneven ground where the planter beds and sidewalk met. No staff were present in the courtyard. In an interview with Staff E conducted on at 1:50pm they said there was no visibility of the courtyard from inside and that there were no assignments for which staff were to monitor the courtyard area. Additionally, they said that staff just talked to coordinate with each other on checking the courtyard area. In an observation of the concierge surveillance camera monitors with Staff H conducted on . . . . . at 1:55pm there was a one camera view missing. There was no view of the memory care patio and center of the courtyard. In an interview with Staff H conducted on at 1:55pm she said the surveillance camera for the patio/courtyard had not been working since early on and a work order would be submitted. In an interview with the Administrator conducted on at 2:00pm she said there were surveillance cameras located on monitors at the front desk to view the patio and courtyard areas. She was not aware the camera that showed the middle of the courtyard was not working.	A 025		

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A 025	Continued From page 5 Furthermore, she said she would have Maintenance look into the safety hazards in the courtyard. In an interview with the Health and Wellness Director conducted on at 2:20pm she said the locks on the memory care patio doors were supposed to be turned off and the blinds next to the patio door should have been opened that morning at 8:00am. At 3:06pm she said she was not aware one of the surveillance cameras was not working and was usually the first to be made aware. (Photographic Evidence Obtained) Class II	A 025		
A 152 SS=G	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with	A 152		

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A 152	Continued From page 6 the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment that was free of hazards by failing to ensure immediate access to locked resident rooms in the event of an electronic lock failure, for 40 resident rooms observed. Failure to provide an immediate alternate room access route, along with failure to implement a safety protocol which included ongoing maintenance of resident room locks, placed all 47 memory care residents at risk for physical or emotional harm and or injury. Finding included: In an observation of all resident room door locks conducted on from 9:30-1:30pm there	A 152		

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A 152	Continued From page 7 were black electronic pads for access using a swipe key fob and no key access. In an interview with Staff A conducted on [redacted] at 9:30am they said they would have to call the front desk where the laptop computer was located to get the code to open the resident doors if the door locks failed. Furthermore, they said if they worked the night shift, they would have to call someone if a resident room lock failed because the front desk laptop was kept by staff. In an interview with Staff B conducted on [redacted] at 9:45am they said they would call the Maintenance Director when a resident door lock battery [redacted]. Furthermore, they stated " he bounces between buildings. He goes to one other sister facility." In an interview with the Maintenance Director conducted on [redacted] at 10:59am he said if the resident room door lock battery [redacted] there was one laptop in the Information [redacted] (IT) room to unlock a door if he was not there. He said he was in the building [redacted] times a week and the staff would email or call him if there was a door lock issue after normal business hours. He said if someone unplugged the facility laptop and the laptop battery was [redacted], he would not know. He said batteries on resident door locks lasted approximately 6 months and would start blinking yellow when they needed changed, but he did not have a log or any tracking of battery checks or replacements. Furthermore, he said a resident had been moved to a respite room when the door lock would not work over the weekend on Saturday ([redacted]), but he was not notified until Sunday morning ([redacted]). He also said the laptop needed to be there in the building to	A 152		

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A 152	Continued From page 8 open doors and that there was no backup key access to get into the resident rooms. Furthermore, he said not all staff are trained to use the laptop to open locked resident room doors because they wait to see which ones will be employed for a while first. In an interview with Administrator conducted on [redacted] at 11:33am she said there was an incident where a resident room lock failed and the resident had to be relocated to another room for the night, and it was not communicated to the Maintenance Director until the next day by the housekeeper. Furthermore, she agreed that in the event of a fire or emergency they would not be able to get to the residents quick enough with the current room locks in the event of a lock failure. Additionally, she said there was no facility policy on the door locks or the process for the laptop oversight, battery maintenance, or an implementation of any safety protocols. She was unable to provide documentation of any staff training utilizing the laptop to open locked resident doors where the battery on the lock was [redacted]. In an interview with Staff F conducted on [redacted] at 12:40pm they said when the light on the resident room door locks flashed orange, they had to notify someone to change the door lock battery. Additionally, they said that the light flashed yellow for 3 to 4 days before the room lock shut down and stopped working. In an observation of the lock on [redacted] conducted on [redacted] at 12:46pm the door lock flashed red and did not open with the key fob. Staff C then walked down the hall to find the Maintenance Director to assist with opening the door.	A 152		

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A 152	Continued From page 9 In an interview with the Maintenance Director conducted on [redacted] at 12:49 pm he said when the doors flashed yellow or red the door lock needed to be re-initiated, and it had nothing to do with the battery. He said they knew the door lock batteries needed to be changed when the door did not open with a key fob. In an observation conducted on at 1:15pm the door to the IT room was located close to the facility front door entrance and reception desk, and before entering the locked memory care doors. The door to the room was left open and the laptop was observed on the desk open with papers on top of the keyboard. No staff were around to monitor the room or the laptop. In an interview with the Health & Wellness Director conducted on at 3:06pm she said she was not aware the IT laptop was not charged on and was not notified until the next day ([redacted]) that the resident room door would not open, and the resident had to be relocated to another room for the night. Photographic Evidence Obtained. Class II	A 152		