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 _____	R 09/18/2023

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 revisit to Complaint Investigation #2023001871 was conducted at Inspired Living Ocoee Assisted Living Facility and Memory Care on . Deficiencies were found to remain uncorrected at the time of the survey 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 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 (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: DEFICIENCY REMAINED UNCORRECTED Based on facility documentation, resident record review and interview, the facility failed to provide care and services appropriately to meet the needs of residents that are risk by providing adequate supervision to ensure safety measures and interventions were in place to reduce with injuries for 2 of 3 sampled residents (#1, #2) as required. Findings:	{A 025}		

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{A 025}	Continued From page 2 1. Resident #1's record review revealed admission date . The 1823 Health Assessment dated listed medical history of history of , Hard of Hearing, , , and . She needs assistance with activities of daily living (ADLs) with all except supervision with eating and special precautions for risk. She needs assistance with self-administration of medications. A facility note dated at 11:30 PM by Resident Care Supervisor Staff A documented around 11:30 PM, found resident #1 in bathroom washing from her hair and then she went into her own room, and it was noticed resident #1 was sitting on the toilet a lot from her and seen all over the bathroom. It was asked to resident #1 what happened? Resident #1 was not able to tell me. Checked resident #1 for bumps and saw a bump on of her . Called the daughter around 11:40 PM, and the daughter mentioned that resident #1 had a hematoma on her from a two weeks ago and her mother tends to pick at the scab. The daughter was skeptical about sending mother out. It was explained to daughter all the staff felt safe her (resident #1) going to the hospital especially with her mother being on , . Resident was sent out to hospital. Physician notified. A facility note dated at 4:26 AM by Resident Care Supervisor Staff A documented resident returned from hospital at 3:41 AM, transported by medical transportation. No new orders received. There was no documentation if resident #1	{A 025}		

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{A 025}	Continued From page 3 received stitches or . . . . . to her . . . . There was no follow up to the hospital or physician of discharge orders. A facility note dated . . . . . at 1:08 PM by Resident Care Supervisor Staff A documented completed wellness check and while caregiver staff was assisting resident with ADLs care, Resident #1 was yelping in , . . . The caregiver staff noticed a big on right , / ˬ area. Notified the Health Wellness Director about the situation via text message. There was no documentation if resident #1 was sent out to hospital or if an internal investigation was completed to see how resident #1 received the . . . . ˬ on her right , / ˬ area. Also, there was no documentation that family or physician notified. A facility note dated . . . . . (two days later after the mysterious ˬ on right , / ˬ area) at 10:02 AM by Med Tech C documented that resident #1 ˬ was , resident #1 was in , . . , contacted resident #1's daughter to inform her that resident #1 was going to be sent to the hospital to see what is wrong. The daughter said to go ahead and send her to the hospital. 911 called. Resident #1 transported to the hospital. There was no documentation by the facility of any investigation, or a assessment completed on resident #1. Resident #1 had been in , . . for two days before she was sent out to hospital. A facility note dated at 12:15 AM by Resident Care Supervisor (A)documented resident #1 returned from hospital to the community at 11:47 PM and was transported by medical transportation. There was a hematoma	{A 025}		

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{A 025}	Continued From page 4 on left . ., and the hospital wrapped the left . . with bandage. No new medication orders for . ..... or no discharge instructions. A facility note dated at 7:48 PM by Resident Care Supervisor (E) documented "a monthly" note that resident #1 ambulates without assistance. Resident #1 complaining of , in right . .. Resident #1 had been seen for the , . . There was no documentation of any follow up by the facility regarding the incidents. No assessment was completed, and the facility was not following their policies and procedures. (Photographic Evidence Obtained) An observation on at 10:50 AM today when arriving at the facility, saw the ambulance wheeling resident #1 on the stretcher into the truck. It was asked of the Health Wellness Director who was the resident? and she answered it was resident #1 for another . . 2. Resident #2's record review revealed an admission date of . . . . The last 1823 Health Assessment listed medical history of . . . . . , Sleep , , and legally . She needs supervision with ambulation, bathing, grooming and toileting and independent with eating and transferring. She is also hearing , . She is able to administer her own medications. A facility incident was reported on . . . . . at 4 PM that resident #2 fracturing her at (. . . . .) C3, C4, and C5 location and an additional injury reported of . hematoma	{A 025}		

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{A 025}	Continued From page 5 on her . . . . A facility note dated . . . . . at 5:10 AM by Health Wellness Manager documented resident #2 . . with injury. Resident #2 was coming from her bathroom going into her bedroom when she . . on the floor. Resident #2's night gown was saturated with . . as she sat with her . . up against the door frame in her bathroom. Resident #2 was sent out to the hospital. A facility note dated . . . . . at 4:07 PM by Health Wellness Director documented that she called the daughter to ask for update on resident #2. The daughter stated that resident #2 has a . . . . . hematoma. The daughter stated resident #2 will be kept overnight for observation and will be returning tomorrow. A facility note dated . . . . . at 3:06 PM by Health Wellness Manager documented resident #2 . . on . . . . . in her bathroom. Resident #2 was sent out to the hospital due to hitting her . . . . and having . . . , ... The daughter was called today to check on resident #2 and she stated that resident #2 has a . . . . . and will be returning with a soft . . . brace. The soft brace is to be worn for 8 weeks while out of bed. Called the social worker at the hospital to inform him that the new 1823 needs to state she can self-manage soft . . . brace. The daughter clarified that the surgeon said there was no surgery needed, just the brace was required to be worn by resident #2 for 8 weeks. A facility note dated . . . . . at 5:41 PM by Resident Care Supervisor Staff A documented resident #2 arrived . . . . from the hospital to the community around 5:25 PM by son's car. The son stated that he's going to be keeping resident #2 at	{A 025}		

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{A 025}	Continued From page 6 his home for 2 days so resident #2 will be out of the facility for another two days. A facility note dated at 4:35 PM by Resident Care Supervisor Staff F documented resident #2 arrived around 2 PM or 2:30 PM with her son to the facility. Resident #2 seems to be doing well as she was smiling and talking with staff. Resident #2 has a in the area and has to wear a soft brace for the next 8 weeks. A facility note dated at 1:38 PM by Resident Care Supervisor Staff A documented wellness check on resident #2. Resident #2 went to the dining room for breakfast and lunch. Staff walked resident #2 to her room and asked how she was feeling? Resident #2 answered not to good but managing. Resident #2 said the , is so much to the point it makes her hurt. I placed her clean laundry up and assisted her into bed. Resident #2 wanted to lie down because the , in her was too much for her. Resident #2 stated she is on , medications that she takes twice daily. 2-hour checks will be monitored. A facility note dated at 9:22 AM by Resident Care Supervisor Staff B documented went to resident #2's room to answer call pendent and resident #2 was found on the floor. Resident #2 stated she when getting up and lost her balance, hit her on the night stand next to her recliner. Resident #2 says she was not hurt and does not want to go the hospital. Resident #2 said she was not in , . I assisted resident #2 off the floor and put in the recliner. Called resident #2's daughter and left a voicemail message to call the facility.	{A 025}		

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{A 025}	Continued From page 7 There was no documented evidence that a risk assessment was completed, or any interventions was put in place due this was resident #2's second within two weeks, with the first on resulting a and a hematoma to her . (Photographic Evidence Obtained) The facility had reported a form to the agency on as a plan of correction that the facility would evaluate within the past 90 days to mitigate for risk residents and follow statutory and regulatory requirements. On at 5:30 PM, an interview with the Health Wellness Director confirmed the findings. Class II	{A 025}		