

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968886	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/23/2023
NAME OF PROVIDER OR SUPPLIER INSPIRED LIVING AT LAKEWOOD RANCH			STREET ADDRESS, CITY, STATE, ZIP CODE 5424 LENA RD BRADENTON, FL 34211		
(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)	
A 000	Initial Comments A biennial with limited nursing services (LNS), a generator survey and complaint investigation (complaint numbers 202311959, 2023015609, and 2023015720) was conducted at Inspired Living at Lakewood Ranch on . Deficiencies were identified at the time of survey.		A 000		
A 010 SS=G	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,		A 010		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a - may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010			

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to determine the appropriateness of residents continuing to live in the facility for 2 (Residents #2 and #3) of 4 residents sampled. The facility retained residents with , who required 24-hour nursing care without providing such necessary nursing care from qualified nurses. This action placed residents at a higher risk of falling, and sustaining injury or . As a result of not receiving qualified 24-hour nursing care Resident #2 sustained a resulting in injuries and subsequently . Findings Included: A review of facility 's self-reported document conducted on dated revealed Resident #2 had an unwitnessed and was found on the floor in her room at 8:15pm on . Staff C, an unlicensed caregiver, observed Resident #2 laying on her side with near her left . Staff D, an unlicensed medication technician, was called and came to assist Staff C with administering first aid to Resident #2. A call was placed to the emergency management services, that paramedics were needed, and they arrived and took the resident to the local hospital. A progress notes in Resident #2 's record conducted om , dated , authored by the facility ' s Health and Wellness Director, stated that the Health and Wellness Manager spoke with her and told her Resident #2 went to the hospital after sustaining a out of bed. As	A 010			

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A 010	Continued From page 5 a result, the resident had a _____ jaw and _____. The Health and Wellness Director spoke with a hospital nurse, who told her that the resident was not eating, drinking or responding. Resident #2 was admitted to hospice and the resident would return to the facility under hospice care. A review of facility's self-reported document conducted on _____ dated _____ revealed Resident #2 was wearing a _____ for a _____ on her _____ and that the _____ was recommended by her primary care physician for faster healing and _____. The resident started the _____ on _____. The _____ on her _____ was small and right above the _____, approximately 1 inch long. The resident returned to the facility, under hospice care, on _____. She later _____, at the facility, on _____. The cause of _____ had not been confirmed, but it was unrelated to the incident, likely natural causes. A review of Resident #2's record, on _____ revealed that the resident moved into the facility on _____. The resident had _____'s _____ and resided in the facility's memory care unit. The resident was not receiving hospice services when she was admitted, but was admitted to hospice while at the hospital, after her _____ on _____. Her health assessment was dated _____. The assessment revealed a diagnosis of _____, _____, and _____. The _____ assessment showed only that she required supervision, but it did specify for what activities, and that she needed assistance with ambulation, _____, and transferring and supervision with bathing, eating, grooming and toileting. The health assessment noted that Resident #2 was an appropriate _____ for living in an assisted	A 010		

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A 010	Continued From page 6 living facility (ALF). The health assessment also noted that she was medically stable, with a decline and no further decline. Further review of Resident #2's record, on 10/23/2023, revealed progress notes in the record, dated 10/23/2023, that the resident had a small burst open on the side of her right heel, unnamed facility staff applied a bandage on it. The resident expressed discomfort while standing up and walking to her bed. Resident #2 had no further issues on her right heel. Resident #2's healthcare provider recommended that the resident go to a wound care center to have it cleaned out. Resident #2's healthcare provider followed up with orders for backless shoes and floating heels. Record review of a report from a home health agency conducted on 10/23/2023 dated 10/23/2023 described their wound care visit that day, as follows: skilled nursing visit for wound care, right heel size 5.6 centimeters (cm) x 9.6 cm x 0.1 cm. A statement in the records from the wound care center Resident #2 visited on 10/23/2023, describes treatment for a wound on the resident's right lateral malleolus (ankle), prescribed off-loading via a heel pillow, and for a home health to provide wound care to the resident every other day. An interview was conducted with Resident #2's Home Health Provider Clinical Supervisor at 4:19pm on 10/23/2023 via telephone. In the interview, the Clinical Supervisor stated that the home health agency started care for Resident #2 on 10/23/2023, after they received a referral for wound care on her right heel. They last treated her on 10/23/2023, one day before she was hospitalized, and subsequently returned to the facility.	A 010		

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A 010	Continued From page 7 A note in Resident #2 's record, reviewed on _____, and dated _____ revealed Staff O was informed by the Health and Wellness Manager that Resident #2 went to the hospital after sustaining a _____ out of bed. As a result of the _____, Resident #2 had a _____ jaw and a _____. Staff O called the hospital and spoke to nurse who stated the resident wasn ' t eating or drinking, and she was not responding. Resident #2 was subsequently admitted to hospice and the plan was to return to the facility under hospice services. An interdisciplinary report sheet dated _____ in Resident 2 's record, from hospice providing end of life care to the resident after her _____ on _____. It was dated _____ and stated that their patient (Resident #2) was observed laying supine with her _____ closed. The patient did not arouse when verbal or _____ stimulation were provided. A _____ and _____ noted to left _____ and forehead. The patient ' s right heel had a _____ and a _____ was applied for _____ pressure. A progress note, dated _____, was that the facility received information that Resident #2 had _____. An interview was conducted with the Health and Wellness Manager, an unlicensed employee, on _____ at 2:25pm. In the interview, she stated that Resident #2 was not on hospice when she had a _____ on her heel, prior to after she _____ on _____. She received _____ care treatment from two different providers, a _____ care _____ facility, and a home health provider that came into the facility to perform _____ care. She had been ordered to wear a heel pillow _____ on her _____ by the _____ care _____ facility on _____. The Health and Wellness Manager described the _____ as being _____ high and that it closed with _____.	A 010		

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A 010	Continued From page 8 Velcro. It was puffy, like it was inflated. She was supposed to keep her elevated, so the care staff would put pillows under it while she laid in the bed. She said the care staff would also look at the to make sure it was okay. She stated there were no nurses working in the facility. She stated that Resident #2 was not on hospice, prior to her on . At 3:00pm on , she stated they have one other resident that had been receiving care and resided in the facility, she said it was Resident #3. Resident #3 was receiving hospice services. Resident #3 also had on both , like Resident #2's . The care staff were supposed to check the and try to keep them on her. The hospice nurse would come in a few times a week and perform care for Resident #3. An interview was conducted with Staff D, an unlicensed medication technician, at 2:34pm on . In the interview, she stated that she provided care to Resident #2, at times, when she lived in the memory care unit. She said that sometimes she would assist with making sure that Resident #2 had her elevated with a pillow. Resident #2 needed assistance with getting up and out of bed, sometimes she needed two staff to help. On , when Resident #2 , Staff C called her to come help her, because the resident was found on the floor, and she had on her . They called the emergency management services, who came and took her to the hospital. A review of Resident #3's record on , revealed that she had been living in the facility since , and resided in the facility's memory care unit. The resident's most recent health assessment was undated but was conducted	A 010			

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A 010	Continued From page 9 after she was admitted to hospice on _____, because it stated she was receiving hospice services. The undated health assessment stated that Resident #3 had no _____, but that she required total care for all her activities of daily living (ADLs) except for eating. The undated health assessment revealed that Resident #3 had no physical or sensory limitations and that she had "mild _____". It noted that Resident #3 was a _____ risk. There was no mention in undated health assessment that Resident #3 was immobile and used a high-_____ wheelchair. Resident #3's original health assessment was dated _____ and revealed that the resident was independent for all ADLs, and that she had no _____. A review of Resident #3's hospice care plan conducted on _____, revealed the care plan dated _____ had a plan of care for _____ that were _____ and deep tissue injuries. In the plan it designated that facility care staff would turn and reposition the resident every 2 hours, and as needed. Facility staff would also be responsible for ensuring that the resident's heels "were floated off the chair or mattress while in bed". Resident #3's record also revealed, on _____, care notes from a hospice nurse, starting on _____. Later _____ care notes (_____) revealed day's treatments; the first (_____, #5), located on her left heel, was a _____, which measured at 5.0 cm x 4.3 cm x 0.3 cm. The second _____ (_____, #6), located on her right lateral heel, was a _____ and was measured at 2.5 cm x 1.6 cm x 0.2 cm. An interdisciplinary report sheet from the Hospice Nurse, dated _____, stated that the resident was alert and oriented to only herself and	A 010		

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A 010	Continued From page 10 communicated nonsensical replies. She had 2 _____, to _____. The left heel measured 4.5 cm x 4.1 cm 0.3 cm, with a mild odor. The _____ on the right lateral heel measured 2.5 cm x 2.0 cm x 0.3 cm. A _____ care consultation with their team would be requested. The resident remained dependent with ADLs. An observation of Resident #3, at 3:15pm on _____, revealed the resident sitting in a high-backed wheelchair, in a common area amongst other residents, in the facility 's memory care unit. An attempt was made at having a conversation with Resident #3; however, the resident was not able to communicate in an understandable way, due to her advances _____. She seemed somewhat agitated, and trying to communicate something, but she was not able to get her convey her message in an understandable way. An interview, conducted at 12:05pm on _____, via phone call, with the Hospice Nurse, a registered nurse, she stated that Resident #3, had been a patient with hospice since _____. The resident ' s admitting diagnoses to hospice were _____, and she also had _____. _____ (staging at 3 and 4) on her heels (non-healing), _____ (_____ lower _____) and _____. She stated that the resident was a huge _____ risk. Hospice provided her with a high-_____ wheelchair, which would prevent her from trying to stand up, to prevent her from falling. When she was admitted to hospice, she already had _____ on both heels. The _____ had been worsening, and showed no signs of healing, no matter what they did. Hospice would come out to treat and redress her	A 010		

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A 010	Continued From page 11 a couple of times per week. The resident had been wearing "off-loading" (blue foam with Velcro) to keep pressure off her heels, and she was supposed to wear them all the time. The nurse stated that every time hospice went to visit, the resident was either not wearing her "off-loading" or they are crooked, not applied properly, and it was constant problem. An interview was conducted with the Corporate Executive Director at 11:30 on In the interview, she stated that the former Health and Wellness Director, had left her employment with the facility on Friday She stated the company that owns the facility no longer wanted to retain their limited nursing services specialty license (LNS), that would require that they employ nurses to work in the facility to provide nursing care and/or oversee nursing care that occurred in their facility for residents who required such services. She stated that they had no nurses working in the facility. Photographic evidence obtained. Class II	A 010			
A 030 SS=J	59A-36.007(5) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule	A 030			

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A 030	Continued From page 12 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; _____, Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida _____ Hotline, 1(800)96- _____ or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. _____ and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident _____, neglect, and _____; 6. Administrative and housekeeping schedules and requirements; 7. _____ control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968886	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/23/2023
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A 030	Continued From page 13 of services to residents by third party providers; 9. Assistive devices; and 10. Physical _____ (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can	A 030			

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A 030	Continued From page 14 demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . . . for health care services, the provision of or	A 030		

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A 030	Continued From page 15 arrangement of transportation to health care ... , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ... , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without ... , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that	A 030			

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A 030	Continued From page 16 a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and _____, Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated _____ or _____ under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or	A 030		

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A 030	Continued From page 17 representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor resident rights to provide adequate and appropriate health care by not providing emergency care for one Resident (#1) of 17 sampled residents. Additionally, the facility failed to follow emergency policy and procedures and did not administer () to a nonresponsive memory care resident who was a full code. The facility's non-compliance with their emergency policy and procedure, the lack of memory care staff's awareness of resident advanced directive's location and meaning and delay of emergency medical treatment, posed a direct threat to the resident affected (Resident #1) and leaves all remaining eleven memory care residents who are Full Code at imminent risk of harm or Findings Included: A review of the facility's reported incident conducted on revealed a preliminary report submitted on at 4:12pm that noted the following: -Resident #1 was last provided care at approximately 6:30pm on during medication pass.	A 030		

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A 030	Continued From page 18 -The resident was later observed in bed at 8:05pm on _____ by Staff A, an unlicensed Resident Care Supervisor, during routine rounds. The report noted that Resident #1 was "unresponsive to communication and had no _____." -Staff A called Staff B, an unlicensed Medication Technician, for assistance and called 911. -The report noted an officer with a local law enforcement agency arrived at the facility at 8:35pm and the resident was pronounced with a time of _____ of 8:53pm. -Resident #1 was picked up by the funeral home at 11:00pm. -A review of the facility investigation summary from the reported incident submitted on _____ at 2:53pm revealed Resident #1 did not have a _____ (_____ / _____). -An update to the facility reported incident submitted on _____ at 2:13pm revealed " _____ was not initiated. "Supervisor (Staff A - unlicensed caregiver) thought it had been too long after to initiate." (Staff A is an unlicensed staff not qualified to make a determination of _____, or assess that it has been too long to initiate _____.) -The corrective action summary submitted on _____ at 3:43pm stated "Not applicable in this situation." -The corrective action summary submitted on _____ at 10:40am stated "Supervisor _____ noted, recently _____ certified, was sat down with and reminded of _____ processes, tips & signs, and when to initiate _____. Remainder of _____ certified staff will be reminded of _____ steps in _____ all staff meeting." A record review for Resident #1 conducted on _____ of a progress note dated _____ at 11:37pm by Staff A noted that Staff A found	A 030			

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A 030	Continued From page 19 Resident #1 unresponsive in her bed at 8pm and Staff B was notified at 8:05pm and could not get a The Health and Wellness Director was notified via phone at 8:11pm. Emergency medical services (. . .) were called at 8:18pm. A Law enforcement officer could not find a . . . on resident and subsequently pronounced the resident . . . with a time of . . . of 8:53pm. (Photographic Evidence Obtained) During an interview with the Administrator, conducted on at 11:00am, he stated that Resident #1 had been seen for medication pass at 6:50pm and took her medication, but staff later found her at 8:05pm. He said Staff A said she was not alive and had no He said Staff A called for another staff member, but they did not perform . . . as Staff A thought it had been too long. He stated Staff A said she was not warm but not yet . . . , and had no He said that if a resident had a . . . it would be placed in the chart and electronic file. Additionally, he stated that he had a sit-down meeting with Staff A and went through the steps with him, but he did not receive disciplinary action. He said no staff did . . . and no disciplinary action was given to those involved. He said he would be doing a refresher course for staff at the next all-staff meeting on Wednesday, . . . An attempted record review of the facility's investigation of Resident #1's incident, conducted on . . . , revealed no documentation on an investigation and only one progress note completed by Staff A about the incident. During an interview with Staff A, Resident Care Supervisor conducted on . . . at 11:57am	A 030		

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A 030	Continued From page 20 by phone, he said that he went in Resident #1's room and gave her something to eat and drink earlier in the evening on and then went in the room at 8:00pm and found her nonresponsive so he called Staff B to assist him, and Staff B could not find a He said they called but only a law enforcement officer arrived. Additionally, he said the Health and Wellness Director was a nurse, but she was not in the facility. There were no nurses in the facility, and no one qualified to pronounce Resident #1 He said no one did on Resident #1 and expressed that the resident was a two (with his assistance) or three-person assist (with all female staff) and it would have been difficult for him to get her on the floor for He said he did not want to leave her after he found her and was trying to get another staff to help him, but it was busy, and everyone was putting residents to bed. He said Resident #1 was a heavy transfer and he was trying to remember the protocol for a nonresponsive resident. During an interview with Staff G, Medication Technician, conducted on at 1:09pm in the memory care unit she said she was unaware of how many residents with or full codes, were in the memory care unit. She said were posted in the resident rooms and in the electronic system. During an interview with Staff M, Care Partner, conducted on at 1:15pm she said stood for "department of natural resources" and did not know about During an interview with Staff N, Medication Technician, conducted on at 1:18pm she said a stood for do not wash or do not force the residents if they refuse to take	A 030		

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A 030	Continued From page 21 medication. She said she forgot what it was. After surveyor explanation she said the form was yellow and was on the resident bathroom mirror or bathroom door. During an interview with Staff K, Medication Technician, conducted on _____ at 1:26pm she said you could see who had a _____ or was a full code on the computer, but that since they switched to electronic charts a couple of months ago, she was not aware of any other way to find them. Additionally, she said that Resident #1 received hospice services and was at the end of her life. In an observation with Staff G, Medication Technician, conducted on _____ at 1:34pm she was trying to pull up the code status of the residents in the electronic system and it took 4 minutes to pull one resident MOR (medication observation record) up on the screen. At 1:38pm she provided a folder containing yellow forms in sheet protectors for 16 residents on memory care. During an interview with Staff G, Medication Technician, conducted on _____ at 1:34pm she said, "sometimes the internet doesn't work very well" when trying to pull up the code status in the computer for a sample resident. At 1:38pm she said she thought the _____ /Code status was in the computer, but they had taken them out. At 1:38pm she said the _____ forms were now kept in a folder and not in the resident rooms like she said earlier. During an interview with Staff A, Resident Care Supervisor conducted on _____ at 1:41pm he said Resident #1 was in bed most of the time as she had declined, and it took multiple staff to	A 030		

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A 030	Continued From page 22 work with her since she was a large woman and was unable to bear _____. He said he would give her bed baths because it was physically difficult putting her in the shower. He said he gave her soup and a drink on the night of _____ and left the bed elevated and that she received medications after that at 6:00pm. He said he returned and found her at 8:00pm or 8:05pm and he noticed the side of her _____ was pale and her _____ were _____, and he could not feel a _____, so he called for assistance on the walkie talkie, but it was the busiest time of night with staff giving showers and getting residents to bed. He said he finally called Staff B on her cell phone to assist him. He said Staff B called 911. He said he went to print out paperwork for the transport with _____, but they never arrived, and he was _____ on the protocol as he just wanted them to come. Additionally, he said it was the first time it was a non-Hospice resident that _____, and he was used to having to call Hospice. Furthermore, he said Resident #1 had forgotten how to do everything and had been mobile and actively participated when she first was admitted but had declined over the last 6 months to a year. Management was aware that she required total care, and she required two to three people to lift her from the bed to the wheelchair. He said the Administrator talked to him about the incident to "make sure stories matched up on what I was saying versus what I wrote" and said he told the Administrator that _____ was not done on Resident #1. He did not recall any counseling or that he was told by the Administrator if _____ should have been done in this situation. He said _____ have never been on the _____ of the door in memory care and that they were kept in the medication room. During an interview with the Health and Wellness	A 030		

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A 030	Continued From page 23 Manager of Memory Care conducted on at 2:05pm she said no refresher training on had been done with staff since the incident with Resident #1. She was only aware of an upcoming meeting with families in the first part to meet with all those who had family that were residents without She revealed she made a folder for (Photographic Evidence Obtained) and that they could tell those with a full code in the electronic system. Additionally, she said her expectation was that should have been performed on Resident #1 and should be performed when the resident did not have a Furthermore, she stated, "I was like guys, we just had a class!" During an interview with the Administrator conducted on at 2:31pm he said he had not done any refresher training on with the staff since the incident on During an interview with Staff D, Medication Technician, conducted on at 2:33pm she said that she was called on by Staff A because he said [Resident #1] and they had to call the ambulance because they could not pronounce her Additionally, she said she was not sure who could determine if someone was or not. During an interview with Staff B, Medication Technician, conducted on at 3:01pm she said she was at lunch on when she received a call on her personal cell phone from Staff A who said he thought [Resident #1] so she went to the room and checked her and said her color was not good and she was clammy and had no	A 030		

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A 030	Continued From page 24 She further said she was pale, unresponsive, and was not opening her , or talking. She said she called the prior Health and Wellness Director who was the only nurse on staff, and was not in the building, and she did not tell them to do . and just told her to call 911. She was not sure if Staff A checked to see if Resident #1 was a . and said she did not check the code status for Resident #1. Additionally, she said "I think everyone has a form and it says whether they have a . or they are not." During an interview with Staff L, Medication Technician, conducted on . at 3:14pm she said she was working on the night of . and got a call from Staff A that one of the residents was not responding and she needed to go to the memory care unit. She said the staff were in . and the resident was unresponsive, pale, and not talking or opening her . She said she was asked to watch for and direct the police to arrive to pronounce the resident . Additionally, she said it took law enforcement a long time to arrive at the facility and that it was almost an hour and a half before they got there, and it was closer to 9:00pm when they arrived, and she knew this because she was out doing her rounds. In a record review of the facility staff with training conducted on . there were 21 employees with . certification, Staff A was the only staff of five staff working in the memory care building on the 2:00pm to 10:00pm shift on . with . certification. (Photographic Evidence Obtained) In a record review of the facility staff list conducted on . there were no licensed nurses employed by the facility.	A 030		

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STREET ADDRESS, CITY, STATE, ZIP CODE

INSPIRED LIVING AT LAKEWOOD RANCH

**5424 LENA RD
BRADENTON, FL 34211**

(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 030	Continued From page 25 In a record review for Resident #1 conducted on _____ there was a Resident Health Assessment, Agency Health Care Administration form 1823 (1823) dated _____ that listed diagnoses of _____, _____, and _____. Additionally, it revealed the resident was a _____ risk and needed supervision for safety with ambulation, needed assistance with bathing, and _____ and supervision with grooming, toileting, and transfers. (Photographic Evidence Obtained) In a record review conducted on _____ of the Facility policy entitled "_____ / _____" dated _____ it noted that the purpose was "to set forth the guidelines for responding to an emergency situation with regard to the initiation of _____ (_____) or the withholding of _____ as designated through an advance directive, the Out of Hospital _____ (_____) document or _____ order." It noted the policy is "Staff will make a good faith effort to follow the directives of the resident, as allowed by applicable law and assisted living regulations, regarding the initiation or withholding of _____." It listed the procedure as: 1."If required by state regulation, staff will be trained in _____. 2.If state assisted living regulations require that _____-certified staff be on duty at all times and a resident is found without obvious signs of life (not breathing and no _____), staff will respond as follows: a.If the resident is receiving hospice services, staff will notify hospice nurse on call and the Health and Wellness Director."	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968886	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/23/2023
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A 030	Continued From page 26 b.If the resident is not on hospice services, and the resident has a valid Out of Hospital document or order (if allowed by state regulations), staff will notify the Health and Wellness Director. If the resident does not have a order or state form, staff will initiate and call -1. Emergency personnel will either take over or will verify upon their arrival." (Photographic Evidence Obtained) A record review of the facility staff list conducted on revealed there was no staff designated as the Health and Wellness Director. (Photographic Evidence Obtained) During an interview with the Administrator and Executive Director conducted on at 5:30pm they said the Health and Wellness Director was no longer employed as of Friday, During an interview with the Administrator conducted on at 5:25pm he said they were aware of a change in condition Resident #1 and that her doctor had recently recommended she be transferred to a skilled nursing facility. He agreed should have been given to Resident #1 on Class I	A 030		
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	A 052		

Agency for Health Care Administration

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A 052	Continued From page 27 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. (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	A 052		

Agency for Health Care Administration

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A 052	Continued From page 28 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. (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 _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and	A 052			

Agency for Health Care Administration

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A 052	Continued From page 29 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 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	A 052		

Agency for Health Care Administration

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A 052	Continued From page 30 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 and interview, the Facility failed to ensure proper assistance with self-administration of medication for two residents (Resident #15 and Resident #16) of two sampled residents that required assistance with self-administration of medication. Findings Included: In an observation on the memory care unit conducted on at 1:05pm Staff G was walking down the hall with a pill cup containing one capsule and a cup of water. There were no residents nearby. In an interview with Staff G conducted on at 1:05pm she said she had pre-pulled the medication for Resident #15 and was taking it to her down the hall. When asked to see the medication order on the electronic	A 052			

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A 052	Continued From page 31 medication observation record (MOR), she said she could not understand why the order was not showing up on the electronic MOR and why she could not find the medication pack in the drawer. At 1:09pm she stated the pill pulled was an _____ for Resident #16 and not Resident #15 as she initially said. She said she had just started at the facility and finished training on Friday, _____ and she knew she should not pre-pull medications. In an observation conducted on _____ at 1:09pm Staff G found the pill pack for Resident #16 in the medication cart drawer and then pulled up the corresponding order for 500mg capsules, take three times a day for five days, on the MOR for Resident #16. (Photographic Evidence Obtained.) In an interview conducted on _____ at 2:05pm with the memory care Health and Wellness Manager she said her expectation was that the Medication Technicians would bring the resident to the medication room and pull the medication in front of the resident. She said they should never pre-pull medications, and Staff G was new and needed more training. In an interview with the Administrator conducted on _____ at 5:31pm he said no medications should be pre-pulled. Class III	A 052		

Agency for Health Care Administration

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A 162	Continued From page 32	A 162			
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practitioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, . . . , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A . . . record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their . . . recorded	A 162			

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A 162	Continued From page 33 semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that _____ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____ (_____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004 . The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has	A 162		

Agency for Health Care Administration

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A 162	Continued From page 34 made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's _____, DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain accurate and complete records for 3 (Residents #2, #3 and #4) of 3 residents sampled.	A 162			

Agency for Health Care Administration

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A 162	Continued From page 35 Findings Included: During an interview with the Administrator, at 9:30am on _____, he provided information that the facility had residents who had _____ and _____ and required home health services. The Administrator identified Resident #3 as having _____ and Resident #4 as having _____. A review of Resident #2's records, on _____, revealed that the resident had moved into the facility on _____. The resident's health assessment was dated _____, and it stated that Resident #2 had no _____, and that the resident's needs could be met in an assisted living environment. Regarding the need for any nursing, treatment or _____ services, the health assessment stated only "supervision". The care plan in the record was dated _____, and it stated that the resident was independent with her own skin care needs. A progress note in the record for Resident #2 conducted on _____, dated _____, written by the facility's Health and Wellness Director, read that a _____ was observed on her right heel. The resident's provider recommended for the resident to go to a _____ care center to have it cleaned out. The next note in the progress notes, dated _____, read that the resident's _____ burst open on the right side and a bandage was applied to it, the resident experienced _____ when standing and walking, that there was _____ on the right _____, and that her right had been elevated. An interview was conducted with Resident #2's Home Health Provider Clinical Supervisor at _____.	A 162			

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A 162	Continued From page 36 4:19pm on In the interview, the Clinical Supervisor stated that the home health agency started care for Resident #2 on, after they received a referral for care on her right heel. A review of Resident #3's records, on, revealed that the resident had moved into the facility on The records revealed that the resident was admitted to hospice services on The latest health assessment provided in the record was undated, however it stated she was receiving hospice services. The undated, post-hospice admission 1823 assessment stated that resident did not have any A review of Resident #3's hospice care plan, in the record, on, revealed the care plan dated had a plan of care for that were and deep tissue injuries. In the plan, it designated that facility care staff would turn and reposition the resident every 2 hours, and as needed. Facility staff would also be responsible for ensuring that the resident's heels "were floated off the chair or mattress while in bed". An interview was conducted at 12:05pm on via phone call, with the Hospice Nurse, a registered nurse, who was familiar with the history of care the hospice provider had with Resident #3. In the interview, she stated that Resident #3, had been a patient with hospice since The resident's admitting diagnoses to hospice was, and she also had (staging at 3 and 4) on her heels (non-healing), (. lower) and When she was admitted to hospice, she already had on both heels.	A 162			

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A 162	Continued From page 37 The , , , , , had been worsening, and showed no signs of healing, no matter what they did. A review of Resident #4's records was conducted on . Resident #4's record revealed that the resident had moved into the facility on . The resident's latest 1823 assessment in the record was dated . The assessment stated the resident required , , , , , and skilled nursing services, however there was no mention that the resident had a permanent in-dwelling . An interdisciplinary report in her record stated that on , , , , , a 3rd party nurse changed her , , , with difficulty. In an interview with Staff E at 11:05am on , , , , , she stated that Resident #4 had a , , , . Photographic evidence obtained. Class III	A 162		
AN276 SS=D	59A-36.022(1) FAC LNS - Nursing Services (1) NURSING SERVICES. In addition to any nursing service permitted under a standard license pursuant to Section 429.255, F.S., a facility with a limited nursing services license may provide nursing care to residents who do not require 24-hour nursing supervision and to residents who do require 24-hour nursing care and are enrolled in hospice. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility that held a limited nursing services (LNS)	AN276		

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER INSPIRED LIVING AT LAKEWOOD RANCH			STREET ADDRESS, CITY, STATE, ZIP CODE 5424 LENA RD BRADENTON, FL 34211		
(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
AN276	Continued From page 38 specialty license, failed to to employ or contract with a qualified nurse, or employ any nurses to perform limited nursing services to any residents, for 109 of 109 residents who resided in the facility. Findings Included: A review of the facility's assisted living facility (ALF) license was reviewed on _____, and it revealed that the facility held a limited nursing services specialty license (LNS). The facility's ALF with LNS license had an expiration date of _____. A record review of the facility's LNS program was attempted at 9:05am on _____. Facilities, with LNS nursing programs, typically have a binder containing all records, such as a list of residents receiving LNS services, medical orders, monthly health assessments, and nursing progress notes, and documents such as copies of nurses' licenses - most importantly a copy of the license of the RN who is required to oversee the program. The review was not possible because the facility had no LNS binder to offer for review. An interview with the Administrator at 9:05am on _____. He stated that the facility had decided to relinquish their LNS specialty license and that they were not providing any nursing services. He stated they they employed no nurses in the facility at all. He stated he would have to check with corporate to find out if they had contacted AHCA licensing and had notified them of their decision not to continue with the LNS program. At 9:30am on _____, the Administrator returned and presented a copy of an email, that was forwarded to him, regarding some of the	AN276			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968886	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/23/2023
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AN276	Continued From page 39 other corporately owned facility's in the area, but not his facility. The email stated they sent in the renewal applications for those other facilities and removed the LNS license portion of their ALF renewal applications. The Administrator stated that when they send in the renewal application for his facility, they will also remove the LNS specialty license. When asked to see all of the nursing licenses of all nurses working in his facility, he stated they had no nurses at all working in the facility. He expressed understanding that, given the facility has not yet sent in their renewal application for their ALF license and thus removing the LNS designation, they would still be responsible for complying with all LNS licensure requirements. He stated they had no qualified RN, as required, and they had no nurses on staff to provide any nursing services. An interview conducted with the Corporate Executive Director , , , , , at 11:30am on , she stated that the former Health and Wellness Director had ended employment with the facility recently and she was filling in for her because the facility did not have a replacement Health and Wellness Director. The facility no longer wanted to retain the LNS licensure and they had no nurses working in the facility. It was a new corporate model. She stated they could not keep nurses working there because of the job market, so instead decided not to employ any and they were going for more of a wellness model. She stated they had residents in the facility who were receiving third party nursing services or who were on hospice. An interview was conducted with the Administrator and the Corporate Executive Director at 5:24pm on . It was discussed that the biennial relicensure survey with LNS was	AN276		

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AN276	Continued From page 40 completed, and there were concerns regarding LNS portion of the survey related to the facility not offering the program to residents, or having any nurses on staff. They both acknowledged that the facility was responsible for complying with LNS regulations while the LNS portion of their ALF license was still active. The Administrator stated he was not sure, and would have to ask corporate, if the facility was planning to notify the residents and their families that the facility was relinquishing their LNS license. Photographic evidence obtained. Class III	AN276		