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 _____	01/08/2024

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 Complaint investigations #2023014919 and 2023016530 were conducted on [redacted] at Inspired Living, Ocoee. A deficiency was found at the time of the visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 interviews, observation, and record review the facility failed to provide adequate supervision to ensure safety through proactive measures to minimize the potential for elopement for 1 of 4 residents (#3). Findings: In a record review of resident#3's health assessment and record dated [redacted] it revealed an admission date of [redacted]. The resident had a medical history of [redacted], hard of hearing, alert and oriented, and forgetful. He is independent of activities of daily living. He resides on the	A 025		

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A 025	Continued From page 2 assisted living side and is not marked as an elopement risk. In further review of the facility notes it stated the following: 11:27am resident was spotted walking down the sidewalk and crossing highway. Staff brought the resident across the highway. The director is aware of the resident taking walks and then would come to the community. Staff saw resident walking towards the housing division by the lake next to the facility and staff brought him to the facility. Resident shows signs of about his wife who , some years ago. Resident is asking for his parents and his wife and little girl. In review of the facility elopement policy, it states a resident leaving the community without community employees' knowledge. This applies especially when the resident has decision-making abilities and is unaware of his own safety and needs. Should elopement occur and evaluation of the health and wellness director for elopement risk. Employment training is provided, and drills are conducted. Interventions are noted in the resident's service plan. There were no interventions or care plan noting elopement for resident#3. In an interview on at 9:50am with the health and wellness director she stated resident #3 has increased . He asks for his wife and little girl. He the community kitchen. The day of the incident he went to the next neighborhood looking for his family. His lab work and ammonia level were believed to be high and were within normal limits at the time. We have	A 025		

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A 025	Continued From page 3 recommended memory care to the family. She stated he is not listed as an elopement risk but is on . . decline and is a matter of time before the family decides to put him in memory care. In an interview on at 10:30 am with resident#1 he was observed to be that he was living in an assisted living and instead stated he was the boss of this company. He stated he does what he wants and does not have to let anyone know he is leaving. He stated he has a little girl and a wife. His wife is . . . . . , his little girl is a grown woman. He was not oriented to time, date, or place at the time of the interview. In an interview on at 12pm with Staff A. She started it was about 8am in the morning, the day of the elopement and the overnight supervisor called me and said she was leaving and saw the resident on the sidewalk by the facility by the housing division next door to the facility. She stated but when I found him, he was on his way . . . to the facility. She stated I heard he does this a lot from other staff. She stated he does have a safety check for every. She stated he is still allowed outside without supervision. The resident is . . . , , but he does not like to walk around under supervision. She stated he says he is boss, and he does what he wants to. She stated she has seen him walk around the parking lot many times, but he still does not let staff know. In an interview on at 2:10pm Staff I stated I saw him walking around the parking lot and this is not usual for him to do. However, he was past the perimeter this time, so I called one of the staff in the facility and stated he was past	A 025		

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A 025	Continued From page 4 the sidewalk and to go and get him. He does not normally tell us when he leaves to walk or sit outside in the front. We did additional training for elopement after that. Since it is assisted living, they have the freedom to come and go. He does not tell us where or when he is going. In an interview on at 2pm the family member of resident#3 stated the staff does a good job and keeps on top of him. He likes to walk around. She stated the quality of care is excellent and I don't feel he needs to be in memory care. I do not think he is out of place where he is or a danger to himself. I do not feel he is at risk and will not try to get away from the property. They notify me of any changes good about communications. I was alerted that day when that happened, they are good at that. She stated he is stubborn, but he is enough to live in an assisted living. She stated she has no issues at all. On at 2:11pm resident #3 was observed in the parking lot and walking towards the end of the building. No staff were outside and did not know he was outside. There was no supervision of the resident as he the parking lot. There was no documentation that the resident's health care provider had been made aware of the resdient's decline and the facility's recommendation for memory care. In an interview on with the administrator, she stated she does not consider resident#3 an elopement risk as he resides on the assisted living side and is independent of activities with daily living. She stated she has reminded resident #3 to sign in and out but often forgets to do so.	A 025		

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A 025	Continued From page 5 Photographic Evidence Obtained Class III	A 025		