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
	AL11968977	A. BUILDING: _____ B. WING _____	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT BONITA SPRINGS	27221 BAY LANDING DR BONITA SPRINGS, FL 34135

(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 An unannounced complaint survey for #2022017423, #2022017714, #2023007391, #2023011706, and #2023013543 was conducted on . . . . . at Inspired Living at Bonita Springs, an assisted living facility in Bonita Springs, Florida. Complaint #2022017423 was substantiated at A 028 under Complaint #2023013543. Complaint #2022017714 was substantiated without citation. Complaint #2023007391 was unsubstantiated. Complaint #2023011706 was substantiated without citation. Complaint #2023013543 was substantiated at A 010, A 028, and A 053. The following is a description of the deficiencies.	A 000		
A 010	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 010		

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A 010	Continued From page 1 (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, 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	A 010		

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A 010	Continued From page 2 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 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	A 010		

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A 010	Continued From page 3	A 010		

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 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

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A 010	Continued From page 4 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 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 ensure residents had a -to- medical examination by a health care provider after a significant change to determine the continued appropriateness of residency for 3 (Resident #9, #10, #11) of three residents reviewed. The findings included: Facility admission and retention agreement Exhibit J outlines the admission and retention Criteria. It notes "An individual must meet the following minimum criteria to be admitted to a community holding a standard, limited nursing license, or limited mental health license. The resident must be able to perform the activities of daily living, with supervision or assistance if necessary; be able to transfer with assistance if necessary ...; The Community has a Standard and Limited Nursing Service License which allows the Community to: Provide assistance with ADLS. "Assistance means direct physical assistance	A 010		

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A 010	Continued From page 5 with ADLS rather than actually performing the task for the resident". Assistance with self-administered medication by reminding Residents to take the medication, open the bottle cap for the residents, open pre-packaged medications for Residents, reading the medication labels to residents, observing residents while they take medications, checking the self-administered dosage against the label on the container ... 1. Resident # 9 was admitted to the facility on [redacted]. The Resident Health Assessment - Form 1823 (1823) dated [redacted] included diagnoses of major [redacted]. Resident #9 required total assistance with ambulation and transferring. The 1823 was not updated upon discharge from hospice services on [redacted]. Resident #9's service plan indicated 2 persons for transfers. Resident #9 was observed from 10:50 a.m. until 2:10 p.m. Resident#9 was observed being fed breakfast in a Broda (specialized wheelchair) then wheeled to her room in the Broda chair and remained in the reclined position in her room mostly sleeping. At 12:03 p.m., the Med Tech entered her room, combed her hair, set her upright and rolled the Broda chair to lunch. Resident #9 was wheeled [redacted] to her room at 1:38 p.m., by Caregiver Staff F. The Caregiver wiped the residents [redacted], then was observed to pick the resident up from the Broda chair and position her in bed. Resident #9 was not able to assist with the transfer or reposition herself in the bed. She required total assistance. Staff F verified the resident is a 2 person transfer and	A 010		

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A 010	Continued From page 6 was not able to assist to bear or pivot. He said the resident was unable to help with or and needed to be fed. On at 4:10 p.m., Med Tech Staff G was observed to crush a tablet, mix it in pudding, and feed it to Resident #9 by spoon. Resident #9 was unable to assist due to of both of her . On at 9:11 a.m., a hospice spokesperson verified Resident #9 was discharged from hospice services on . The resident was in her 16th hospice benefit period and had plateaued. Further review of Resident #9's record showed there was no 45-day discharge notice. 2. Resident #10 was admitted to the facility on . The 1823 dated included diagnoses of with behavior disturbance. Physical limitations included mobility and status noted advanced without behavioral disturbance. The 1823 noted resident #10 required assistance with all activities of daily living. Resident #10's service plan documented needs/receives physical assistance of 2 for transfers, resident is not ambulatory, needs/receives assistance of 2 staff for . A Nursing progress note dated documented Resident #10 required a wheelchair with the assistance of 2 for transfers, and needed to be fed. On from 12:07 p.m. to 1:10 p.m., Resident #10 was observed being wheeled in a	A 010		

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A 010	Continued From page 7 high wheelchair to lunch and fed 100% of lunch by the facility LPN. The resident did not assist with eating or drinking. On at 2:16 p.m., Resident #10 was observed in bed in one piece jump suit. The facility nurse unzipped the jump suit, the resident was not able to assist with or or taking her arm out of the sleeve to assist. On at 3:55 p.m., the facility nurse verified Resident #10 was not able to assist with any Activities of Daily living. Further review of Resident #10's record showed there was no 45-day discharge notice. Resident was not receiving hospice services. 3. Resident #11 was admitted to the facility on , admission agreement was signed on . The 1823 dated included diagnoses of , , and Major . Resident #11 required the assistance of 2 persons to transfer and required medication administration. The diet listed was regular-pureed and Resident #11 required assistance to eat. Resident #11's Nursing Progress Note dated indicated the resident required wheelchair with assist of , needs to be fed and reminded to chew and swallow every bite, pockets food and is a high risk for . Multiple observations were made on and of Resident #11 being wheeled in her wheelchair, sitting in the activity room and being fed. Resident #11 did not participate or assist with any of the care being provided.	A 010		

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A 010	Continued From page 8 On . . . . at 12:07 p.m., Resident #11 was observed being fed by an activity's assistant. The diet was pureed. The juice thickened. The resident was unable to suck through the straw provided by the staff person. The staff person tipped the cup up to the residents' to attempt to engage her to drink. Resident #11 did not attempt to hold her cup or silverware to eat and was fed entirely by the staff person. On . . . . at 4:10 p.m., the Medication Tech was observed to crush an , . 5mg tablet and mix in pudding, then fed it to the resident by plastic spoon. Resident #11 was unable to assist. Further review of Resident #11's record showed there was no 45-day discharge notice. On . . . . at 2:20 p.m., the Acting Executive Director (ED) said Residents #9 and #10 were discharged from hospice services. The Acting ED said each resident needs to be able to assist with activities of daily living and assist with transferring. On at 3:55 p.m., Staff C Licensed Practical Nurse (LPN) said Resident #9, #10 and #11 were not able to assist with their activities of daily living. On . . . . at 9:30 a.m., the ED said Resident #9 should have had a new 1823 from the provider. In this case, it . through the cracks. The resident should have had a new 1823 then a notice of discharge. The ED verified Resident #9, #10 and #11 require total care. Class III	A 010		

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A 028	Continued From page 9	A 028		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide resident specific necessary activity of daily living care for 2 (Resident #9, #10) of 2 residents reviewed for activities of daily living. The findings include: 1. Resident # 9 was admitted to the facility on [redacted]. The Resident Health Assessment -Form 1823 (1823) dated [redacted] included diagnoses of major [redacted]. Resident #9 required total assistance with ambulation and transferring. The 1823 was not updated upon discharge from hospice services on [redacted]. Resident #9's service plan indicated 2 person assist for transfers. Resident #9's service plan indicated to invite and escort to all activities of interest. On [redacted] 10:50 a.m. - 2:10 p.m., Resident #9 was observed in a Broda (specialized wheelchair) and remained in the reclined position in her room mostly sleeping. No [redacted] care was provided during this time. No activities or social interaction provided, the television was not on in the room and there was no music playing. Resident #9 was not turned or repositioned during this time.	A 028		

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A 028	Continued From page 10 On at 1:38 p.m., Resident #9's wheelchair was pushed to her room by Caregiver Staff F, . The Caregiver picked the resident up from the Broda chair and positioned her in bed by himself. Resident #9 was not able to assist with the transfer, bear , pivot, or reposition herself in bed. She required total assistance. Staff F verified the resident is a 2 person transfer and she was not able to assist to bear or pivot. He said she was unable to help with or and needed to be fed. Resident #9 did not receive any care. On at 2:15 p.m., Licensed Practical Nurse (LPN) Staff C verified Resident #9 was in a hospital bed with bolsters and air mattress. LPN Staff C removed Resident #9's pants. The resident was observed to be wearing 2 heavily saturated adult briefs and dried feces was on Resident #9's skin. Staff F said he got Resident #9 out of bed at 8:15 a.m. On at 3:55 p.m., LPN Staff C verified Resident #9 , . She was observed on a specialty air mattress. The air pressure setting based on was set at , and the light was showing low pressure. LPN Staff C said the residents husband purchased the mattress. On at 12:20 p.m., Resident #9's lunch was placed on the table in front of her. Staff F began to feed here but was called away. No staff returned to feed Resident #9 until 1:10 p.m. Resident #9's food was not reheated prior to feeding her. The nurse sitting at the same table agreed, the resident's food must be .	A 028		

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A 028	Continued From page 11 On [illegible] at 1:12 p.m., the Acting Executive Director said there are usually management team members assisting in the dining room. She confirmed there are 6 residents requiring assistance with feeding today. 2. Resident #10 was admitted to the facility on [illegible]. The 1823 dated [illegible] included diagnoses of [illegible] with behavior disturbance. Physical limitations included [illegible] mobility and [illegible] status noted advanced [illegible] without behavioral disturbance. The 1823 noted Resident #10 required assistance with all activities of daily living. Resident #10's service plan documented needs/receives physical assistance of 2 for transfers, resident is not ambulatory, needs/receives assistance of 2 staff for [illegible]. On [illegible] from 12:07 p.m., to 1:10 p.m., Resident #10 was observed being wheeled in a high [illegible] wheelchair to lunch and fed 100% of lunch by the facility LPN. The resident did not assist with eating or drinking. On [illegible] at 2:16 p.m., LPN Staff C observed Resident #10 wearing a one piece jumpsuit lying on her [illegible] in bed. Staff nurse unzipped the zipper from the [illegible] and said the one piece outfit is the only way to keep the resident from putting her [illegible] in her pants. Resident #10's brief was heavily saturated. Staff F was called to the room. He said he last provided [illegible] care around 8:30 a.m. when he got her up for breakfast. LPN Staff C said both ladies should have been changed when they were put [illegible] to bed after lunch. On [illegible] at 3:35 p.m., the Acting ED said the	A 028		

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A 028	Continued From page 12 expectation was for residents to be changed/toileted every two hours. Class III	A 028		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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(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 032	Continued From page 13 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to determine residents at risk for elopement have identification on their person that includes the resident name, the facility address, name and telephone number for 20 residents (# 11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, and #31) of 20 residents identified as	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968977	A. BUILDING: _____ B. WING _____	01/10/2024

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INSPIRED LIVING AT BONITA SPRINGS	27221 BAY LANDING DR BONITA SPRINGS, FL 34135

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A 032	Continued From page 14 at risk for elopement. On [redacted] at 10:10 a.m., Caregiver Staff F said he does not know if anyone is at risk for elopement. He said he did not know if there was an elopement list or notebook. On [redacted] at 10:20 a.m., Licensed Practical Nurse (LPN) Staff C said: "They used to wear the inspired living rubber bracelet that had the name of the facility and telephone number, it was on the medication record but not anymore". LPN Staff C said there are no residents at high risk of elopement in the building, no list of residents at risk for elopement, no elopement binder or resident binder with pictures. On [redacted] at 2:20 p.m., the Acting Executive Director said, "certainly there are residents that are high elopement risk, there are elopement evaluations done on move-in, 30 days after, and every 6 months or change in condition. The interventions would be tailored based on the individual service plan. Our residents do not routinely wear identification. During a tour with the Executive Director he verified the residents were not wearing any form of identification. On [redacted] at 9:31 a.m., the administrator stated the facility does have [redacted] that have the name of the facility and they are required to be on each resident in the facility because most of the residents are memory care and are all considered elopement risk. On [redacted] at 10:03 a.m., a tour and observation with the administrator revealed residents #11, #12, #13, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, and #31 in the facility were not wearing ID bracelets as required. The administrator confirmed the	A 032		

Agency for Health Care Administration

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	AL11968977	A. BUILDING: _____ B. WING _____	01/10/2024

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A 032	Continued From page 15 residents did not have on ID bracelets as required.	A 032		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home	A 053		

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A 053	Continued From page 16 Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to provide medication administration by a licensed staff member in accordance with a health care providers order for 4 (Residents #8, #9, #10 and #24) of 4 reviewed who were unable to assist with self-administration of medication. The findings include: Review of Resident #24's Health Assessment - Form 1823 dated noted the resident required assistance with self-administration of medication. On at 4:10 p.m. the Medication Technician (Med Tech) Staff G was observed administering the 5:00 p.m. medication to resident #9. Med Tech Staff G said the process for this resident was to crush the medication, mix it in pudding, and feed it to the resident because Resident #9 could not assist. On at 4:45 p.m., Staff G opened 2 capsules of . . . , crushed an , . tablet, and mix the medications with pudding in a small med cup. Staff G stirred the contents of the cup with a spoon and fed it to Resident #24 while in the main activity area. The resident was not able to assist. The resident was not told the names of the medication or purpose. On at 5:00 p.m., the Med Tech was observed crushing , , mixing it in pudding,	A 053		

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A 053	Continued From page 17 and feeding it to a resident with a plastic spoon. The resident was not able to hold the cup or spoon or assist in any way. On at 9:30 a.m. the Executive Director said residents requiring medication assistance should be assisted with under technique. Staff have been instructed to assist and not spoon feed the medications to the residents. In situations where a resident is unable to assist with self-administration, the nurse should be administering the medications. On at 12:02 p.m., Med Tech Staff H said he had to spoon feed Resident #2's medication to her because she was not able to feed herself. Class III	A 053		