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 _____	05/09/2024

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 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c),	A 161		

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A 161	Continued From page 1 F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure 1 of 4 sampled staff was given a job description upon hire (H). Findings: A review of unlicensed caregiver H's personnel record revealed a hire date of . The record did not contain a job description. On at 4:05 pm, the business office manager said the caregiver did not have one. Class III	A 161		
A 000	Initial Comments A re-licensure survey, a complaint investigation (#2024005430) and a generator monitoring were completed at Inspired Living, Ocoee. Deficiencies were found at the time of the survey.	A 000		

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A 008	Continued From page 2	A 008		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s.	A 008		

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A 008	Continued From page 3 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the	A 008		

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A 008	Continued From page 4 special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care	A 008		

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A 008	Continued From page 5 practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule.	A 008		

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A 008	Continued From page 6 (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure a health assessment form (1823) was complete to include the examiner's address and telephone number for 1 of 9 sampled residents (#10.) Findings: A review of resident #10's 1823 revealed it was missing the examiner's address and telephone number. There was no additional documentation provided to indicate the facility contacted the health care provider to obtain the omitted information.	A 008		

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A 008	Continued From page 7 On at 1:30 pm, the finding was discussed with the memory care director, who said the documents provided were all the facility had for this resident. Class III	A 008		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 8 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure the safety and quality of care of residents (#1, #12) to prevent and injury for 2 of 7 sampled residents. Findings: In a record review of resident#1's health assessment confirmed a date of with an admission date of . It revealed a medical history of , , mixed hyperlipemia, , repeated ,	A 025		

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A 025	Continued From page 9 difficulty in walking, , and collapse, , essential , , communication , personal history of ( ) and infraction without residual , and . Resident #1 required assistance with daily living to include ambulation, transfer, grooming, bathing, , toileting, and assistance with medication. Resident#1 resides in the memory care unit. In a review of the facility observation notes, it revealed the following unwitnessed : 2:13pm Resident tripped in courtyard and staff found her right away Resident incurred a scrape right side of . Around 3:47 pm resident was out in the courtyard with other residents when she seen a male resident she tried getting up to to him and tripped and in the grass. Resident had on close shoes and used her manual wheelchair at the time of the in the grass. No injuries Resident was sitting in her wheelchair facing the door in the activity room. Staff then looked up and saw a resident standing up and trying to turn her wheelchair in the opposite direction. Staff asked the resident to please sit down, resident suddenly tripped over the of the wheelchair then lost her balance and backwards toward the TV in the activity room. Staff assisted the resident with getting off the floor and into her wheelchair. The resident did not hit her . 911 called. Resident incurred a . Review of care plan dated Needs assistance with transferring. interventions are to always use assistive devices, call for assistance as needed, proper fitting footwear, safety checks every 2 hours, walkways free of	A 025		

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A 025	Continued From page 10 clutter and well lit. In an interview on at 12pm caregiver C stated she was there when resident#1 . She stated she was passing out medications in the activity hallway. She stated resident #1 was in her wheelchair in the activity room facing the doors that look outside on the patio. She stated she stood up in her wheelchair and was told to sit down. She continued to stand up and on to the chair but did not hit her . She stated this happened in the late afternoon, she stated there are always enough staff it is just that the resident is very fidgety and likes to do things on her own. She stated we did supervise her, but she would not sit down. In an interview on at1pm caregiver F stated resident #1 when she was informed to sit in her wheelchair. She stated the residents are monitored in the common area. She stated she was administering medications at the time of the incident and could not get to her in time. She stated she is not aware of interventions other than reminding residents to use their assistive devices. 2. In a record review of resident#12's health assessment confirmed a date of and an admission date of . It revealed a medical history of 's , assistance with daily living to include bathing, , self-care, transferring, toileting, ambulation, and assistance with medications. In a review of the facility observation notes, it revealed the following unwitnessed ; at 2:20pm found lying on the floor in her apartment close to the door on her right side.	A 025		

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A 025	Continued From page 11 Resident stated while reaching for items in the refrigerator she lost balance and to the floor. Residents left thumb was and discolored. 911 was called. Resident incurred broken left thumb and right . There was no evidence the care plan was updated to ensure interventions for were put into place. In an interview on at 12:15pm caregiver D stated residents#1 and #12 had multiple and they are risks. She stated the staff monitors the risk resident every 2 hours. She stated we remind them to ask for assistance when transferring but they like to do it themselves. In an interview on at 12:30pm caregiver E stated she is not sure what a care plan is, and everything is in the computer. She stated the caregivers do 2-hour checks on the residents. She stated she is not aware of any interventions or increased supervision for risk residents. During an interview on at 3pm with Staff B who stated that the facility does not implement any interventions for risk residents. She stated she has not seen a care plan for residents. In an interview on at 2pm with the administrator, she confirmed the findings and stated the care plans will be updated.	A 025		

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A 025	Continued From page 12 There was no documentation provided during the survey that residents that were identified as risks received 2-hour checks. Class II	A 025		
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	A 032		

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A 032	Continued From page 13 at risk residents on file that is accessible to all 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 record reviews and interview, the facility failed to ensure 1 of 4 sampled staff participated in a minimum of two resident elopement drills each year (A.) Findings:	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 14 A review of caregiver A's personnel record revealed a hire date of . A review of the elopement drills dated , , , , and , revealed caregiver A was not listed as a participant on any of them. On at 4:35 pm, the finding was discussed with the administrator. No additional documentation was provided. Class III	A 032		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by:	A 034		

Agency for Health Care Administration

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	AL11969074	A. BUILDING: _____ B. WING _____	05/09/2024

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A 034	Continued From page 15 Based on observations, record reviews and interview, the facility failed to follow its policy on assistive devices by not having a health care provider's order for a wheelchair and side rails for 1 of 9 sampled residents (#10) and failed to assist with and ensure 1 of 9 sampled resident's wheelchair was clean (#10.) Findings: On . . . . . at 10:20 am, resident #10's wheelchair was found to be dirty. The resident said she lived at the facility since approximately , and no one ever discussed the process for cleaning the chair. Half side rails were seen on her bed. The facility's assistive devices policy indicated devices shall have a provider order and be included in the resident service plan. Assistive devices shall be maintained by the resident/responsible party. Should resident need assistance with maintenance education or cleaning of assistive devices, that shall be placed on resident service plan in coordination with resident/responsible party. A review of the residents' printed record revealed there was not an order for the wheelchair and side rails. There was not a service plan. On at 1:30 pm, the finding was discussed with the memory care director, who said the documents provided were all the facility had for this resident. Class III	A 034		

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A 052	Continued From page 16	A 052		
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 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	A 052		

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A 052	Continued From page 17 dose of [redacted] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [redacted]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [redacted], converting, or [redacted] medication doses, except for measuring a prescribed amount of liquid 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 [redacted] of the body. (d) Administration of [redacted] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [redacted], or [redacted] 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.	A 052		

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A 052	Continued From page 18 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 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,	A 052		

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A 052	Continued From page 19 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 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, record reviews, and interviews the facility failed to ensure 2 of 2 residents received assistance with self-administration of medication by observing the resident take the medication. (#7 & #8). Findings: 1. On at 10:48am observations revealed Resident #8 entering her bedroom and removing a medicine cup from the nightstand. The resident returned to the kitchenette and retrieved a cup of water along with a napkin. The	A 052		

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A 052	Continued From page 20 resident emptied the 5 pills onto the napkin and the cup had partial letters of what appeared to be her first name. Resident #8 stated during the interview, "they bring them to me in a cup. I have no idea what I'm taking. I take them when I'm ready. I tell them I'm not taking them on an empty . . . Yes, I just leave them in the room or if I'm not there they will leave for me." Continued observations upon exiting the room at 10:53am, "Resident #8 stated I'm going to take the pills now." Resident #8 self-administered her medications unsupervised. A record review of Resident #8 revealed a facility's admission date on . A 1823 Health Assessment Form indicated a medical history of , , Type 1 , of , Retention, forgetful at times and needs assistance with self-administration of medications. A record review of Resident #8's Medication Observation Record (MORs) revealed the following medications were administered at 0800. D3 tabs 1000 U take 1 tablet by once daily, 1mg tabs take 1 tablet by once daily, 500 mg tabs every morning and before bedtime, , DR 20mg caps take 1 capsule by QAM, and , 10mg tabs - take 1 tablet by once daily. On at 1:48pm Unlicensed Caregiver G stated, "yes, I administered the meds at 8:00am. Resident #8 answered the door, took the meds from me, closed the door and locked it." The staff was asked to explain the steps of how she	A 052		

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A 052	Continued From page 21 administered the medications to Resident #8. Unlicensed Caregiver G stated, "I put her name on the cup, popped the medications, updated the Medication Observation Record (MORs) before taking to her, and I did not watch her take them. Yes, popping before is how I normally administer the medications to all the residents. Unlicensed Caregiver G further stated, yes, I know I'm supposed to pop the pills one by one, name it, the milligrams, what's it's for, watch them take, and then update the MORs. Yes, we're supposed to pop in front of them, but I don't." On at 12:58pm Unlicensed Caregiver A stated, "Yes, I give meds to Resident #8, but I didn't today. When I was trained, Resident #8 had a red cup in her room, and we know to leave it there. Resident #8 knows to look for the meds if she's not there we come to give. No, I don't watch her take the medications." 2. A record review of Resident #7 revealed a facility's admission date on . A 1823 Health Assessment Form indicated a medical history of acute (HLD), , recurrent , and needs assistance with self-administration of medications. On at 10:22am Resident #7 stated the staff whose first initial is D does not tell me what I'm taking or prepare the meds in front of me. The medication is brought to me in a cup. I'm not sure of her name, but she administered my meds today." A facility note on at 12:43pm read, "daughter also asked if staff could let her know	A 052		

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A 052	Continued From page 22 how many med she is getting when they bring them into her." On at 12:58pm Unlicensed Caregiver A stated, "Sometimes I just take the meds to Resident #7 and give them to her in the cup. No, I don't tell her what I'm giving here. If she asks, I'll tell her. There are times when I've taken her meds, she would say that she didn't get them or she's not taking it." On at 2:48pm Unlicensed Caregiver H stated, "if Resident #7 asks, I tell her what I'm giving her. Sometimes, I pre-pop the meds and give them to her in the cup. I don't leave until Resident #7 takes it and then I update the MORs. No, I do not update the Medication Observation Record (MORs) before she takes them. I completed the med training and yes, we're supposed to one by one explain what they are. No, I don't know if the resident has a waiver, and I don't know what that is." (photographic evidence obtained) On at 5:15pm the Administrator and Director of Nursing confirmed the findings. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their	A 055		

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A 055	Continued From page 23 possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is	A 055		

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A 055	Continued From page 24 located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing	A 055		

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A 055	Continued From page 25 pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a medicated cream was not left in the room of 1 of 9 sampled residents who required assistance with self-administration of medications (#10.) Findings: On at 10:20 am, a medicine cup with a cream in it was seen on the resident's table next to where she sat in her recliner. The resident said the cream was prescribed for a . She said that approximately one hour prior to coming out of her bathroom when the staff member giving her medications put the cream on the bathroom counter then said she would return to apply it. The resident said she brought the cup out of the bathroom and set it on the table so it would be available when the staff member returned. A review of the resident's 1823 revealed the resident needed assistance with self-administration of medications. A review of the resident's Medication Observation Record (MOR) revealed an order for cream to be applied twice daily for a . A review of the resident's printed record revealed there was not an order for the resident to self-administer the cream and keep it at her bedside. On at 12:41 pm, unlicensed Caregiver A said she did leave the cream unattended in the resident's room then returned and applied it to the	A 055		

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A 055	Continued From page 26 resident. Class III	A 055		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of	A 078		

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A 078	Continued From page 27 education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience by allowing unlicensed caregivers to prepare , for injection and/or administer to 3 of 3 sampled residents (#14, #15, #16.)	A 078		

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	AL11969074	A. BUILDING: _____ B. WING _____	05/09/2024

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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 078	Continued From page 28 Findings: A review of resident #14's 1823 revealed the resident needed assistance with self-administration of medications. The resident's medical history included type 2, dependence. The resident had a and was forgetful. A review of resident #14's medications revealed he received 14 units three times daily after meals and 34 units at bedtime. A review of resident #15's 1823 revealed the resident needed assistance with self-administration of medications. The resident's medical history included type 2. A review of resident #15's medications revealed he received Lispro 7 units three times daily and 30 units at bedtime. A review of resident #16's 1823 revealed the resident needed assistance with self-administration of medications. The resident's medical history included type 2. A review of resident #16's medications revealed he received 6 units three times daily and 42 units at bedtime. On at 12:41, unlicensed caregiver A said she assisted residents #14, #15 and #16 by dialing the , to the prescribed units. On the caregiver received 6-hours of training on assisting with self-administration of medications. On at 1:40 pm, resident #15 said the staff dialed the pen for him. On at 1:55 pm, unlicensed caregiver G	A 078		

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 _____	05/09/2024

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A 078	Continued From page 29 said she assisted all three residents by telling them how many units to dial then she checked it for accuracy. The caregiver said for resident #16 she used over technique to inject the . The caregiver said the reason was because the resident's pants and diaper were high up on his abdomen, so she helped him inject the under them. On the caregiver received 6-hours of training on assisting with self-administration of medications. On at 2:03 pm, resident #16 said staff dialed the pen then showed him the amount of units. The resident said he was usually able to inject the himself and sometimes staff had to help. On at 2:30 pm, unlicensed caregiver H said to assist residents #14 and #15 with she placed her own on top of the resident's, whose was on the pen button, then she used her to push down on the resident's to inject the . On the caregiver received 6-hours of training on assisting with self-administration of medications. On at 3:28 pm, unlicensed caregiver B said to assist resident #14 she dialed the pen to the prescribed units. For resident #16 she dialed the pen to the prescribed units. The resident then pulled the top of his pants down. The caregiver cleaned the resident's abdomen with then she injected the . On the caregiver received 6-hours of training on assisting with self-administration of medications. On at 4:25 pm, resident #14 said the staff injected the . He did not know whether the staff or he dialed the pen.	A 078		

Agency for Health Care Administration

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A 078	Continued From page 30 A review of resident #14's and #15's , Medication Observation Record (MOR) revealed caregiver A assisted them on , and . Caregiver G on . Caregiver H on and . A review of resident #16's , MOR revealed caregiver A assisted the resident on and . Caregiver B on and , Caregiver G on and . Caregiver H on . Class III	A 078		