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 _____	R 03/04/2024

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 revisit survey was conducted on . . . . at Inspired Living at Bonita Springs, an assisted living facility in Bonita Springs, Florida. The follow-up was in response to the complaint survey completed on . The following is description of the deficiencies found at the time of the visit.	{A 000}		
{A 028} SS=D	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 . . . . . care for 2 (Resident #9, #10) of 2 residents reviewed for care. The findings include: 1. Resident # 9 was admitted to the facility on . . . . . The Resident Health Assessment -Form 1823 (1823) dated included diagnoses of major . . . . . Resident #9 required total assistance with ambulation and transferring. Resident # 9's service plan included: 2 person assist for transfers; Invite and escort to all activities of interest; and Toilet every 2 hours to prevent	{A 028}		

AHCA Form 3020-0001

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

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{A 028}	Continued From page 1 On . . . . 8:35 a.m. - 12:50 p.m., Resident #9 was observed in a Broda chair (specialized wheelchair) and remained in the reclined position in facility hallway mostly sleeping. No . . . . . care was provided during this time. No activities or social interaction was provided, Resident #9 was not turned or repositioned or toileted during this time. On at 12:50 p.m., observation and interview with care staff, Resident #9's was wheeled to her room by Caregiver Staff J. Resident #9 was transferred from the Broda chair to her bed by Staff J and Staff I to provide . . . . . care. Staff J verified the resident is a 2-person transfer and is to be is to be changed every 2 hours. Staff J confirmed resident #9 had not been changed since getting dressed for breakfast at 7:30 a.m. Resident # 9' s adult brief was soaked in when removed by staff J and I. 2. Resident #10 was admitted to the facility on . . . . . The 1823 dated included diagnoses of . . . . . with behavior disturbance, , , , and , ... 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 included: Needs/receives physical assistance of 2 staff for transfers; Needs/receives assistance of 1 staff for toileting; Is . . . . . of . . . . . and . . . . . On . . . . 8:35 a.m. - 1:11 p.m., Resident #10 was observed in a Broda chair and remained in the reclined position in facility . . . hallway mostly sleeping. No care was provided	{A 028}		

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{A 028}	Continued From page 2 during this time. No activities or social interaction was provided, Resident #10 was not turned or repositioned or toileted during this time. On . . . . at 1:15 p.m., Staff J stated Resident #10 is a 2-person transfer and is to be changed every 2 hours. Staff J confirmed Resident #10 had not been changed since getting dressed for breakfast at 7:00 a.m. Resident #10's adult brief was saturated in when removed by staff J and I and her clothing was wet when transferred from her wheelchair. Staff J confirmed she did not check on Resident #10 from getting her dressed this morning until now. On at 1:42 p.m., the Health and Wellness Manager (HWM) stated the expectation was for residents to be changed/toileted every two hours. HWM stated Residents #9, and #10 are to be changed every 2 hours and prior to breakfast, after breakfast, and before lunch. On . . . . at 2:44 p.m., the Executive Director stated for residents that require assistance with toileting, the staff are to check and toilet every 2 hours, for residents that are hospice and require toileting, positioning and turning the staff are to assist them every 2 hours. The Executive Director confirmed Residents #9 and #10, should be toileted and repositioned every 2 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 032}		

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{A 032}	Continued From page 3 (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 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	{A 032}		

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{A 032}	Continued From page 4 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 ensure residents at risk for elopement have identification on their person that includes the resident name, the facility name, address, and telephone number for 14 residents (#12, #13, #14, #17, #20, #21, #26, #27, #30, #33, # 34, # 35, #36, #37) of 26 residents observed for identification. The findings included: On . . . at 9:30 a.m., the Health and Wellness Manger (HWM) stated all residents in the facility are considered elopement risks and wear ID bracelets with their name, the facility name and telephone number on it. On at 9:35 a.m., observation during a tour with the HWM revealed 10 residents #12, #14,	{A 032}		

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{A 032}	Continued From page 5 #20, #21, #26, #27, # 34, # 35, #36, #37 in the facility were not wearing ID bracelets as required. The HWM confirmed the residents were not wearing any form of identification as required. Mark Gephart: On [redacted] at 9:50 a.m., during a tour with Assistant Executive Director, it was observed that of 4 residents #13, #17,#30, #33 were not wearing elopement identification bracelets as outlined in facility plan of correction dated [redacted]. Class III	{A 032}		
A 052 SS=D	429.256([redacted]); 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 [redacted] syringe that is prefilled with the proper dosage by a pharmacist and an [redacted], [redacted] 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	A 052		

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A 052	Continued From page 6 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 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,"	A 052		

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A 052	Continued From page 7 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 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,	A 052		

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A 052	Continued From page 8 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 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	A 052		

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A 052	Continued From page 9 medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff who assist residents with self-administration of medications do so in accordance with proper procedure for 5 (Residents # 22, #27, # 32, #39, # 40) of 5 medications observations. The findings included: 1. On at 8:47 a.m., Medication Technician (Med Tech) Staff H was observed assisting Resident #39 with medications. Staff H opened resident #39's profile on the computer, and proceeded to prepare the medications placing the medication dosages into a souffle cup. No hygiene was performed. Staff H took the medication to Resident #39 in the dining room. Staff H handed Resident #39 the cup of pills and said, "this is your meds." Staff H continued to prep medications for other residents. Staff H did not inform Resident #39 what medications were given, and no hygiene was performed in between residents. On at 8:52 a.m., Med Tech Staff H was observed assisting Resident #27 with medications. Staff H opened Resident #27's profile on the computer, and proceeded to prepare the medications placing the medication dosages into a souffle cup. Staff H took the medication to Resident #27 in the dining room. Staff H handed Resident #27 the cup of pills and said, "hi, here is your meds." Staff H did not inform Resident #27 what medications were given, and no hygiene was performed in between residents.	A 052		

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A 052	Continued From page 10 On at 8:55 a.m., Med Tech Staff G was observed assisting Resident #32 with medications. Staff G opened resident # 32's profile on the computer, and proceeded to prepare the medications placing the medication dosages into a souffle cup. No hygiene was performed. Staff H and took the medication to Resident #32 in the dining room. Staff H handed Resident #32 the cup of pills and said, "Hi, how are you doing? I have some medications for you." Staff H did not inform Resident #32 what medications were given, and no hygiene was performed in between residents. On at 9:00 a.m., Med Tech Staff G was observed assisting Resident #22 with medications. Staff G opened Resident #22's profile on the computer, and proceeded to prepare the medications placing the medication dosages into a souffle cup . Staff H and took the medication to Resident #22 in the dining room. Staff H handed Resident #22 the cup of pills and said, "Hi, how are you doing? I have some medications for you." Staff H did not inform Resident #22 what medications were given, and no hygiene was performed in between residents. On at 9:10 a.m., Staff G said, "We are supposed to tell the resident what meds they are being given but some residents have and don't understand what I am giving them, so I don't tell them." On at 9:20 a.m., Med Tech Staff H was observed assisting Resident #40 with medications. Staff H rolled the med cart down the hallway to Resident #40's room and opened resident # 40's profile on the computer. No	A 052		

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A 052	Continued From page 11 hygiene was performed. Staff H proceeded to prepare the medications placing the medication dosages into a souffle cup. One pill . onto the top of the med cart. Staff H took a spoon and scooped the pill up and placed it into the cup with the other pills and went into Resident #40's room. Staff H said, "Hi, I have your meds for you." Staff H did not inform Resident #22 what medications were given, and no . . hygiene was performed in between residents. On at 11:28 a.m. in an interview, the Health and Wellness Manager (HWM) stated the med techs are required to tell the residents what medications they are being given. HWM said the med techs have a bottle of sanitizer and are to use the sanitizer between residents. Staff H said after every 3rd resident they are to wash their . . . Staff H stated he thought they could use the ABHR between residents for three times and then wash their . . . with soap and water after the 3rd resident for med pass. The HWM confirmed the med techs did not follow proper procedure when assisting the resident with the medications. On at 3:00 p.m., the Executive Director stated when assisting with self-administration of medications the med techs are to tell the residents what medications they are being given and what they are for, and they should be sanitizing their between each resident during med pass. The Executive Director confirmed the med techs did not follow the proper procedure when assisting the residents with self-administration of medications. Class III	A 052		

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