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 _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint investigation #2025003268 and Generator Monitoring surveys were conducted on to at Inspired Living, Ocoee. The complaint was substantiated with deficiencies. Class I deficiency was identified at A0025.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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

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

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

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on resident record review, and interview, the facility failed to obtain an updated 1823 Health Assessment, Agency for Healthcare of Administration (AHCA) form by a healthcare provider for significant changes in condition for 3 of 5 sampled residents as required for continued residency, (#1, #4, #5). Findings: 1. Resident#1's record review revealed admission date . The last 1823 health assessment form dated listed medical history of with behavioral disturbances, D deficiency, assistance with daily living for ambulation, use of physical devices, and assistance with medications. The resident was not listed at risk for elopement. Review of the record noted resident #1 was not reassessed for elopement risk after she was found throughout the facility and near the woods on facility grounds. In an interview on 1 PM, the Health Wellness Director confirmed the resident's care plan dated and the health assessment dated were not updated to reflect the resident's behavior. 2. Resident #4's record review revealed an admission date of . The last 1823 Health Assessment dated listed medical history of 's without dyskinesia and . His status listed oriented x3 with no special	A 010		

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A 010	Continued From page 5	A 010		

precautions. He was independent with all activities of daily living (ADLs) and needed assistance with self-administration of medications.

A facility note dated at 4:20 PM, by the Health Wellness Director documented a care staff had found Resident #4 in a bush by the pool area. Resident #4 stated he had lost his balance and over. There were no injuries observed, and he had no complaints of .

There was no documented evidence that a new 1823 Health Assessment was completed after a significant change, .

3. Resident #5's record review revealed an admission date of . The last 1823 Health Assessment dated listed the medical history of ( ), hyponatremia, and fatty . The resident was noted to smoke, wore eyeglasses and ambulated with a walker. The assessment showed the resident required supervision with ambulation, bathing and toileting. The resident was independent with , eating, grooming and transfers. She needed assistance with self-administration of medications.

There was no documented evidence that a new 1823 Health Assessment was completed by a healthcare provider required after three (3) years and no updated 1823 Health Assessment completed.

On at 10:45 AM, the Health Wellness Director confirmed the findings.

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A 010	Continued From page 6 Class III	A 010		
A 025 SS=J	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, 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,	A 025		

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A 025	Continued From page 7	A 025		

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 observation, record review, and interview, the facility failed to provide appropriate supervision to prevent elopement, failed to document significant changes for 1 of 2 sampled residents, (#1), and failed to ensure appropriate care and services were implemented to maintain safety and mitigate risk for for 2 of 5 sampled residents, (#4, #5).

Findings:

1. Record review for resident #1 revealed the resident was admitted on . The resident had medical history of with behavioral disturbances, ambulated with assistive devices, and had . The resident was assessed to require supervision with ambulation. The resident was not an elopement risk at the

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A 025	Continued From page 8 time of the incident. An incident report dated noted resident #1 was last seen on at midnight and was redirected to her room. At 9:00 AM, the care staff went to remind the resident to come down for breakfast but the resident was not in her room. At 9:45 AM, the Medication Technician proceeded to the resident's room to give her medications but was called away for an emergency. The report noted staff informed the Health and Wellness Director at 11:00 AM that the resident could not be located. The resident had not signed out and the Power of Attorney (POA) did not know the resident's whereabouts. The incident report showed the elopement protocol was implemented at 11:15 AM. At 11:45 AM, Law Enforcement was notified and arrived at the facility at 12 PM. Law Enforcement conducted a search for the resident and Silver Alert was issued. The resident was known to carry an air tag on her keys for entry in the building. At 7:15 PM the resident was found by Law Enforcement approximately mile away from the facility, lying in a ditch near a retention pond. Emergency Management Services ( ) were called and the resident was transferred to the hospital and admitted for sunburns and Review of the report noted they were dispatched on at 7:09 PM to the area where the resident was found. The report showed Law Enforcement were still at the location. The resident was found lying in dirt, approximately 200 from the road, near the wall of two major, heavily trafficked highways. The report indicated the resident had slight , pain to her upper right upon palpation and did not have , or difficulty breathing. The resident was described as visibly shaken with dirt	A 025		

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A 025	Continued From page 9 all over her and body. She was unable to walk, and had sunburn on her , and . The resident was transferred to the hospital. Review of the hospital admission records dated revealed the resident was admitted for , elevated Troponin levels, , and unspecified mental status. The report showed the resident was found in a ditch. The resident resided in an Assisted Living Facility and had been missing from the facility. The resident was found covered in dirt and severely . The resident was and unable to cooperate with the interview. Mental status showed she was . The record noted, poor appetite, , , , wasting, , and skin peeling. The record indicated the resident was discharged on to another Assisted Living Facility. Observation of the area and ditch where the resident was found noted it was approximately 1000 from the facility. The ditch was about 4 deep noting the resident would not have been visible from the street. The ditch was adjacent to a major high trafficked highway. Review of the weather website for the date of the elopement ( ) when the resident's air tag pinged at 2:15 AM was 56 degrees Fahrenheit. The high temperature for on was 79 degrees Fahrenheit. At 7:15 PM, when the resident was found, the temperature was 73 degrees Fahrenheit. On at 2:53 AM, the Regional Vice President (VP) of Operations said they were doing an internal investigation of resident #1's elopement incident. She stated their investigation	A 025		

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A 025	Continued From page 10 showed the resident was last seen on video camera at 12:04 AM. She explained the resident went out the side door at the end of the building and noted anyone was able to exit that door but could not come in. The Regional VP reported there was no alarm at that door and for safety reasons the door locked from outside so that no one could come in the building but anyone could go out. She indicated there was no policy on how often staff checked on residents and added the residents' care plan would determine the frequency of checks. The Regional VP was informed the resident's family received a ping from the resident's air tag at 2:15 AM on . She said she was not aware the resident had an air tag. She stated elopement risk residents were listed in a binder located at front of the facility. She explained they had one other resident at risk for elopement. On at 8:30 AM, the Maintenance Plant Operator showed the door where the resident exited from the facility. He stated a person could exit from this door but could not come inside. He said as long as the door closed at exit, it was not an issue, and no reason to fix the door. He stated his supervisor told him the door did not need to be fixed as no one could come in from outside. He indicated the door was not broken, the facility wanted the door to function this way. On at 10 AM, during a telephone interview, unlicensed staff M stated that on at 7 PM, she went to resident #1's room but found out the resident was out with her daughter. Staff M said she was familiar with resident #1 and noted the resident should have been placed on a memory care unit as she had exit seeking and _ behaviors. She explained during her shift, she kept resident #1 by	A 025		

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A 025	Continued From page 11 her side to observe her closely and prevent her from exiting the facility. On at 12:26 PM, Night Supervisor F recalled she assisted resident #1 to bed at 12 AM. She remembered she then continued with her tasks and at 2:30 AM, she returned to the 3rd floor where resident #1 resided and provided care to other residents. She said she did not return to resident #1's room as she assumed the resident was sleeping. She explained that staff on every shift were assigned to complete checks every 2 hours on all residents that required help with Activities of Daily Living (ADL) during the night. The 2-hour checks were assigned at 12 AM, 2 AM, 4 AM and 6 AM. She reiterated resident #1 was not checked as she did not require ADL care during the night. Supervisor F stated resident #1 had been presenting with exit seeking behaviors, forgetfulness and for some time. She said she reported these behaviors to her Supervisor by using the facility's group chat text message. She further stated the day before the elopement, on that resident #1 was on the elevator repeatedly going up and down. She recalled then at 2 AM, she to 1st floor near the front desk, pacing and stated that she could not sleep. The front desk, concierge H, redirected her and took her upstairs to her room on the 3rd floor and helped resident #1 to bed. The Night Supervisor recalled resident #1 was once found sleeping on the bench outside the front of the facility. She could not remember the date. Supervisor F recalled another incident, on unknown date where resident #1 to the of the facility in the woods and staff had to search for her. She could not remember the date, but it wasn't that long ago. She said that if you spoke to resident # could tell she was and should have been placed in	A 025		

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A 025	Continued From page 12 memory care. She explained on , the evening before the elopement, the resident's daughter visited and stayed until about 8 PM. The daughter spoke about moving the resident to a memory care unit. She noted she had no idea resident #1 had exited the facility during the night until she was contacted by phone by the Administrator and Wellness Director on at 9:30 AM . Supervisor F stated she took full responsibility for what happened to resident #1 on and resigned from her position on . She noted she should have checked on the resident during the night as all residents on the 3rd floor were her responsibility. Review of the facility's investigation and interviews showed resident #1 was missing between 12:00 AM and 2:00 AM on . Facility staff were not aware the resident was missing until 11:15 AM on . The resident was found 19 hours later by Law Enforcement lying in a deep ditch near a heavily trafficked highway. She was then admitted to the hospital with severe sunburns, abnormal Troponin levels and . The last time the resident was seen is when the Night Supervisor put her to bed at midnight. Interviews noted the resident had presented with and exit seeking behaviors and had exited the facility on two previous occasions yet no interventions were implemented to ensure the safety of resident #1. The only documentation of the resident's behavior showed a meeting was held with the family where memory care unit was discussed on , the day before the elopement. Review of the resident's care plan showed the care plan was not updated since the resident was admitted on . On at 6:38 AM, the Health and Wellness Director stated she was	A 025		

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A 025	Continued From page 13 new. She did not explain why the care plan had not been updated for almost one year despite the changes in resident #1's behaviors. There was no facilty policy to indicate how frequently residents needed to be checked. There was no training or in-services conducted by the facility after the elopement incident to prevent reoccurrence. Review of the facility's Elopement Policy revised read, residents have the right to live at ease, in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce the risk of resident elopement. When a resident elopement occurs, the community will provide a coordinated effort to ensure prompt, thorough search of the missing resident. The goal is to locate and safely return the missing resident to the community. Review of the facility's policy for resident care plans noted, "The Health Wellness Director will complete the care plan every 180 days or whenever there is a significant change in the resident's status." 2. Resident #4's record review revealed a date of admission of . The last 1823 Health Assessment form dated listed medical history of 's without dyskinesia and . His status noted he was oriented x 3 with no special precautions. The assessment noted the resident was independent with all ADLs and needed assistance with self-administration of medications.	A 025		

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 _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

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A 025	Continued From page 14 Review of a facility note dated at 4:20 PM, by the Health Wellness Director documented a care staff found resident #4 in a bush by the pool area. Resident #4 had explained he had lost his balance and . There were no injuries observed, and he had no complaints of , . A review of the last service plan for dated and revised on showed no documentation of any interventions implemented to mitigate the risk of further . There was no documented evidence the physician or family were notified of resident #4's . 3. Resident #5's record review revealed a date of admission as . The last 1823 Health Assessment form dated (expired , last year) listed medical history of , ( ), , , , , , , hyponatremia, and fatty . The resident smoked, wore eyeglasses and ambulated with a walker. Treatments included physical and occupational therapies with no special precautions noted. The assessment showed the resident required supervision with ambulation, bathing and toileting. The resident was independent with , eating, grooming and transfers. A facility note dated at 10:44 PM, by the Night Supervisor F documented resident #5 was coming from the facility's activity program at about 4 PM and needed assistance to go outside to smoke a cigarette when lost her balance and . The note indicated was called and the resident was transported to the hospital. A facility note dated at 11:16 PM, by the Night Supervisor F showed resident #5	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 025	Continued From page 15 returned from the hospital to the facility transported by her daughter. A facility note dated at 10:45 PM, by the Night Supervisor F documented the resident had activated her help alarm. The resident was found on her in her room by the bed. Her vital signs were within normal limits and the resident said she was not hurt and did not have , . A review of the service plan for dated , with revisions on and showed no interventions in place to mitigate further . There was no documentation to indicate the physician was notified of the two . On at 10:45 AM, the Health Wellness Director acknowledged the findings and did not explain why the service plans had not been updated to include any interventions to prevent . (Photographic Evidence Obtained) Class I	A 025		