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 _____	06/24/2025

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

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ZZ000	Initial Comments	ZZ000		
ZZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse	ZZ821		

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ZZ821	Continued From page 1 incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar	ZZ821		

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ZZ821	Continued From page 2 days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or	ZZ821		

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ZZ821	Continued From page 3 more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on the facility reviews and interviews, the facility failed to electronically submit to the agency a preliminary report within 1 business day of the incident and a full report within 15 days of the incident for 1 of 8 sampled residents (#8). Findings: On at 9:30 AM, during the entrance conference, the director of health and wellness stated resident #8 was out of the building due to a that occurred while she was with her son. Review of resident #8's 1823 Health Assessment indicated a medical history type 2 ( ), , , , ( ), , , and not identified as a risk. A facility note on at 12:00 read, spoke with the case manager, she stated the resident	ZZ821		

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ZZ821	Continued From page 4 has a follow up , , with a neurosurgeon on . A facility note on at 15:12 read, called the case manager to get an update on the resident's progress. The case manager said that , , , , ( ) is still working on brace management with the resident. A facility note on at 15:10 read, spoke with case manager at Sky Top rehabilitation. Resident has a pending discharge (d/c) in the next two weeks. The resident still has the brace and . Cast to be removed on per notes. A facility note on at 18:28 read, resident is currently at Sky Top rehabilitation, resident does not have brace and has a right . Waiting on orders from surgeon to see if the will be removed sooner. , follow-up on . As of right now resident cannot manage brace due to the right . A facility note on at 10:33 read, spoke with resident's POA/son regarding the resident falling at a birthday party in the park under their care on . The resident went to bathroom on her own and when coming out, tripped and , causing her to her T4, L1 horizonal and her right . On at 12:22 PM during a phone interview, the POA stated, resident #8 at the park, but had a prior at the facility at the facility and broke her tailbone. The director of health and wellness was asked to provide a copy of the incident report for resident	ZZ821		

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	Continued From page 5 #8's . On at 2:09 PM, the director of health and wellness stated, the happened outside of the facility. So, we would not have needed to report. On at 3:14 PM, the director of health and wellness stated, oh, I thought I gave you the incident report for resident #8. No, we didn't report it because it didn't happen here. On at 4:15 PM, the administrator and director of health and wellness confirmed the findings. Unclassified	ZZ821		
A 000	Initial Comments Two complaint investigations # 2025005139 and #2025008118 were conducted on at Inspired Living Ocoee, Florida 34761. The facility had deficiencies at the time of the visit.	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	A 010		

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A 010	Continued From page 6	A 010		

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, 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

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A 010	Continued From page 7 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 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	A 010		

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A 010	Continued From page 8 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 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	A 010		

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A 010	Continued From page 9 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 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 record reviews and interviews, the facility failed to obtain a new AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency for 1 of 8 sampled residents (#2) as required in an assisted living facility (ALF). Findings: Review of resident #2's record revealed a facility's admission on . A . 1823 Health Assessment indicated a medical history of , , , , , non-applicable physical, sensor limitation, special precautions, and or behavioral status. A facility note on at 18:39 read on	A 010		

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A 010	Continued From page 10 , resident was not able to transfer with assistance nor able to pivot, recommendation was for the resident to go to rehab for balancing and strengthening. A facility note on at 16:10 read, med tech and care partner were assisting the resident in the bathroom during transferring to the toilet, resident buckled, and he while being assisted by 2 care staff members. A facility note on at 13:00 read, Regional/VP/Clinical, sat down with resident #2's daughter and her husband and explained that the resident is not actively assisting with transfers and yelling for help. A facility note on at 14:00 read, Resident has motorized wheelchair that he wants to use, also has a manual wheelchair that / wants the resident to use instead of motorized. On at 1:00 PM, the director of wellness stated resident #2 is at Lake Bennett and we sent him there after leaving the hospital due to the change of condition. Resident #2 refuses to help with transferring. Yes, he has a motorized wheelchair that he uses. Further review of resident #2's admission 1823 Health Assessment indicated a medical history of , paraparesis of both , wheelchair dependent, and . The director of wellness was made aware after review of resident #2's admission 1823, identifying the resident had a history of , identified as a risk and the use of an assistive device.	A 010		

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A 010	Continued From page 11 (photographic evidence obtained) Class III	A 010		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of	A 030		

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A 030	Continued From page 12 its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.	A 030		

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A 030	Continued From page 13 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both	A 030		

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	AL11969074	A. BUILDING: _____ B. WING _____	06/24/2025

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A 030	Continued From page 14 are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a	A 030		

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A 030	Continued From page 15 facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman	A 030		

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A 030	Continued From page 16 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure safety for 1 of 4 sampled residents (#1) the ability to live in a safe living environment free from neglect. Findings: A review of an incident report dated indicated any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident.	A 030		

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A 030	Continued From page 17 Location to which the resident was transferred: Advent Health Winter Garden. On at 10:25 AM, resident #1 stated yes, I do recall not getting my medications. I was going out to Target or Walmart that day. I waited in my room, but the staff never came. Resident #1's POA (power of attorney) called during the interview stating. Resident #1 missed her morning medications due to going on a trip the facility planned. She added, the facility should have made sure resident #1 had her medications before leaving. She stated, "I don't understand how they refused resident #1 her medications when she returned asking specifically for her due to having . The facility's Medication Administration Policy stated the community staff will comply with resident's healthcare practitioner orders; state law and regulations may be applicable. Alternative medication administration methods may be utilized according to state regulations. Administer medications at least within 60 minutes on each side of ordered time, except for medications to be administered immediately or other time-sensitive medication. Medications ordered in the AM will be administered between the hours of 6am - 11am. A record review of resident #1's 1823 Health Assessment indicated needs assistance with self-administration of medications. Resident #1's medication observation record (MORs) revealed on at 0900 0.25mcg caps, 200mg caps, 10mg tabs, 100mg caps, 2.5mg tabs, 40mg caps, 20mg tabs, 100mg caps, 25 mg tabs, ER 50mg tabs,	A 030		

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A 030	Continued From page 18 Mutlaq 400mg tabs, , 40mg tabs, and Prerevision Areds caps. All updated with group observed 1 = absent from the home without meds. A facility note on at 11:02 read, I (director of wellness) checked on the resident this morning, the resident is doing well. A facility note at 7:07 read, I (director of wellness) checked on the resident this morning, the resident is doing well. A facility note on at 19:00 read, alert return from hospital, resident returned to the facility at 1900. A facility note on at 18:27 read, resident is being discharged. Resident is doing better, follow up with and recommended / services. A facility note on at 13:32 read, I (director of wellness) called and spoke with the nurse. The resident is currently in the clinical decision unit. The resident is under observation, awaiting and , consult. Troponins were elevated on intake, leveled out and is increasing , . The resident has an electrolyte imbalance and will be replacing . The resident is currently going and forth into and is on fluids for hydration and vitals are within normal limits. A facility note on at 14:30 read, the resident was complaining of , and due to her A-fib. A facility note on at 14:00 read, the resident went to Target earlier and was unable to	A 030		

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A 030	Continued From page 19 take her morning medications. When the resident came , she was having symptoms, , , , and . was called and the resident was taken to Advent Health Winter Garden for further evaluation. On at 2:15 PM, unlicensed caregiver D stated yes, I give resident #1 her meds. I saw resident #1 at breakfast the day she went out. I reminded her to take her meds and to go to her room and wait. I started doing meds on the first floor where resident #1's room is located. Resident #1 doesn't like to take her medications before breakfast. After I finished the 1st floor meds I continue to the 2nd floor. When I came downstairs, resident #1 was not in her room. When I checked with the concierge they accidentally checked out the wrong resident and I was told resident #1 was in the building, but I couldn't find her. No, I didn't tell anyone prior to resident #1's return to the facility that she didn't receive her morning meds. When she returned, she expressed to another staff member that she wasn't feeling well. I was asked by the staff to go and talk to resident #1 about her medications. I explained to resident #1 that she missed her window to receive her meds. Resident #1 stated she wanted her meds and if I didn't give to her, she would call 911. That's when I told the director of wellness what happened. She told me to give resident #1 her . After resident #1 took the medications, she then asked to go to the hospital. The facility's Elder /Neglect policy states elder includes physical, emotional, or harm inflicted upon an elder adult, financial , , or neglect of their welfare by people who are directly responsible for their care.	A 030		

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A 030	Continued From page 20 Neglect; failure to meet an older adult's basis needs including food, water, shelter, clothing hygiene and essential medical care. Driver C was asked if the facility maintains a transportation list of residents who went to Target or Wal Mart on , and the process for signing up. On at 8:30 AM, driver C stated yes, the facility maintains a list and I'll get it for you. He stated a sign-up sheet is posted in advance at the concierge desk on the side counter so that the staff are aware of the medications of the residents that are going out. There is a cut off for signing up. The sheets are removed the day before and returned early enough in the morning so that staff can review. On at 8:45 AM, driver C stated, I am working on figuring out to print the list. He added, I provide the list of names to the staff so they can make sure the residents get their medications before leaving. I also give a copy to the front desk concierge so that they can input the names into Accushield to have a record in the computer for signing in and out. On at 9:40 AM, driver C provided the transportation log which revealed resident #1 signed out at 10:12 AM on , returning at 12:00, stating I took resident #1 to Target. I stay with the residents, allowing them 1 hour to shop before returning to the facility. It was probably a little before 12 to ensure she was in time for lunch. On at 12:45 PM, the director of wellness stated I was notified afterwards that resident #1 wanted her morning med and didn't	A 030		

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A 030	Continued From page 21 receive any before going out. I asked unlicensed caregiver D why resident #1 didn't receive her medication. The unlicensed caregiver stated that resident #1 went out and didn't get her meds. She continued stating, the resident wasn't in her room when she went there. So, after the resident threatened to call the police and while I was on the phone with resident #1's doctor. I advised the unlicensed caregiver to give resident #1 the . I'm not sure what happened that day. The alert and oriented residents usually tell the unlicensed care staff they are going out. The staff has been trained going forward to make sure resident #1 gets her meds first each day. The facility's Medication Errors/Adverse Drug Events stated an adverse drug effect is defined as an occurrence where an injury due to the use of a drug (including failure to administer or late administration) occurs. The facility neglected resident #1 by not administering her medications at the scheduled time nor did the staff immediately notify the director of health and wellness or executive director. (photographic evidence obtained) Class III	A 030		
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	A 052		

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A 052	Continued From page 22 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 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	A 052		

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A 052	Continued From page 23 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," 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	A 052		

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A 052	Continued From page 24 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, 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	A 052		

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A 052	Continued From page 25 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 record reviews and interviews, Unlicensed care staff E failed to follow proper medication - assistance with self-administration of an improper med pass for 1 of 2 sampled residents (#6). Findings: On at 9:30 AM during the entrance conference, the director of health and wellness, identified resident #6, was out of the building due to a medication error. Review of an incident report dated indicated a condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Location to which the resident was transferred: Health Central Hospital. On , at approximately 9:30 PM, the resident was given	A 052		

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A 052	Continued From page 26 her physician ordered and was given another resident's , , , , and . Review of resident #6's 1823 Health Assessment indicated needs assistance with self-administration of medications. A facility note on at 13:36 read, the resident is being evaluated by Gentiva Hospice today at 3 PM. A facility note on at 16:16 read, met with resident #6's daughters today regarding the president's plan of care. A facility note on at 13:04 read, spoke with case manager regarding rehab placement. A facility note on at 13:00 read, spoke with resident #6's daughter regarding the resident going to rehab. A facility note on at 11:02 read, I (director of health and wellness) called the hospital to get a status update on the resident. A facility note on at 14:00 read, I (director of health and wellness) spoke with resident's daughter to give her an update on the resident's status. A facility note on at 11:40 read, I (director of health and wellness) called Health Central Hospital to get a status update on the resident from the nurse. The resident has been admitted to the observation unit due to medication error. The resident is still very sleepy and dozing off.	A 052		

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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 052	Continued From page 27 A facility note on at 11:30 read on at 2130 the resident was given one of her medications, which was to help her sleep and also help with , since she just lost her husband. She was also given , (treats), (, ,), (sleep aid), and (treats , and is an appetite stimulant) belonging to another resident with a similar first name. On at 10:48 AM, resident #6's POA stated during a phone call, I was not present at the time of the med pass. When I arrived resident #6 appeared . I saw that the staff had left the medication basket on the table in the room. So, I decided to look at the medication packets and they were . I looked at the medications and one stated resident #6's name and the other was for another resident #10. I called the director of health and wellness to resident #6's room and she called the unlicensed caregiver to return to the room. The unlicensed caregiver confirmed that she had given resident #6 the wrong medications. The doctor was called stating nothing taken would cause any adverse or required poison control. She stated resident #6 would be very sleepy. Resident #6 was sent out to the hospital. On at 1:48 PM, the director of health and wellness stated the medication in the cart right behind resident #6 belonged to resident #10. The med tech grabbed the whole and didn't go through the medication and assumed all the medications were for resident #6. The staff did not check the MORs (medication observation record) before retrieving the meds. The meds were taken to the room in the caddy, and she administered the medications. She did not state	A 052		

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	AL11969074	A. BUILDING: _____ B. WING _____	06/24/2025

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A 052	Continued From page 28 the name and dose of the medications, and she left the caddy in the room. I assessed the resident; she was able to tell me her name. I called the doctor as well to make them aware of what happened. On at 2:22 PM, unlicensed caregiver E stated I was trying to run 2 carts. Someone (another staff) asked me if I could finish giving their meds to the residents because they had to leave. I didn't check the electronic Mar (e-Mar). I just took the meds from the cart and gave them to the residents. They were already . I was rushing. I didn't state the name or dose to the residents. I left the meds in resident #6's room in error. I believe I got a call to assist someone else and just rushed out. The facility's Medication Errors / Adverse Events policy states all licensed nurses and authorized employees will report, record, and analyze medication errors in order to prevent medication errors and facilitate quality improvement in all aspects of medication administration. A medication error is defined as: administration of the wrong medication and administration to the wrong resident. On at 4:15 PM, the administrator and director of health and wellness confirmed the findings. (photographic evidence obtained) Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 29 (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new	A 056		

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A 056	Continued From page 30 directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary	A 056		

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A 056	Continued From page 31 prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to follow physician orders for 1 of 2 sampled resident (#1) as required. Findings: The resident was asked if she had any issues with her medications or missed doses. On at 10:25 AM, resident #1 stated yes, I do recall not getting my medications some time ago. I was going out to Target or Wal-Mart that day. I waited in my room, but the staff never came. Resident #1's POA (power of attorney) called during the interview stating. resident #1 missed her morning medication due to going on a trip the facility planned. A record review of resident #1's 1823 Health Assessment indicated needs assistance with self-administration of medications. Resident #1's medication observation record (MORs) revealed on at 0900 0.25mcg caps, 200mg caps, 10mg tabs, 100mg caps, 2.5mg tabs, 40mg caps, 20mg tabs, 100mg caps, 25 mg tabs, ER 50mg tabs, Mutlaq 400mg tabs, 40mg tabs, and Prerevision Areds caps. All updated with the group observed 1 = absent from the home without meds.	A 056		

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A 056	Continued From page 32 On at 2:15 PM, unlicensed caregiver D stated I reminded resident #1 to take her meds before going out, to go to her room and wait. I start doing meds on the first floor where resident #1's room is located. Resident #1 doesn't like to take her medications before breakfast. After I finished the 1st floor meds. I continue to the 2nd floor. When I came downstairs, resident #1 was not in her room. No, I didn't tell anyone prior to resident #1's return to the facility that she didn't receive her morning meds. On at 12:45 PM, the director of wellness stated I was notified afterwards that resident #1 wanted her morning med and didn't receive any before going out. I asked unlicensed caregiver D why resident #1 didn't receive her medications. The unlicensed caregiver D stated that resident #1 went out and when I went to her room she was not there. The facility's Medication Administration Policy stated the community staff will comply with resident's healthcare practitioner orders; state law and regulations may be applicable. Alternative medication administration methods may be utilized according to state regulations. Administer medications at least within 60 minutes on each side of ordered time, except for medications to be administered immediately or other time-sensitive medication. Medications ordered in the AM will be administered between the hours of 6am - 11am. The facility's Medication Errors / Adverse Events policy states all licensed nurses and authorized employees will report, record, and analyze medication errors to prevent medication errors and facilitate quality improvement in all aspects of medication administration. A	A 056		

Agency for Health Care Administration

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A 056	Continued From page 33 medication error is defined as: failure to administer a medication and failure to administer a medication at the prescribed time (including missed dose). The unlicensed caregiver D completed her 6hr initial medication training in , but did not follow the physician orders to administer the medications at the scheduled time of 0900. On at 4:15 PM, the administrator and director of wellness confirmed the findings. (photographic evidence obtained) Class III	A 056		