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 _____	03/11/2026

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 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (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	A 056		

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A 056	Continued From page 1 the resident's health care provider. The new 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.,	A 056		

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A 056	Continued From page 2 before dispensing any sample or complimentary 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 interview and record review, the facility failed to make every reasonable effort to ensure that prescriptions for 2 of 10 sampled residents (#6, #12) were refilled in a timely manner. Findings: 1. Review of resident #6's record revealed a medical history of and , and that he needed assistance with self-administration of medications. Review of a facility note, dated at 7:45 AM, revealed the resident's family member took him to a hospital for having , all over. The note indicated the resident missed one dose of , a , on the evening of . Review of the resident's Medication Observation Record (MOR) revealed his 50 milligrams (mg) was unavailable on for the 7 PM dose. Neither the MOR nor the record had documentation to indicate the facility tried to obtain a refill prior to the medication running out. During an interview on at 2:30 PM, the Director of Memory Support said there was no documentation to indicate the facility tried to obtain a refill prior to the medication running out.	A 056		

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A 056	Continued From page 3 During an interview on at 10:44 AM, unlicensed caregiver I, who gave the on , said she did not remember the running low. Review of a facility note, dated , revealed the resident moved to another facility. 2. During an interview on at 10:50 AM, resident #12 said the facility ran out of his and as a result spent three days in a hospital. The resident said he experienced drooping after not receiving the medication. The resident said he was told only that the medication ran out. Review of resident #12's record revealed a medical history of , , , iron deficiency , prostatic hyperplasia, , , , and that he needed assistance with self-administration of medications. Review of a facility note, dated at 5:45 PM, revealed the Director of Memory Support documented the resident came to her and asked about the status of his medications. The note indicated the Director of Memory Support told the resident his medications were not delivered from the pharmacy yet. Review of a facility note, dated at 7:09 PM, revealed that the Director of Memory Support documented that a caregiver conducted a wellness check and observed the left side of the resident's was drooping and his speech was slurred. The note indicated the Director of Memory Support responded and observed the same. Emergency medical services were called, and the resident was taken to a hospital.	A 056		

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A 056	Continued From page 4 Review of a facility note, dated at 7:42 PM, revealed that the Director of Memory Support documented the resident came to her on at about 5 PM and said he did not receive medication that day. The note indicated the pharmacy reported the medications were not sent because updated prescriptions were needed. The note indicated the pharmacy would send a 3-day emergency supply until the provider was notified. Review of the residents' MOR revealed his , Acidophilus, , , , , , , , , , and were unavailable on , , and . During an interview on at 10:11 AM, unlicensed caregiver A, who gave the resident medications on and , said that when medication was down to seven pills, the pharmacy was to be called. Caregiver A said she could not recall if she requested refills for the medications. During an interview on at 2:10 PM, The Director of Memory Support said she learned the resident was out of medication when he, and not staff, told her. The Director of Memory Support said resident #12's medications were on cycle fill, which meant the pharmacy automatically delivered the medications every month. The Director of Memory Support said that when pharmacy delivered the cycled medications, they provided the facility with a list of residents whose medications were delivered. The Director of Memory Support said that if a medication could not be filled, the pharmacy noted the reason on the list, which was maintained in the facility for	A 056		

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A 056	Continued From page 5 about thirty days. The Director of Memory Support said resident #12's medications were not filled because new prescriptions were needed. The Director of Memory Support said it was the facility's responsibility to follow up. During an interview on at 9:27 AM, unlicensed caregiver G, who gave the resident medications on and , did not remember if she requested a refill before the medications ran out. During an interview on at 10:09 AM, the Director of Memory Support provided emails from the pharmacy. Review of the emails revealed the pharmacy delivered cycle-filled medications on and put them in the medication carts on , two days before resident #12 ran out of medications. During an interview on at 10:44 AM, unlicensed caregiver I, who gave the resident medications on , did not remember the medications running low. Review of the medication refills policy, issued , revealed if a cycle-fill medication required a refill authorization, pharmacy would notify the facility, who would work with the pharmacy to ensure medications were available. The policy indicated if the medication was a , the medication would be ordered a minimum of 14 days prior to running out. Class III	A 056		
ZZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning;	ZZ830		

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ZZ830	Continued From page 6 emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of	ZZ830		

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ZZ830	Continued From page 7 emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to	ZZ830		

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ZZ830	Continued From page 8 the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on facility record review and interview, the facility failed to provide the letter of approval from the office of emergency management on annual basis as required. Findings: On , the Administrator was asked to provide the current CEMP for review. Review of the letter revealed a date of which is valid for one year, resubmission required within 60 days before its expiration date. On at 4:12 PM, the Administrator stated he submitted the document to the office of the emergency management on or which was before the expiration. Adding, the representative told him everything was fine and the letter was approved. The administrator further stated the only thing that he's waiting for was a letter of compliance from Fire Safety. There was no documentation provided for submission of the CEMP. On at 8:32 AM, the Administrator was made aware during the morning conference of the state regulations regarding the requirements of maintaining an annual CEMP and submission prior to the expiration of the current letter. On at 1:35 PM, during a phone conference with the Administrator, he confirmed the findings. (photographic evidence obtained)	ZZ830		

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ZZ830	Continued From page 9 Class III	ZZ830		
A 000	Initial Comments Five (5) complaint investigations #2025016356, #2025016268, #2026001149, #2026001459, #202603035, and generator monitoring was conducted at Inspired Living on - . The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and	A 025		

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A 025	Continued From page 10 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, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for and injuries for 3 of 6 sampled residents (#20, #21, #24).	A 025		

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A 025	Continued From page 11 Findings: 1. On during the entrance conference the Director of Health and Wellness (DHW) identified resident #20 as being out of the facility due to a . On at 9:36 AM, the DHW stated she would check with the Administrator for any incident reports submitted for resident #20. On at 9:43 AM, the Administrator stated he did not do an incident report for resident #20 because she was identified as a precaution on her 1823. Review of resident #20's record revealed a facility admission on . A 1823 health assessment indicated a medical history of , , , , and identified as a risk. The resident needed assistance with ambulation, bathing, , toileting, and transferring. Review of the risk evaluation effective date revealed a score of 14, high risk. A history of in the last 12 months, disoriented, at all times. A risk evaluation effective date revealed a score of 14, high risk. A history of in the last 12 months, disoriented, at all times. Review of the service plan report date initiated with a revision on stated will maintain independence with transferring, grooming/oral hygiene, and toileting. An incident report dated , revealed unwitnessed in resident's room. Staff doing wellness checks and found the resident on the	A 025		

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A 025	Continued From page 12 floor on her right side. A facility note on at 7:50 AM, resident still out. A facility note on at 7:53 AM, resident is not in the facilities. A facility note on at 7:12 AM, in the hospital. A facility note on at 3:50 PM, hospitalized. A facility note on at 7:39 AM, hospital. A facility note on at 7:47 AM, resident out of facilities. A facility note on at 7:38 AM, resident still in the hospital. A facility note on at 7:17 AM, hospital. A facility note on at 7:27 AM, hospital. A facility note on at 7:48 AM, resident is in the hospital. A facility note on at 11:47 PM, resident had an unwitnessed and was taken to hospital. A facility note on at 8:00 PM, resident on the floor in her room. resident lying on her on the floor. A facility note on at 1:58 PM, resident was observed following a , noted resident doing ok.	A 025		

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A 025	Continued From page 13 A facility note on at 3:35 PM, resident was observed following a , resident was calm and not in any , . A facility note on at 10:18 PM, resident said she has no , . A facility note on at 9:50 AM, resident returned from hospital. A facility note on at 3:31 PM, resident was found on the floor on her right side. Stated she had trying to go to the bathroom. Stated she her right , and lower , . Resident sent to hospital. On at 10:18 AM, Caregiver A stated she did not work in memory care on the day resident #20 . Adding, she provide constant reminders to tell the resident she cannot get up on her own. On at 10:47 AM, Caregiver F stated she was not working on the day resident #20 . Adding, sometimes when she tell her to sit down, she does not listen and wants to do it by herself. On at 11:18 AM, the Director of Memory Support stated resident #20 has had frequent in her apartment. Further stating, they redirect the resident out of her room to bring her to activities to get her engaged. Adding, the resident will only stay a short while and goes to her apartment. We have not had any discussions at this time for her to have a sitter or to put one on one in place. On at 1:49 PM, Caregiver L stated resident #20 wants to do everything herself and she is one of the resident who requires frequent checks. Adding, we sent the resident out due to	A 025		

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A 025	Continued From page 14 the as she was complaining of . . . The hospital sent her same day and she was sent out again and has not returned. The facility's response procedures policy stated should a resident experience a , staff will provide immediate care and follow through with service planning. If a previous risk assessment has not been completed within the past 30 days. A risk assessment and a risk analysis may be completed to assist in identifying progressive measures to help avoid future . 2. On during the entrance conference the Director of Health and Wellness (DHW) identified resident #21 as being out of the facility due to a . Review of resident #21's record revealed a facility admission on . A 1823 health assessment indicated a medical history of . . , . , . . , memory . , and identified as a . risk. For nursing/ , , service requirements revealed none. The resident need assistance with all activities of daily living. An incident report dated revealed unwitnessed in activity room. Review of the service plan report indicated transferring date initiated , revision on - will maintain independence with transferring by getting and . Review of the risk evaluation effective date revealed a score of 11, high risk. A history of in the last 12 months, disoriented, at all times. A risk evaluation effective dated with a score of 11, high	A 025		

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	AL11969074	A. BUILDING: _____ B. WING _____	03/11/2026

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A 025	Continued From page 15 risk. A history in the last 12 months, disoriented, at all times. A risk evaluation effective dated with a score of 13, high risk. A risk evaluation effective date with a score of 13, high risk. A facility note on at 6:00 PM, resident was sent out to the hospital. A facility note on at 3:50 PM, care partner notified another staff while in activity room she heard the noise of the chair sliding and immediately ran towards the sound and saw resident #21 on the floor. On at 10:18 AM, Caregiver A stated the resident sleeps in the activity room all the time. Further stating, they try to go and help him in the chair because he slides out and he's not really falling. Adding, we would do an incident report for the unwitnessed . On at 10:47 AM, Caregiver F stated she was not working the day resident #21 . Adding, he did not have any prior to this incident. On at 11:18 AM, the Director of Memory Support stated they try to monitor the resident as closely as they can because he slides down in the chair. Adding, sometimes they will try to push him up. Further stated, if he needs more sleep, they will put him in bed and when he's ready, he'll come out. Further stating, they have not had any discussions at this time about having a sitter or one on one put in place. On at 12:40 PM, the DHW stated whatever interventions you see is what they're doing. Further stating she has not spoken with the families about one on one for residents 20 or	A 025		

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A	Continued From page 16 #21. On at 4:44 PM, the Administrator stated the interventions put in place for resident #20 is activities, music , , , painting, and safety checks. The interventions for resident #21 is more safety checks, reminders to call for assistance and the resident responds to tall women and will list to redirection. 3. Review of resident #24's Heath Assessment 1823 revealed a medical history of . A facility note dated at 1:45 PM read on staff requested help to get the resident out of bed and resident was so weak. A facility note dated at 4:10 PM read, resident is very weak, cannot stand, and used wheelchair. A , , , , communication form dated read patient complained of right lower extremity , with movement. Resident needed two-person assistance and was unwilling to step. A , , , , communication form dated , read patient limited with right lower extremity. A , , , , communication form dated read, resident needed a of two with two steps. A , , , , communication form dated , read resident needed max verbal/ cues for right lower extremity placement.	A 025		

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A 025	Continued From page 17 Review of resident #24's record revealed on a health care provider ordered of the right and right . A report revealed the resident had a right . A facility note dated at 4:12 PM read, was sent to physician, physician will follow up with family for results. During an interview on at 9:59 AM, Caregiver C said resident #24 could not stand by herself and needed two-person assist. During an interview at 10:45 AM, Caregiver F, resident # 24, needed two persons to assist her to transfer to the wheelchair. During an interview on at 11:10 AM, the Director of Memory Support said resident #24 needed two-person assistance and did not have , no grimacing, and was not showing any signs of . Adding, the Assistant (PTA) did not inform her that resident #24 was having any . Further stating, the PTA informed her that resident #24 did not want to bear on her right side. During an interview on at 11:32 AM, resident #24's family said the resident received , replacement surgery. The family said resident #24 was walking in , then at the end of she was informed by the facility staff that the resident was weak, needed to use a wheelchair and needed people to assist her. The family said the resident #24 started in . The family said informed her on that they were trying to obtain an order for 2 weeks. The family said no one could recall the reason how the resident sustained the . The	A 025		

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A 025	Continued From page 18 family said they could not tell if resident #24 was in , because she did not speak. During an interview on at 1:28 PM, the Health and Wellness Director (HWD) said resident #24 did not apply on her right lower extremity. The HWD said she was never informed by the PTA that the resident was in . The HWD said the resident #24's family never said the resident was in . The HWD said the PTA did not come to her to request the x-ray. The HWD said she decided to reach out to the health care provider to get an , due to the PTA notes indicating the resident was declining and putting less on the right lower extremity. The HWD said the resident was putting some then she was hardly putting any at all. The HWD said the resident's , was done on and the resident was ordered to be sent to the hospital by the healthcare provider because the resident had a . During an interview on at 1:53 PM, the Director of Memory Support stated the PTA reached out and informed her that the resident was not bearing on her right . She was not informed that the resident was in , . Further stating, the resident was overcompensated by using the left side and the health care provider was contacted and informed. During an interview on at 9:56 AM, HWD said she reviewed the , , , note from and it prompted her to do something due to the note indicating resident #24 needed max verbal and cues for right lower extremity placement. The HWD director said she did not review the previous , , , notes, and she was not aware of the resident being in , .	A 025		

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A 025	Continued From page 19 During an interview on at 10:11 AM, the PTA said it was difficult for #24 to communicate. The PTA said resident #24 had difficulties with standing and needed a maximum of two people to assist her because she could not stand by herself. The PTA said the resident was in , since the first time she had a visit with her on . The PTA added that resident #24 was always in , . The PTA said she had frequent communication with the Director of Memory Support regarding resident #24's right lower extremity , . The PTA said after a few visits resident #24 was trying to hold her right up. During an interview on at 11:13 AM, the Director of Memory Support said, in , prior to resident 24's last visit with the PTA, she was informed the resident was not bearing and was overcompensating on the left side. Adding, she reached out to the health care provider and he ordered . The resident did not have any indication of , and she had no . Further stating, prior to the resident going to the hospital in the resident was walking and only used her rollator. The Director of Memory Support stated when the resident came from the hospital she does not recall if she was doing a lot of walking, and she used a wheelchair. During an interview on at 11:52 AM, Resident Care Supervisor, said on she went to the resident's room, staff told me she was weak, she assisted her out of the bed, and she notified the health care provider. The Resident Care Supervisor said it was the first time the resident was weak since she returned from the hospital.	A 025		

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A 025	Continued From page 20 During an interview on at 12:30 PM, the Health and Wellness Director (HWD) said after she read the , , , notes for resident #24 dated she became aware of a change with the resident. The HWD said she asked the memory care staff if resident #24 was in any , or if there was an incident with the resident. The HWD said the resident was not in any , and there were no reported or documented incidents. The HWD said the PTA did not inform her of resident #24's condition or that the resident was in , . The HWD director said she realized there was a change in the resident's condition from the , , , notes. The HWD said she did not reach out to the PTA with her concerns about the change in the resident's condition. The HWD said there were no more follow ups with the PTA after the visit. The HWD said after realizing there were no additional , , , , sessions, she contacted and informed the healthcare provider. During an interview on at 2:01 PM, Caregiver A said the few times she worked with the resident she did not complain of any , . During an interview on at 2:07 PM, Caregiver B said the resident did not show signs of , . During an interview on at 2:28 PM, Nurse Practitioner (NP) M said the facility staff had informed him that the resident could not bear on the right . The NP said he initially ordered the , of the right and right , on . The NP said he was informed by the facility they were having issues with the imaging company to come out to complete the . The NP said he ordered the , for resident #24 due to being informed by the staff she could not bear	A 025		

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A 025	Continued From page 21 ˬ on the right ˬ and due to the resident having . The NP said resident #24's age is a contributing factor. The NP said the resident could not verbalize if she was having ¸ . Review of the resident's record revealed a date of service to an imaging company was cancelled. There was no documentation to indicate the facility had issues contacting the imaging company to complete the original ˛ orders. During an interview on at 3:47 PM the Director of Memory Support stated she did not see the original ˛ order until when she reached out to the healthcare provider for a follow up. Further stating, there were issues with the imaging company coming out to the facility to do the ˛ for the resident. Adding, she contacted the imaging company multiple times. She stated she does not have documentation of the imaging company being contacted and it was phone calls she made to the imaging company. The Director of Memory Support stated she does not know why the initial ˛ order which was sent to the imagining company on was cancelled. The HWD then said the health care provider was informed that a new ˛ order was placed on and when the imaging company was contacted. The HWD said the ˛ was completed on and received the results on . The HWD said the healthcare provider was informed of the ˛ results and instructed that the resident be sent to the hospital. The Director of Memory Support stated the facility has changed imaging companies from Trident to Atlantic Imaging.	A 025		

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A 025	Continued From page 22 On at 4:53 PM, the Administrator and Director of Health and Wellness confirmed the findings. (photographic evidence obtained) Class II	A 025		
A 170 SS=D	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to honor the accurate amount of a refund for 1 of 2 sample residents based on the termination date to the responsible party (#2). Findings: Review of resident #2's record revealed an admission date on with a discharge date on . Further review revealed resident #2 transitioned on . Review of the resident detailed ledger revealed a refund issued for $4,406.88 from - for Inspired standard program Assisted Living (rent) and level 5 premium Assisted Living.	A 170		

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A 170	Continued From page 23 Due to the date of , the resident is owed an additional refund of $535.22. On at 3:15 PM, the Administrator confirmed resident #2 , , on and her level of care would have stopped on that day. Adding, he will let the department know who handles the financials that the resident is owed an additional refund. (photographic evidence obtained) Class III	A 170		