AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968715	**10/12/2015**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT SUN CITY CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1320 33RD ST SE** **SUN CITY CENTER, FL 33570**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015007930, was conducted on .

The Inspired Living at Sun City Center, assisted living facility, had a deficiency at the time of the visit.

0054 Medication - Records

Based upon record review & interview, the facility did not ensure medication observation records (MOR's) were maintained up to date for 1 (#6) of 4 residents reviewed.

Findings include:

A ../../.. review of the ..... 2015 MOR for resident #6 revealed that the record had not been annotated to reflect the resident received her . Dis 9.5mg/24 (patch) to be applied once daily at 8am on ..... . There was not further documentation on record for the reason the MOR was not annotated. In addition the MOR for the same month had not been annotated that the resident received Resource 2.0 Liq. to be given 3 oz. twice daily at 8pm on 10/3 & . No notations were on the reverse side of the record as to why it was not received.

During interview with the facility LPN at approximately 3:30pm, it was verified that no further information was available to explain the reason for these omissions.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Inspired Living at Sun City Center
1320 33rd St Se
Sun City Center, FL 33570

RE: CCR# 2015007930

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2015, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

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Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid ...uffman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form