STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968822	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING AT TAMPA	5130 KELLY RD TAMPA, FL 33634

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

0000 Initial Comments

Assisted Living Facility
A Limited Nursing Services (LNS) survey was conducted at Inspired Living at Tampa on [illegible]. Inspired Living at Tampa had deficiencies at the time of the visit.

N278 LNS - Records

Based on interview and record review the facility failed to conduct a nursing assessment at least monthly on each resident who received limited nursing services (LNS) on 3 of 3 sampled residents.
Findings included:
1. Resident #1 is an [illegible] female admitted on [illegible]. Diagnoses include but not limited to: [illegible]'s, [illegible] and sleep [illegible]. Resident has [illegible] and periods of [illegible]. Review of Resident #1 ' s medical record showed an order for [illegible] at 2 liters / minute via nasal cannula continuously. Review of Resident #1 ' s medical record showed " LNS Monthly Summary " for [illegible] and [illegible] of 2015. The forms were filled out by Staff A, Licensed Practical Nurse (LPN). The facility failed to show evidence that Resident #1 had been assessed by the Registered Nurse (RN) and /or have the monthly summaries reviewed and signed by the RN.
2. Resident #2 is a [illegible] female admitted on [illegible]. Diagnoses include but not limited to: [illegible] and [illegible] type II. Resident is [illegible]. Review of Resident#2 ' s medical record showed a physician ' s order to perform [illegible] glucose monitoring before meals and at bedtime. Resident #2 has an order for [illegible] to be administered three times a day before meals, [illegible]. Hold [illegible] if [illegible] sugar is below 100. Review of Resident #2 ' s medical record showed " LNS Monthly Summary " for [illegible] and [illegible] of 2015. The forms were filled out by Staff A, Licensed Practical Nurse (LPN). The facility failed to show evidence that Resident #2 had been assessed by the Registered Nurse (RN) and /or have the monthly summaries reviewed and signed by the RN.
3. Resident #3 is a [illegible] male admitted on [illegible]. Diagnoses include but not limited to: [illegible] and [illegible]. Review of Resident #3 ' s medical record showed a physician ' s order to perform [illegible] glucose monitoring twice a day and administer [illegible] sliding scale depending on [illegible] glucose levels. Review of Resident #3 ' s medical record showed " LNS Monthly Summary " for [illegible] and [illegible] of 2015. The forms were filled out by Staff A, Licensed Practical Nurse (LPN). The facility failed to show evidence that Resident #3 had been assessed by the Registered Nurse (RN) and /or have the monthly summaries reviewed and signed by the RN.
4. During an interview on [illegible] at 2:45 p.m., Staff A, LPN and Executive Director (ED) stated that the monthly summaries had not been signed by the reviewing RN. Staff A stated that the LNS residents

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monthly summaries were reviewed monthly and the RN signed on the " Limited Nursing Service Log " instead. Both Staff A and the ED confirmed that this process does not indicate that the resident was being assessed monthly by the RN by including a status summary of the resident, written by the RN, on page 2 of the " LNS Monthly Summary " form.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Inspired Living At Tampa
5130 Kelly Rd
Tampa, FL 33634

Dear Administrator:

This letter reports the findings of a limited nursing services (LNS) monitoring visit 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 deficiencies that were 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 , 2016.** 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.

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,

for Patricia Reid Cauffman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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