STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968822	01/30/2016
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **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 complaint investigation (CCR#2015012431) was conducted at Inspired Living of Tampa. Inspired Living of Tampa, Assisted Living Facility, had a deficiency at the time of the visit.

0025 Resident Care - Supervision

Based on record reviews and interview the facility failed to provide appropriate supervision regarding documentation verifying the family/POA and the physician were notified following incidents for residents #1 and #2.

Findings included:

A record review for resident #1 contained 3 incident reports without documentation stating the family was notified following the incident. 1 of 3 incident reports reviewed for resident #1 was without documentation stating the physician was notified.

A record review for resident #2 contained 2 incident reports without documentation stating the family was notified following the incident. 1 of 2 incident reports reviewed for resident #2 was without documentation stating the physician was notified.

In interview with staff A on / / at 10:32am she stated it is facility policy to notify the residents family/POA and the physician following any incident.

On / / the surveyor reviewed the facilities policies and procedures for incident reporting. The facilities policies and procedures state the family/POA and physician will be notified following an incident involving a resident.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Re: CCR 2015012431

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016 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 Caufman
Field Office Manager

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

PRC/clt
Enclosure: State (5000-3547) Form
XG90