STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	**06/19/2017**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1061 TOMYN BLVD** **OCOEE, FL 34761**	

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

0000 - Initial Comments

A Complaint Investigation #2017002927 was conducted on . Inspired Living Assisted Living Facility License #12906 had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility did not obtain an accurate Resident Health Assessment form (1823) for 1 of 5 sampled Residents (#5).

Findings:

Record review for Resident #5 revealed a Resident Health Assessment form 1823 that was dated . The health provider noted she required 24 hour nursing or , , care.

On at 2 PM, the Memory Care's Licensed Practical Nurse said the 1823 was not correct and Resident #5 did not require 24 hour nursing or , , care.

Class

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interview the administrator failed to monitor the continued appropriateness of placement for 1 of 5 sampled residents (#2) and retained the resident who required total care with all activities of Daily living, (ADL's), which exceeded the continued residency criteria.

Findings:

Observations on at 11:45 AM revealed her family member was wheeling Resident #2 in her wheelchair. Observations at 12:15 PM revealed the family member was feeding the resident lunch.

Record review for Resident #2 revealed a resident health assessment (1823) dated that noted the resident required assistance with her ADL's. There was no documentation found in the record regarding her decline.

On at 10:55 AM Staff A said she was a caregiver who provided care to Resident #2 and she was total care with all of ADL's. She further stated resident #2 could not assist at all with bathing, dressing or

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On at 11:55 AM Staff B said she was a caregiver who provided care to Resident #2 and she was total care with all of ADL's. She further stated resident #2 could not assist at all with bathing, dressing or

On at 3:15 PM Staff E said she was a caregiver who provided care to Resident #2 and she was total care with all of ADL's. She further stated resident #2 could not assist at all with bathing, dressing or

On at 2:15 PM resident #2's family member said Resident #2 was not able to assist with bathing, dressing or . She required total care.

On at 3:30 PM, the administrator said he was not aware the resident required total care with her ADL's.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on Electronic medication observation record (MOR) review, record review and interview the facility did not follow the physicians orders for 4 of 5 residents who had skin rashes (#1, #3, #4 and #5) and did not notify the health care provider when 1 of 5 sampled residents refused to take the physician ordered medication (#3).

Findings:

1. Record review for resident #1 revealed a health care providers order dated for 3 Milligrams (mg) give 4 tablets (12 MG) times 1 dose. Review of the Electronic MOR revealed on and it had staff initials with circles for both days. The remainders of the days had an "x" in the spaces to indicate the medication was not given. Further review of the MOR revealed on the back of the MOR for at 8 AM noted, "Waiting on Pharmacy"; on at 8 AM it noted "Med not available-back order."

The health care provider's order dated also noted Cream 5% apply , from neck down to feet covering all area. Leave on overnight and wash off in AM. Repeat same routine next

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night and then repeat one time in 7 days. Review of the MOR revealed the cream was applied on 6/9. The next application was due on . The remainders of the days had an "x" in the spaces to indicate the cream was not reapplied as ordered.

2 .Record review for resident #3 revealed an health care providers order dated for 3 Milligrams (mg) give 4 tablets (12 MG) times 1 dose. Review of the Electronic MOR revealed on there were staff initials to indicate the medication was given at 8 AM. On at 8 AM, there were staff initials with a circle. The remainder of the days had an "x" in the spaces to indicate the medication was not given. Further review of the MOR revealed on the back of the MOR for at 8 AM it noted "other not in cart"; on at 8 AM it noted "Med not available-back order."

The health care provider's order dated also listed Cream 5% apply , , from neck down to feet covering all area. Leave on overnight and wash off in AM. Repeat same routine next night and then repeat one time in 7 days. Review of the MOR revealed there was staff initials with Circles on , and . The remainder of the days had an "x" in the spaces to indicate the cream was not applied.
The back of the MOR noted "other: not due this shift." On at 9 PM, on at 9 PM the MOR noted "Other not due today."

Record review for resident #3 revealed observations notes that documented the following:
-11 PM-7 AM shift-Tired 3 times to get resident to take 4 tablet. Refused it and the cream.
-11 PM-7 AM Shift-Again tried to get resident to take and cream
-7 AM-3 PM shift-Resident took pills on will continue to monitor.
There was no documentation to confirm that the Cream was applied. The MOR noted the was not given on or , which contradicted what, was written in the notes.

3. Resident review for resident #4 revealed health care providers order on for 3 mg 4 tablets (12 mg) today and repeat in 14 days

Review of the Electronic MOR revealed the medication was marked as given on . The remainder of the days had an "x" in the spaces to indicate the second dosage of the medications that was due on was not given as ordered.

Another health care providers order dated not 3 mg give 4 tablets (12 m) today and repeat in 14 days.

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Review of the MOR for revealed on there was an "x" in the space. The MOR for had staff initials with a circle on through . There were staff initials to indicate the medication was given on , , and .

Record review for Resident #4 revealed the observations notes documented on -3PM- 11PM shift First dose of (12 mg) was given.

3 PM-11 PM-shift-Dose of was given.
There was no way to determine the actual days the medications were given because the MOR and notes conflicted with each other.

Another order dated noted Start 5% cream apply from head to toe and leave on for 14 hours and then rinse.
The MOR had "x" in all spaces to indicate the cream was not applied on .
The MOR had staff initials to indicate the cream was applied at 8 PM , , , , . The Back of the MOR noted on at 8 PM-"Waiting on Pharmacy."
A Dermatologist noted on "clinical improvement noted post treatment. Skin scrape was negative for , ."

4. Record review for Resident #5 revealed a health care provider order dated that noted 3 mg give 4 tablets (12 mg) today and repeat in 14 days.
Review of the MOR for revealed it was not marked as given until ; the second dose would have been due on . Review of the MOR revealed the was not listed.
Further record review revealed an order dated for , 25 mg give one tablet at bed time for 7 days.
Review of the MOR revealed it noted twice , (, ,) 25 mg (,) give one tablet at bedtime for 7 days.
The MOR also noted , (, ,) 25 mg (,) give 1 tablet at bedtime.
There were staff initials on through (8 days) for the , (, ,) 25 mg (,) give 1 tablet at bed time for 7 days.
There was also staff initial on for , (, ,) 25 mg (,) give 1 tablet at bedtime.
The staff initialed the MOR as giving 50 mg of Bendadryl on .
There was a health care providers order dated for 3 mg tab give 4 tablets (12 mg) today and repeat in 14 days. 1 refill. Review of the Electronic MOR revealed the medication was not given until (10 days after the medication was ordered). Review of the and MOR revealed there was no documentation to confirm the second dose was given that was due on

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On at 2:45 PM, the Director of Nursing reviewed the electronic MOR and notes and confirmed the findings.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on Electronic Medication Observation Record (MOR), record review and interview, the facility had no evidence to confirm that every reasonable effort was made to ensure that prescriptions for residents who receive assistance with self-administration of medication was refilled in a timely manner for 4 of 5 sampled residents (#1,#3, #4 and #5).

Findings:

Record review for Resident's #1, #3, #4 and #5 revealed they all required assistance with the self-administration of medications.

Review of their MORs for and revealed there were times when their medications was not available and there was no documentation to confirm that the facility had made every reasonable effort to ensure their prescriptions were refilled timely as follows:

1. The MOR review for resident #1 noted on at 8 AM and 8 PM for 25 Milligrams (mg) was "Waiting on Pharmacy Delivery" on 5/9, at 8 AM "Waiting on Pharmacy Delivery; on 5/7, at 8 PM "Waiting on Pharmacy Delivery.

The MOR noted On 5/7 at 2 PM for /SOL noted "med not available back order."; 5/7 at 10 PM not in cart; 5/8 at 6 AM, 2 PM, 10 PM noted "waiting on pharmacy delivery"; 5/9 at 2 PM noted "Waiting on Pharmacy Delivery; On 5/9 at 10 PM the MOR noted "refused was sleeping"; On at 6 AM, 2 PM noted "Waiting on Pharmacy Delivery; On the MOR noted at 10 PM "other not given, waiting on equipment delivery" ; On at 6 AM the MOR noted "Waiting on Pharmacy".

On at 8 AM the MOR noted for tab 3 mg "waiting on pharmacy delivery"; on at 8 AM, the MOR noted "Med not available back order."

2. The MOR review for resident #2 noted on , 6/3 at 8 AM for 1000 micrograms (MCG) noted "waiting on pharmacy delivery".

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The MOR noted on at 8 AM for 3 Milligrams (mg) "other; not in cart: on at 8 AM "Med not available back order."

The MOR noted on at 8 AM , 10 mg "waiting on Pharmacy Delivery".

3. The MOR review for resident #4 noted on and 6/1 at 8 PM 3 mg "waiting on Pharmacy Delivery".

4. The MOR review for resident #5 noted for Ibesartan 150 (mg) at 8 AM on 5/5, 5/8, 5/9 noted "waiting on pharmacy delivery".

The MOR noted for 40 mg on at 8 AM "med not available back order"; On 6/6 at 8 AM "Med not available-family"; 6/7 at 8 AM "waiting on pharmacy delivery."

The MOR noted for , (,) 25 mg on at 8 AM and 8 PM "waiting on pharmacy delivery" on , , at 8 PM "waiting on pharmacy delivery."

The MOR noted for 50 mg on and at 8 PM "waiting on pharmacy delivery." at 8 PM "Med not available-back order"; PM at 8 AM and 8 PM "Med not available-back order."

On at 2:45 PM, the Director of Nursing reviewed the electronic MOR and notes and confirmed the findings.

Class III