STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968977	07/27/2017
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT BONITA SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **27221 BAY LANDING DR** **BONITA SPRINGS, FL 34135**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR#2017006096 and CCR#2017007511 was completed on at Inspired Living, an assisted living facility (License #12802) in Bonita Springs, FL.

The complaint CCR#201006069 contained 2 allegations, of which 2 were substantiated with deficiencies.
The complaint CCR#2017007511 contained 4 allegations, of which 3 were substantiated with deficiences.

The following is a description of the deficiencies.

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on record review, observation, and interview the facility failed to ensure appropriate assistance with activities of daily living (ADL) was provided for 1 (Resident #1) of a sample of 3 residents with identified deficients in ADLs.

The finding included:

Review of a Resident Health Assessment (AHCA Form 1823) dated revealed that Resident #1 has severe , receives Hospice Services, is a risk, has a history of left hip , and is of bowel and . The assessment also identified that the resident requires of 1 person for ambulation with a wheelchair and bathing; and requires minimum assistance of 1 person for transfer, toileting, dressing, , and eating.

A Monthly Assignment/Sign Off Sheet/Service Plan dated , 2017 stated that Resident #1 is a "heavy wetter" and requires a change of Depends (brief) every 2 hours with assistance of 1 staff member. It also stated that the resident resists care, requires safety checks, has a hospital bed, and has mats (next to her bed).

The facility policy entitled Service Plan, dated , states "7. Service plan (as set) forth will be completed every shift by care associates ( )." Review of the "Shift/Day" documentation (initials) entered by care associates, on the , 2017 Service Plan for Resident #1, revealed no initials for 3 day (First) shifts, 2 evening (Second) shifts and 15 night (Third) shifts.

Interview of Staff D, on at 7:15 a.m., revealed that she provides Resident #1 with 2 hour checks on the night shift (11:00 p.m. to 7:00 a.m.) to provide care and that she signs the

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Service Plan that care was provided. Staff D continued to state that the resident sometimes refuses care and she reports that to the nurse who will then help her with the care.

Review of the medical record electronic progress notes, for Resident #1, revealed that the resident was observed to have a left eye, with active , at 7:00 a.m. on . Review of a documented interview done by LPN Staff I, at this time, revealed Staff G (assigned to the resident) stated, "I found her like that."

A subsequent telephone interview, to Staff G, was conducted by the Executive Director (ED Staff J), on . ED Staff J documented that Staff G stated that she did not know what happened to Resident 1's eye and also stated "I never had time to check on her all night, I was swamped."

Upon interview at 3:30 p.m. on , the Health and Wellness Director (HWD Staff H) verified that was Staff G's last working day. HWD Staff H also stated that an investigation was conducted by ED Staff J (the former Executive Director of the facility), and that she was unaware of the outcome of that investigation. HWD Staff H provided copies of statements from that investigation.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review, observation and interview the facility failed to ensure that 3 (Resident #1, #2, and #3) of 3 residents reviewed for requiring Assistance with Daily Living assistance due to and physical , , received that identified assistance without evidence of neglect.
Neglect includes the failure of a caregiver to provide any part of the or duties as required to meet resident needs.

The finding included:

1. Review of a Resident Health Assessment (AHCA Form 1823) dated revealed that Resident #1 has severe , , receives Hospice Services, is a risk, has a history of left hip , and is of bowel and . The assessment also identified that the resident requires assistance of 1 person for ambulation/wheelchair and bathing; and requires assistance of 1 person for transfer, toileting, dressing, , and eating.

A Monthly Assignment/Sign Off Sheet/Service Plan dated , 2017 stated that Resident #1 is a "heavy wetter" and requires a change of Depends (brief) every 2 hours with assistance of 1 staff member. It also stated that the resident resists care, requires safety checks, has a hospital bed, and

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has mats next to her bed.

The facility policy entitled Service Plan, dated , states "7. Service plan (as set) forth will be completed every shift by caregiver associates ( )." Review of the "Shift/Day" documentation (initials) entered by caregiver associates, on the , 2017 Service Plan, for Resident #1, revealed no initials for 3 day (First) shifts, 2 evening (Second) shifts and 15 night (Third) shifts.

Interview of Staff D, on at 7:15 a.m., revealed that she provides Resident #1 with 2 hour checks on the night shift (11:00 p.m. to 7:00 a.m.) to provide care and that she signs the Service Plan that care was provided. Staff D continued to state that the resident sometimes refuses care and she reports that to the nurse who will then help her with the care.

Review of the medical record electronic progress notes, for Resident #1, revealed that the resident was observed to have a left eye, with active , at 7:00 a.m. on . Review of a documented interview done by LPN Staff I, at this time, revealed that Staff G (assigned to the resident) stated, "I found her like that."

A subsequent telephone interview, to Staff G, was conducted by the Executive Director ED Staff J, on . ED Staff J documented that Staff G stated that she did not know what happened to Resident 1's eye and stated, "I never had time to check on her (Resident 1) all night, I was swamped."

In addition, LPN Staff I had documentation on file (with no date) stating "On , 6 (2017), I came to work my usual shift from 12 a.m. - 8 a.m. I received a report from the evening nurse who advised me one of the night shift caregivers was leaving due to illness and I would be working the night with the only one other scheduled caregiver (Staff G). The caregiver (Staff G) was observed sleeping in the Country Kitchen Dining was later found sleeping on a bench near the front door/great . The caregiver was reluctant to assist residents and stated she wasn't going to perform her usual duties because she was the only caregiver."

LPN Staff I knew that Staff G was not performing her duties in relationship to resident needs and service plans. There was no documented evidence, on record, that LPN Staff I notified the Health and Wellness Director (HWD Staff H) or the Executive Director (ED Staff J) to report the situation and request help on the shift. LPN Staff I knew, or should have known, that Staff G did not document on the service plan that any care was given to Resident #1 for the 11 p.m. - 7:00 p.m. on .

The facility advertises that they provide special care for persons with 's and related . Upon interview on at 8:00 a.m., the HWD Staff H verified that all residents in the

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facility were receiving this special memory care.

2. Review of a Resident Health Assessment (AHCA Form 1823) dated revealed that Resident #2 has diagnoses of , unsteady gait, and auditory hallucinations. The assessment also identifies that the resident requires assistance with ambulation, bathing, dressing, , toilet and transfer.

There was no documented evidence, on the Monthly Assignment/Sign Off Sheet/Service Plan, that the resident received this assistance on night shift (11 p.m. - 7 a.m.).

3. Review of a Resident Health Assessment (AHCA Form 1823) dated revealed that Resident #3 has diagnoses of , , , , and . The assessment also identified that the resident requires assistance with bathing, dressing and toilet.

There was no documented evidence, on the Monthly Assignment/Sign Off Sheet/Service Plan, that the resident received this assistance on night shift (11 p.m. - 7 a.m.). The electronic progress note records indicate that the resident had 1 with injury and 2 without injury during the last 60 days.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review, observation and interview the facility failed to ensure enough qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with the residents' needs. This was evidenced on 12 day shifts, out of 24 day shifts; 4 evening shifts, out of 24 evening shifts; and 11 night shifts, out of 24 night shifts, reviewed for the staffing of qualified personnel in , 2017.

The findings included:

1. Review of the "Employee Schedule" form revealed that Staff E worked 10 night shifts, as a Caregiver Associate, during the time period through . Review of Staff E's personnel record revealed a hire date of . There was no documented evidence that she received Control training prior to her providing direct care to residents on these 10 night shifts.

In addition, according to her personnel record, this employee worked over 30 days without receiving required training in Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe

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Handling of Food.

2. Review of the "Employee Schedule" form revealed that Staff G worked 3 night shifts, as a Caregiver Associate, during the time period through . Review of Staff G's personnel record revealed a hire date of . There was no documented evidence that she received Control training prior to her providing direct care to residents on these 3 night shifts.

In addition, according to her personnel record, this employee worked over 30 days without receiving required training in Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe Handling of Food.

3. Review of the "Employee Schedule" form revealed that Med Tech Staff B worked 12 day shifts and 4 evening shifts, as a Medication Technician, during the time period through . Review of her personnel record revealed that there was no documented evidence that this unlicensed employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

4. Upon interview on at 3:00 p.m., the Personnel Manager acknowledged that Staff E and Staff G did not have documents verifying required training in Control, Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe Handling of Food.

In addition, she acknowledged that Med Tech Staff B had no documented evidence that this unlicensed employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

5. Interview of LPN Staff K at 4:45 p.m. on revealed she felt more staffing is needed on the evening shift due to "sun downing" of residents. LPN Staff K verified there were 4 staff on duty this shift (including her) for 47 residents and that "would be the minimum. It is a lot better with 5, but we had a call off without any replacement. This past Sunday ( ) we had a total of 3 staff because of 2 call off's. That is difficult." Review of the schedule verified the staffing levels stated by LPN Staff K.

In addition, Staff F was one of the 3 staff members that worked the Sunday evening shift on . Review of this employee's personnel record revealed there was no job description on file acknowledging that he knew his role and responsibilities as a caregiver associate.

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6. Review of the Employee Schedule and payroll records for the night shift, starting at 11:00 p.m. on and ending on at 7:00 a.m., revealed that there was one Licensed Practical Nurse (LPN Staff I) and one Caregiver Associate (Staff G) that worked the shift. There were originally one LPN and 3 CAs scheduled.

On at 7:00 a.m., Resident #1 was found with a left eye with active . Documented interviews conducted by LPN Staff I and ED Staff J revealed that Staff G stated, "she wasn't going to perform her usual duties because she was the only caregiver (that night)", "she never had time to check on her (the resident) all night" and "she was swamped."
LPN Staff I wrote a statement that Staff G was observed sleeping, on 2 occasions, during the night shift. There is no documented evidence that LPN Staff I notified the Health and Wellness Director or the Executive Director regarding Staff G's reluctance to "perform her usual duties" and sleeping. There was no documented evidence that an attempt was made to obtain additional staff for the shift.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review, observation and interview the facility failed to ensure enough qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with the residents' needs. This was evidenced on 12 day shifts, out of 24 day shifts; 4 evening shifts, out of 24 evening shifts; and 11 night shifts, out of 24 night shifts, reviewed for the staffing of qualified personnel in , 2017.

The findings included:

1. Review of the Employee Schedule form revealed that Staff E worked 10 night shifts, as a Caregiver Associate, during the time period through . Review of Staff E's personnel record revealed a hire date of . There was no documented evidence that she received Control training prior to her providing direct care to residents on these 10 night shifts.

In addition, according to her personnel record, this employee worked over 30 days without receiving required training in Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe Handling of Food.

2. Review of the "Employee Schedule" form revealed that Staff G worked 3 night shifts, as a Caregiver Associate, during the time period through . Review of Staff G's personnel

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record revealed a hire date of . There was no documented evidence that she received Control training prior to her providing direct care to residents on these 3 night shifts.

In addition, according to her personnel record, this employee worked over 30 days without receiving required training in Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe Handling of Food.

3. Review of the Employee Schedule form revealed that Med Tech Staff B worked 12 day shifts and 4 evening shifts, as a Medication Technician, during the time period through . Review of her personnel record revealed that there was no documented evidence that this unlicensed employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

4. Upon interview on at 3:00 p.m., the Personnel Manager acknowledged that Staff E and Staff G did not have documents verifying required training in Control, Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect, and Nutrition/Safe Handling of Food.

In addition, she acknowledged that Med Tech Staff B had no documented evidence that this unlicensed employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review, observation and interview the facility failed to ensure that unlicensed staff received training prior to assigning them to assist with the self administration of medication to residents for 1 (Medication Technician B) out of 2 Med Techs (Medication Technician) reviewed.

The finding included:

Review of the Employee Schedule, for , 2017, revealed that Med Tech Staff B worked 10 day shifts and 2 evening shifts during the time period through .

Upon interview on at 6:30 a.m., Med Tech Staff B stated she works as a Med Tech when she is scheduled. At 8:30 a.m., this date, Med Tech Staff B was observed standing at a medication cart giving

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medications to a resident.

Upon interview on at 9:00 a.m., the Health and Wellness Director (HWD Staff H) verified that Med Tech Staff B always works as a medication technician.

Review of Med Tech Staff B's personnel record, on at 3:00 p.m. revealed that there was no documented evidence that this unlicensed employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and interview the facility failed to provide direct care staff with ( ) training within 30 days of hire. This was evidenced upon review of the personal records for 5 (Staff B, C, D, E, and F) out of 5 nursing staff, actively employed by the facility beyond 30 days. , , ( ) cannot be performed on residents with a .

The finding included:

Review of nursing employee personnel records, on at 3:00 p.m., revealed that Med Tech/Staff B was hired on , LPN/Staff C was hired on , /Staff D was hired on , /Staff E was hired on and /Staff F was hired . There was no documented evidence that employees received one hour of training related to .

/Staff F was interviewed on at 3:30 p.m. When asked what he would do in an emergency he said, "I would do , I was trained. I have a card." When asked if he knew what was, he said, "No."

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview the facility failed to have complete/required employee personnel records for 6 out of a sample of 5 staff hired during the time period through . These records included references, communicable statements, job descriptions and required training/inservice.

The findings included:

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1. Review of personnel files for Med Tech Staff B, LPN Staff C, Staff D, Staff E and Staff G revealed no references on file.

2. Review of Staff G's personnel file revealed no statement that she was free from communicable .

3. Review of /Staff F's personnel record, on at 3:00 p.m., revealed no Job Description on file for working as a Caregiver Associate ( ).

4. Review of Med Tech/Staff B's personnel record revealed that there was no documented evidence that this unlicensed nursing employee was trained to assist with self administered medication pursuant to the training requirements of Rule 58A-5.0191, F.A.C.

5. Review of nursing employee personnel records revealed that Med Tech/Staff B was hired on , LPN/Staff C was hired on , /Staff D was hired on , /Staff E was hired on and /Staff F was hired and /Staff G hired . There was no documented evidence that these nursing employee received one hour of training related to .

6. Review of nursing employee personnel records revealed that there was no documented evidence that /Staff E and /Staff G received Control training prior to working with residents. In addition, these nursing employees had no record of receiving required training in Activities of Daily Living/Behavioral Needs, , Elopement, Emergency Preparedness and Evacuation, and Neglect and Nutrition and Safe Handling of Food within 30 days of hire.

7. Upon interview on at 4:00 p.m., the Personnel Manager acknowledged the missing training documentation, references, communicable statements, and job description.

Class III

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NAME OF PROVIDER OR SUPPLIER **ANGEL WORKS MANAGEMENT LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **411 NE 16 PLACE** **CAPE CORAL, FL 33909**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced Extended Congregate Care (ECC) survey was conducted on at Angel Works Management, LLC an Assisted Living Facility (license #12326) in Cape Coral, Florida.

The following is description of the deficiency.

E210 - ECC - Training - 58A-5.0191(7) FAC

Based on a review of 1 of 2 employees hired in 2017 of a total of 6 staff members reviewed, and interview with the charge staff, the facility failed to ensure the required ECC (Extended Congregate Care) training was completed in a timely manner for staff C.

The findings included:

Staff C was hired on . Review of staff C's file revealed there was no ECC training noted in the personnel file for this staff member. This was requested from the charge staff B and she was unable to provide the training documentation.

On at 2:30 p.m., charge staff B said it has not been done as yet.

Class III