STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	R 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	**1061 TOMYN BLVD** **OCOEE, FL 34761**

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

0000 - Initial Comments

A revisit to complaint investigation #2017002927 was conducted on . Inspired Living, license #12906, had deficiencies at the time of the visit.

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

DEFICIENCY REMAINED UNCORRECTED

Based on Resident Record Review, Medication Observation Record (MOR) review and interview, the facility failed to ensure that medications were given as prescribed for 1 of 4 residents sampled (#1)

Findings:

Review of the record for resident #1 revealed a refill order for , 5mg tab that was dated .

Review of a print out of the , 2017 electronic MOR for resident #1 revealed an order for , 5mg tab; give 2 tab (10mg) by mouth every morning. The medication was documented as not given on , , , , , 2017 as indicated by a circle on each of those dates on the MOR. The legend on the MOR documented that a circle indicated "not given" with the reason to be written in the notes. Electronic notes on the MOR read "Med not available- backordered" from - . On , note stated "Waiting on Pharmacy" The medication was marked as given on & .

In an interview with the Director of Nursing on at 5:55 PM, she confirmed the MOR documented the medication was not available from through , 2017. She said on one of the days, either or , the resident's daughter brought in one dose of the medication and he got it that day. She confirmed there was no documentation on the MOR to indicate this. She also stated she did not have an explanation as to why it was documented as being given on the other date when they were out of the medication.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on Medication Observation Record (MOR) review and interview, the facility failed to ensure that medications were given as prescribed for 1 of 4 residents sampled (#1)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	R 08/23/2017
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)

Findings:

Review of the record for resident #1 revealed a refill order for , 5mg tab that was dated .

Review of a print out of the electronic MOR for resident #1 revealed an order for , 5mg tab; give 2 tab (10mg) by mouth every morning.
The medication was documented as not given on , , , , , 2017 as indicated by a circle on each of those dates on the MOR. The legend on the MOR documented that a circle indicated "not given" with the reason to be written in the notes. Electronic notes on the MOR read "Med not available- backordered" from -. On , note stated "Waiting on Pharmacy" The medication was marked as given on & .

In an interview with the Director of Nursing on at 5:55 PM, she confirmed the MOR documented that the medication was not available from through , 2017. She said on one of the days, either or , the resident's daughter brought in one dose of the medication and he got it that day. She confirmed that there was no documentation on the MOR to indicate this. She also stated she did not have an explanation as to why it was documented as being given on the other date when they were out of the medication. The Director of Nursing (DON) said they ordered the refill on , but it was delivered to a different facility with the same name by mistake and it took a couple of days to track it down. She said the family was not willing to pay for the medication to be replaced. She said she could not explain why the refill was not ordered until after the medication had run out.

Class III