STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	**03/20/2018**
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 #2018000434 was conducted on . . . . . Inspired Living Assisted Living Facility License #12906 had deficiencies at the time of the visit.

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

Based on observations, record review and interview, the administrator failed to monitor the continued appropriateness of placement for 1 of 5 sampled residents (#3) and retained the resident who required total care with all activities of Daily living, (ADL's) and could not transfer and ambulate which exceeded the continued residency criteria.

Findings:

On through interview with facility staff, it was revealed that resident #3 required total care she could not use her hand to assist at all with toileting bathing, dressing, , , toileting, transferring and ambulation, she could not feed herself and the staff had to feed her. The staff stated they had to lift her to her wheelchair because she could not move her feet to transfer. All exceeded the continued residency for an Assisted Living Facility.

Observations on at 10 AM, revealed resident #3 was operating a motorized wheelchair, an interview was attempted with her however, she did not respond.

Record review for resident #3 revealed a resident health assessment form 1823 dated that noted diagnosis of (Lou Gehrig's , , affect and , , .

On at 3 PM, the memory care coordinator said she was not aware that the resident required total care; the memory care director went to speak with one of the resident's caregivers. When she returned from speaking with the caregiver, she stated the staff did confirm the resident required total care.

Class III

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

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Based on interviews and the call log, the facility failed to ensure the residents were treated with consideration for their needs, and did not timely answer calls for assistance for 11 of 11 samples residents who requested help through the call light system used by the facility.

Findings:

Through resident interviews on , it was revealed that they were provided a pendant to use to call when they required assistance from the facility staff. The residents said that when they pressed their pendants for assistance they did not always get assistance from staff in a timely manner. Some said they had to wait for 30 minutes before a staff would come to check on them.

Review of the call light log form through revealed there were delays in clearing the pendant at times, some examples include the following resident ;

on call for assistance at 1:21 PM and was not cleared until 1:49 PM; on at 5:16 AM not clear until 6:30 AM
on call for assistance at 8:57 AM and was not cleared until 9:31 AM
on call for assistance at 2:33 PM and was not cleared until 3:20 PM; on at 7:32 PM not cleared until 8:06 PM; on at 6:09 AM, not cleared until 6:48 AM; on at 7:12 AM not cleared until 9:29 AM
on call for assistance at 1:22 AM and was not cleared until 8:23 AM
on call for assistance at 12:06 PM and was not cleared until 12:28 PM
on call for assistance at 10:49 AM and was not cleared until 11:10 AM on at 7:21 AM not cleared until 9:15 AM
on call for assistance at 10:48 AM and was not cleared until 11:29 AM
on call for assistance at 1:21 PM and was not cleared until 1:58 PM
on call for assistance at 4:25 AM and was not cleared until 5:47 AM
on call for assistance at 6:25 PM and was not cleared until 8:08 PM on at 6:04 PM not cleared until 6:28 PM
on call for assistance at 1:21 PM and was not cleared until 1:49 PM on at 5:16 AM not cleared until 6:30 AM.

On at 2 PM, the memory care coordinator said the staff would answer the call bell, she said they would possibly not reset the button until they were finished providing the care, because they would become busy and forget. She had spoken with them to inform them to reset the button when they arrive. She said all staff had an IPOD and when the resident would press their pendants for assistance, they

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would all get the call. She said there were two staff on each floor during the day. She said if the staff were busy assisting another resident they could not get to the resident until they were finished. She confirmed they would not go check on the resident who called while they were providing care to another resident just to make sure they were ok and inform them they would return when they are finished.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 1 of 3 sampled staff (A).

Findings:

Personnel record review for staff A, a caregiver, hired revealed there were certificates that listed multiple training's dated that included resident rights, recognizing and reporting elder , special needs of the elderly, Activities of Daily Living, Safe food handling, wandering and elopement, , , Borne . Further review of the certificates revealed the space for facilitator name, signature and date were all left blank. There was no way to determine who had provided the training.

On at 4 PM, the administrator confirmed the findings.

Class III