STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	R 05/10/2018
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 revisit to 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 reviews, and interviews, the facility retained 2 of 10 sampled residents (#3 & #7) who exceeded the continued residency criteria in an Assisted Living Facility (ALF.)

Findings:

Review of the facility's profile on the Florida health finder website revealed the facility held a standard and Limited Nursing Service (LNS) specialty license.

1. On at 10:10 am, resident #7 was observed sitting in a wheelchair outside with a private caregiver. The resident did not respond to a greeting, did not make eye contact, and mumbled incoherently. The private caregiver said the resident required total assistance with all of her Activities of Daily Living (ADLs) and transferring.

On . . . . at 10:15 am, observations made during a transfer of resident #7 from the wheelchair to a sofa revealed her private aide and facility caregiver M placed their arms under each of the resident's arms and while they each held onto the back of her pants, they lifted her and placed her onto the sofa. The resident did not participate during the transfer and did not pivot her feet during the transfer. Caregiver M said the resident always required total assistance of two people to transfer.

Resident #7's record revealed a facility admission date of . . . . . Facility notes dated . . . indicated the resident was sent out to the hospital with a temperature of 103.8 degrees. She returned to the facility on . . . . .

A health assessment form 1823, dated on . . . , indicated the resident required total assistance with all of her ADLs and transferring. She was bedridden, required 24-hour nursing or , , care, and she had a . . . . . Endoscopic . . . . . , ( ) tube, all of which exceeded the continued residency criteria in an ALF that held a standard and LNS license.

Resident #7's record contained no documented evidence to indicate she received hospice services.

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On at 10:25 am, the memory care director confirmed the findings.

2. Observation of resident #3 on at 12:00 PM revealed the resident was seated in a special high back, powered wheel chair. She required total care she could not use her hand to assist at all with toileting bathing, dressing, , toileting, transferring or 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.

Review of the record for resident #3 revealed a health assessment (1823) dated , which was completed following insertion of a tube. Diagnoses included and . Physical limitations documented "needs assistance with transfers, feeding & medications due to caused by ." The 1823 documented "assist" for all activities of daily living (ADLs). Hospice care was not documented on the1823. A regular diet and assistance with self-administration of medications was documented. She was documented as being appropriate for an Assisted Living Facility. The insertion of the tube was not noted on the 1823.

During an attempted interview with resident #3 on at 12:00 PM, she was unable to speak, but did responded with slight head nods to questions asked. Her upper and lower extremities were contracted. She was able to communicate using the computer when it is turned on (but it was not on at the time of the interview).

A Hospice caregiver was present in the the time of the interview. When the resident was asked if she was fed through the tube, she shook her head "no." When asked if the caregiver feeds her through her mouth, she indicated "yes." When asked if she is able to feed herself, she shook her head no. The hospice nurse confirmed the responses.

Records documented the resident was admitted to hospice on . She was discharged from hospice on when she went to the hospital for tube placement. The resident was readmitted to the facility on . Hospice care was not restarted until . The facility readmitted a resident who exceeded the admission criteria and who did not have hospice care at the time of admission.

On at 12:30 PM, the administrator confirmed the findings.

Class III

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

DEFICIENCY REMAINED UNCORRECTED

Based on record review and interview the facility failed to notify Adult Protective Services of an allegation of staff [redacted] to a resident (#9) and failed to provide consideration to 2 of 10 sampled residents (#2 and #14) whose call lights were not answered in a timely manner.

Findings:

Resident record review of resident # 9 revealed a health assessment report dated [redacted] that listed diagnoses of [redacted], agitation, aphasia. She was under the care of hospice. Assistance was needed with all activities of daily living.
Order dated [redacted] indicated a psychiatrist consult related to behavior disturbances (combative/shouting/curse words).

Facility note dated [redacted] late entry for [redacted] - The writer was notified of an event on [redacted]. The event was reported to the nurse on duty on [redacted]. The nurse notified the memory care director. A caregiver (staff A) reported that she saw another staff (staff C) hold her hand over the resident's (#9) mouth. The nurse on duty and the memory care director assessed the resident. No visible injury was noted. Executive director reported alleged event to law enforcement on [redacted] at 7:45 PM. The primary care provider scheduled the Advanced Registered Nurse [redacted] (ARNP) to come in on [redacted] in the morning to examine the resident.

Incident report dated [redacted] AM indicated another staff member put (staff C) her hand over the mouth of resident #9. Family was made aware.

Review of the facility's investigation of the event indicated staff C said during an interview with the facility director that she put her hand over the mouth of resident #9, caught herself and removed it. The staff (C) resigned on [redacted]. Continued review of the investigation paperwork revealed no evidence to confirm the facility contacted Adult Protective Services (APS) regarding the [redacted].

The facility's [redacted] /neglect policy and procedure indicated - reporting - item #14 "The executive director will investigate the allegation and will enlist the services of APS, the state licensing agency and or the local Ombudsman for assistance".

In an interview with the memory care director on [redacted] at 10 AM who said the executive director

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notified the police, maybe the police notified APS.

On at 2:15 PM, the Agency attempted to obtain/verify if a report was made to APS regarding resident #9. A report was not available.

2. Review of the call light log for resident #2 revealed that on at 6:05 pm a bracelet nurse call was placed from the dining was cleared on at 8:28 pm.

On at 1:04 pm, a bracelet nurse call was placed from the dining was cleared on at 1:31 pm.

Resident #2's health assessment form 1823, dated on , indicated she had diagnoses of type 1, Hashimoto's , Stiff Person , , Ataxia, Double Vision, and she required precautions.

During an interview with resident #2 on at 1:45 pm, she retrieved text messages on her phone that she said were sent to the director of associate development and the administrator on at 10:57 pm in which she informed them both that she waited a long time for someone to help her after she called for assistance. She said on at 6:05 pm she called for assistance while she was in the dining . She said her routine was to call for help after dinner so the staff could meet her in her assist her with a shower. She said although the call was cleared at 8:28 pm, that the staff did not come to her 10:37 pm. She said the staff were able to cancel the call without seeing the resident.

During an interview with the director of associate development and administrator on at 2:15 pm, the administrator confirmed the findings on the call log. The director of associate development confirmed that she received a text message from resident #2 on at 10:57 pm in which the resident reported her wait time for assistance. She noticed the resident had the wrong phone number for the administrator so she emailed the text to the administrator.

3. Resident #14's record contained a health assessment form 1823, dated on that indicated her diagnoses included Parkinson's , , and Dystonia. She had an unsteady gait, generalized , rigidity, speech difficulties, and choking precautions and she communicated with an IPad.

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A facility observation note, dated on , indicated the nurse on duty was called to the dining approximately 12:30 pm. Upon arrival, the resident was choking and turning purple. The activities director was asked to call 911. Three thrusts of the Heimlich maneuver were performed. The resident was transported to the hospital and returned the same day.

Review of the call light log for resident #14 revealed that on at 10:35 am a bracelet nurse call was placed from the dining was cleared on at 11:08 am.

On at 6:30 pm, a bracelet nurse call was placed from the dining was cleared on at 6:47 pm.

When questioned on at 2:45 pm regarding any concerns she had, resident #14 typed on her IPad that the staff could respond faster to her calls.

On at 3:30 pm, the administrator confirmed the findings on the call log and said he was aware that resident #14 was at risk for and choking.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on review of the facility's Comprehensive Emergency Management Plan (CEMP) and interview, the facility failed to have documentation the CEMP was approved by the local emergency management agency according to 58A-5.026(2)(c) (1) FAC.

Findings:

Upon request to review the facility's CEMP the administrator provided an approval letter from the county dated . There was no approval from the current year.

On at 12:50 PM, the administrator confirmed he did not have acknowledgement from the County that the plan was received or approved.

Class III