STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968576	**06/25/2018**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1900 PHILLIPPI SHORES** **SARASOTA, FL 34231**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #2018004734 was conducted . . . through . . . at Inspired Living, an assisted living facility (license #) in Sarasota, Florida.

The following is description of the deficiencies.

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

Based on observation, resident, family and staff interviews, and record reviews, the facility failed to supervise residents and did not have an awareness of the general well-being of 7 (Residents # 1, #2, #3, 4, #7, #8, #16) out of 17 sampled residents.

The findings included:

On at 9:03 p.m., Resident #4 said he said he has been here for 1 year. He stated, "Staffing is bare minimum on the weekends especially on 3-11 shift. It is unbelievable with the size of this corporation that they cannot get more staff. People have to go wandering in the facility because they locked themselves out of their . . . . . cannot find any staff to open their door. There are other times people yell for 30 minutes or more for a staff to help them to the ."

On at 9:51 p.m., Resident Associates Staff B and D said there are many overtime shifts to be picked up. They said they can select when they want to work overtime "a month in advance."

On . . . at 10:30 a.m., Medication Technician Staff I said she picks up overtime on the day shift and evening shifts. She stated, "They need more help on the evening shift because the medication technician quit." She said she offered overtime at least a week in advance. She stated, "I am working 7-9 today because they are short." She said she knows well in advance about the overtime and she volunteers for it when she can.

On . . . . at 10:50 a.m., Resident #3 said she complained of ear pain last night. Before the evening nurse left she gave her something for pain. She said her ear hurt all night and told Staff B her ear was still hurting. Staff B told her he would look into it and get back to her. She said they need more nurses, especially at night.

On at 1:40 p.m., observed Resident #17 lying on . Resident #17 said he and has been lying on the floor since he got back from lunch. He said he does not know how long that is but

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it has been a long time. Observed a to Resident #17's right elbow and small to right flank. He said he has no way to get help, he stated, "I just yell until someone comes."

On at 2:00 p.m., Resident #7's wife said she was very disappointed with the care and lack of care her husband received. She said she feels it was because they did not have enough help. She said she had a camera placed in his would see the aides come in and get him dressed, they did not shave him or brush his . She said she is aware of at least 4 occasions where there was no nurse on the 3 p.m., to 11 p.m., shift. She said there was a time where he needed his sugar checked four times a day and does not know if it was done. One day she asked for help to get him into bed and asked for the nurse to do his sugar. She was told there was no nurse on and became upset and walked out. This was only at 8:30 p.m.,. She stated, "The place is advertised as having nursing on 24/7 and they do not."

On at 2:45 p.m., observed Residents # 9, #11, #12 and #15 with a moderate amount of hair growth on their faces. They said they have not been shaved in a few days.

A review of the facility brochure documented 24/7 nursing + telehealth, "Our team of specifically picked nurses are available - on site- around the clock." The family felt that they should be out on the floor.

On , a review of the facility's grievances revealed a grievance dated by Resident #16's daughter, as she did not think there was enough staff to take care of her mother. Resident #16's private duty caregiver was not there on Sunday. Staff did not get her mother up until after 10:00 a.m., and Resident #16 missed breakfast. On regarding Resident #8. Her family noticed caregivers "sitting in the nursing station laughing and having a good time." The family felt that they should be out on the floor.

On at 3:30 p.m., the executive director (ED) said the staff would be aware of a residents falling in the they do their rounding. She said a resident service plan is made around resident needs. Staff rounds are resident specific based on the plan. She said the company preference or standard is to have nursing 24/7. She said in this community, nursing is on 7 a.m., to 3 p.m., and 3 p.m., to 11 p.m., shifts. She said the 11 p.m., to 7 a.m., was previously staffed but there has been a challenge to find that nurse. The wellness director is on call 24/7 and if needed she would come to the community. She reviewed the facility's brochure and stated, "I was not aware that 24/7 around the clock nursing care was in the brochure. Telehealth is not available here." She said it has been at least since , could be earlier since they haven't had a nurse on the 11 p.m. to 7 a.m., shift. If there were only resident associates on, and there was a resident that maybe needed , they could activate 911 if his lips were blue, they would assess for a significant change in condition; they have all been trained in first aid.

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She said the 's have been in-serviced to call the wellness director if a resident needs care and there is no nurse on. She stated, "I think this might be a heightened awareness to change the service plans, do some trending for location and looking at staffing patterns." The ED said there was a health and wellness director meeting in 2017. A quality assurance (QA) meeting identified some indicators where there are some additional systems needed. She said she needs to make sure the QA indicator is being addressed here. The staff needs to be held accountable and they would be coached. She said an agency is not used because there is a limited nursing requirement and on call coverage has been sufficient. She said she thinks those above her found her predecessors doing "minimal at best" and that is why the ED changes.

On at 5:10 p.m., the wellness director said she was hired on and was under the impression there was an 11 p.m., to 7 a.m. nurse and there has not been seen since she arrived. She said if needed, they call her if a resident . She said the resident associate ( ) would describe what is going with the resident and if the resident has a head injury or . She said since she started, she has come in one time on an 11 p.m, to 7 a.m., shift for a resident. She said many residents and their families have complained of not having a nurse on the 11 p.m., to 7 a.m., shift. She said a licensed practical nurse cannot assess, but that is what they are doing with the 's; asking them to assess. She said she is very upset about not having an 11 p.m., to 7 a.m., nurse. She said when you call the facility and if put on hold, the message on the phone says 24/7 nurse, on-site. She said the brochure says the same. She said she told Resident # 1's family she understood how they felt, there is a problem with staffing and they are working on it. She said Resident #1's son was concerned about her not coming out of her the staff were supposed to check her and they were not. She said Resident # 2's family are dissatisfied with the staff because of lack of care related to staffing. She stated, "Staff are not doing their job, they show up and leave when they want." She stated, "Honestly I told administration in order to fix this staffing problem, they need to turn over 95% of staff, and use agency until they hire new people. I cannot staff 3-11 and 11-7 shifts because I do not have the staff to do it. I always post for overtime. We need to get rid of bad people, the staff that are not attentive." She said she has sign-up sheets for staff to pick up shifts. She stated, "Just because you have a staff body does not mean they are doing their job. We are actively seeking to hire new 's. 's schedule is so badly staffed, I don't want to post it, I can't."

Class III

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

Based on resident, family and staff interviews and record reviews, the facility failed to provide a safe and decent living environment and access to adequate healthcare for 9 (Residents #2, #6, #7, #9, #10, # 11,

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#12, #15, #17) out of 17 residents sampled.

The findings included:

On at 10:01 p.m., observed Resident #15 lying asleep in Resident #6's bed. Resident #6 said this sometimes happens. Resident associate Staff D said he must have been in another resident's Resident #15 went into Resident #6's . Staff D said he did not have a chance to check Resident #15's .

On at 10:55 a.m., observed Resident #9 sitting in a recliner next to his bed. He is wearing shorts and shirt, not shaved and had an odor of feces.

On at 12:30 p.m., resident associate Staff G stated, "I don't know what happen to his [Resident #9] wrist thing or necklace." She stated, "He is a risk and I don't know how he would call for help. He has been very weak lately". She requested assistance from medication technician Staff F. They stood Resident #9 up, Staff F told Staff G he needs to be checked, stating, "don't you smell that? Maybe he just pass gas, we need to check him." Once in the , observed a large, dry bowel movement in the brief.

On at 1:00 p.m., a review of Resident #10's record revealed in the last 3 months she had 9 . Resident #10 had 7 on the 3 p.m., to 11 p.m., shift and two on the 11 p.m., to 7 a.m., shift.

On at 1:10 p.m., a review of Resident #11's record revealed in the last 3 months he had 12 . Resident #11 had 4 on the 7 a.m., to 3 p.m., shift; five on the 3 p.m., to 11 p.m., shift and three on the 11 p.m., to 7 a.m., shift.

On at 1:20 p.m., a review of Resident #2's record revealed he was admitted on and discharged on to another assisted living facility. The reason listed was, "not satisfied with care." Further review revealed Resident #2 had 6 in the last 2 months. Resident #2 had two on the 7 a.m., to 3 p.m., shift; two on the 3 p.m., to 11 p.m., shift and two on the 11 p.m., to 7 a.m., shift.

On at 1:30 p.m., a review of Resident #12's record revealed in the last 2 months he had 8 . Resident #12 had one on the 7 a.m., to 3 p.m., shift; four on the 3 p.m., to 11 p.m., shift and three on the 11 p.m., to 7 a.m., shift.

On at 1:40 p.m., observed Resident #17 lying on the . Resident #17 said he

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and has been lying on the floor since he got back from lunch. He said he does not know how long that is, but it has been a long time. Observed a to Resident #17's right elbow and small to right flank. He said he has no way to get help, he stated, "I just yell until someone comes."

On at 2:00 p.m., Resident #7's wife said she was very disappointed with the care and lack of care her husband received. She said she feels it was because they did not have enough help. She said she had a camera placed in his would see the aides come in and get him dressed, they did not shave him or brush his . She said she is aware of at least 4 occasions where there was no nurse on the 3 p.m., to 11 p.m., shift. She said there was a time where he needed his sugar checked four times a day and does not know if it was done, because one day she asked for help to get him into bed and asked for the nurse to do his sugar. She was told there was no nurse on and became upset and walked out. This was only at 8:30 p.m.,. She stated, "The place is advertised as having nursing on 24/7 and they do not."

On at 3:30 p.m., the executive director (ED) said the staff would be aware of a resident falling in the they do their rounding. She said a resident service plan is made around resident needs. Staff rounds are resident specific based on the plan. She said the company preference or standard is to have nursing 24/7. She said in this community, nursing is on 7 a.m., to 3 p.m., and 3 p.m., to 11 p.m., shifts. She said the 11 p.m., to 7 a.m., shift was previously staffed but there has been a challenge to find that nurse. The wellness director is on call 24/7 and if needed she would come to the community. She reviewed the facility's brochure and stated, "I was not aware that 24/7 around the clock nursing care was in the brochure. Telehealth is not available here." She said it has been at least since , could be earlier since they have not had a nurse on the 11 p.m., to 7 a.m., shift. If there were only resident associates working, and a resident needed , they could activate 911 if his lips were blue, they would assess for a significant change in condition; they have all been trained in first aid. She said the RAs have been in-serviced to call the wellness director if a resident needs care and there is no nurse on. She stated, "I think this might be a heightened awareness to change the service plans, do some trending for location and looking at staffing patterns." The ED said there was a health and wellness director meeting in 2017. A quality assurance (QA) meeting identified some indicators where there are some additional systems needed. She said she needs to make sure the QA indicator is being addressed here. The staff needs to be held accountable and they would be coached. She said she thinks those above her found her predecessors doing "minimal at best" and that is why the ED changes.

On at 5:10 p.m., the wellness director said she was hired on and was under the impression there was an 11 a.m., to 7 p.m., nurse and there has not been seen since she arrived. She said if needed, they call her if a resident . She said the resident associate would describe what is going on with the resident and if the resident had a head injury or . She said since she started,

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she has come in one time on 11 p.m., to 7 a.m., shift for a resident. She said many residents and their families have complained of not having a nurse on 11 p.m., to 7 a.m., shift. She said a licensed practical nurse cannot assess, but that is what they are doing with the RAs; asking them to assess. She said she is very upset about not having a 11 p.m., to 7 a.m., nurse. She said when you call the facility and if put on hold, the message on phone says 24/7 nurse, on-site. She said the brochure says the same. She said she told Resident # 1's family she understood how they felt, there is a problem with staffing and they are working on it. She said Resident #1's son was concerned about her not coming out of her staff were supposed to check her and they were not. She said Resident # 2's family are dissatisfied with the staff because of lack of care related to staffing. She stated, "Staff are not doing their job, they show up and leave when they want." She stated, "Honestly I told administration in order to fix this staffing problem, they need to turn over 95% of staff, and use agency until they hire new people. I cannot staff 3 p.m., to 11 p.m., and 11 p.m., to 7 a.m., shifts because I do not have the staff to do it. I always post for overtime. We need to get rid of bad people, the staff that are not attentive." She said she has sign-up sheets for staff to pick up shifts. She stated, "Just because you have a staff body does not mean they are doing their job. 's schedule is so badly staffed, I don't want to post it, I can't."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to have qualified staff available to assess appropriately for changes in medical conditions for 14 (Residents #1, #2, #3, #4, #6, #7, #8, #9, #10, #11, #12, #15, #16, #17) out of 17 residents sampled.

The findings included:

On at 9:03 p.m., Resident #4 said he said he has been here for 1 year. He stated, "Staffing is bare minimum on the weekends especially on 3-11 shift. It is unbelievable with the size of this corporation that they cannot get more staff. People have to go wandering in the facility because they locked themselves out of their cannot find any staff to open their door. There are other times people yell for 30 minutes or more for a staff to help them to the ."

On at 9:51 p.m., Resident associates Staff B and D said there are many overtime shifts they can pick up. They said they could select when they want to work overtime "a month in advance."

On at 10:30 a.m., Medication Technician Staff I said she picks up overtime on the day shift and evening shifts. She stated, "They need more help on the evening shift because the medication

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technician quit." She said she offered overtime at least a week in advance. She stated, "I am working 7-9 today because they are short." She said she knows well in advance about the overtime and she volunteers for it when she can.

On at 10:50 a.m., Resident #3 said she complained of ear pain last night. Before the evening nurse left, she gave her something for pain. She said her ear hurt all night and told Staff B her ear still hurts. Staff B told her he would look into it and get back to her. She said they need more nurses, especially at night.

On / at 1:00 p.m., a review of Resident #10's record revealed in the last 3 months she had nine . Resident #10 had seven on the 3 p.m., to 11 p.m., shift and two on the 11 p.m., to 7 a.m., shift.

On at 1:10 p.m., a review of Resident #11's record revealed in the last 3 months he had twelve . Resident #11 had four on the 7 a.m., to 3 p.m., shift; five on the 3 p.m., to 11 p.m., shift and three on the 11 p.m., to 7 a.m. shift.

On at 1:20 p.m., a review of Resident #2's record revealed he was admitted on ; and discharged on to another assisted living facility. The reason listed was, "not satisfied with care." Further review revealed Resident #2 had six in the last 2 months. Resident #2 had two on the 7 a.m., to 3 p.m., shift; two on the 3 p.m., to 11 p.m., shift and two on the 11 p.m., to 7 a.m., shift.

On at 1:30 p.m., a review of Resident #12's record revealed in the last 2 months he had eight . Resident #12 had one on the 7 a.m., to 3 p.m., shift; four on the 3 p.m. to 11 p.m. shift and three on the 11 p.m., to 7 a.m., shift.

On at 1:40 p.m., observed Resident #17 lying on . Resident #17 said he , and has been lying on the floor since he got back from lunch. He said he does not know how long that is, but it has been a long time. Observed a to Resident #17's right elbow and small to right flank. He said he has no way to get help, he stated, "I just yell until someone comes."

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became upset and walked out. Resident #7's wife stated, "And this was only at 8:30 p.m." She stated, "The place is advertised as having nursing on 24/7 and they do not."

On at 2:45 p.m., observed Residents #9, #11, #12 and #15 with a moderate amount of hair growth on their faces. The residents said they have not been shaved in a few days.

On at 2:55 p.m., a review of facility's grievances revealed a grievance dated by Resident #16's daughter, as she did not think there was enough staff to take care of her mother. Resident #16's private duty caregiver was not there on Sunday. Staff did not get her mother up until after 10:00 a.m., and Resident #16 missed breakfast. On regarding Resident #8. Her family noticed caregivers "sitting in the nursing station laughing and having a good time." The family felt that they should be out on the floor.

On at 3:30 p.m., the executive director (ED) said the staff would be aware of a resident falling in the they do their rounding. She said a resident service plan is made around resident needs. Staff rounds are resident specific based on the plan. She said the company preference or standard is to have nursing 24/7. She said in this community, nursing is on 7 a.m., to 3 p.m., and 3 p.m., to 11 p.m., shifts. She said the 11 p.m., to 7 a.m., shift was previously staffed but there has been a challenge to find that nurse. The wellness director is on call 24/7 and if needed she would come to the community. She reviewed the facility's brochure and stated, "I was not aware that 24/7 around the clock nursing care was in the brochure. Telehealth is not available here." She said it has been at least since , could be earlier since they have not had a nurse on the 11 p.m., to 7 a.m., shift. If there were only resident associates ('s) working, and a resident needed , they could activate 911 if his lips were blue, they would assess for a significant change in condition; they have all been trained in first aid. She said the 's have been in-serviced to call the wellness director if a resident needs care and there is no nurse on. She stated, "I think this might be a heightened awareness to change the service plans, do some trending for location and looking at staffing patterns." The ED said there was a health and wellness director meeting in 2017. A quality assurance (QA) meeting identified some indicators where there are some additional systems needed. She said she would need to make sure the QA indicator is being addressed here. The staff needs to be held accountable and they would be coached. She said she thinks those above her found her predecessors doing "minimal at best" and that is why the ED changes.

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come in one time on 11 p.m. to 7 a.m., shift for a resident. She said many residents and their families have complained of not having a nurse on 11p.m., to 7 a.m., shift. She said a licensed practical nurse cannot assess, but that is what they are doing with the 's, asking them to assess. She said she is very upset about not having a 11 p.m., to 7 a.m., nurse. She said when you call the facility and if put on hold, the message on phone says 24/7 nurse, on-site. She said the brochure says the same. She said she told Resident # 1's family she understood how they felt, there is a problem with staffing and they are working on it. She said Resident #1's son was concerned about her not coming out of her staff were supposed to check her and they were not. She said Resident # 2's family are dissatisfied with the staff because of lack of care related to staffing. She stated, "Staff are not doing their job, they show up and leave when they want." She stated, "Honestly I told administration in order to fix this staffing problem, they need to turn over 95% of staff, and use agency until they hire new people. I cannot staff 3-11 and 11-7 shifts because I do not have the staff to do it. I always post for overtime. We need to get rid of bad people, the staff that are not attentive." She said she has sign-up sheets for staff to pick up shifts. She stated, "Just because you have a staff body does not mean they are doing their job. We are actively seeking to hire new 's. 's schedule is so badly staffed, I don't want to post it, I just can't the way it is."

Class III