| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11969074 | R<br>05/10/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**INSPIRED LIVING** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**1061 TOMYN BLVD**<br>**OCOEE, FL 34761** | |

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

**0000 - Initial Comments**

A revisit to Conplaint Investigation #2017015860 was conducted from - . Inspired Living Assisted Living
Facility, license #12906, had deficiencies at the time of the visit.

**0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC**

Based on record reviews and interview, the facility failed to ensure a health assessment form 1823 was complete and accurate for 1 of 10 sampled residents (#7).

Findings:

Resident #7's record revealed a facility admission date of . The section on her health assessment form 1823, dated on , that pertained to whether she required assistance with her medications was not answered.

On at 12:28 PM, the administrator confirmed the findings.

Class III

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

REMAINED UNCORRECTED

Based on record reviews and interviews, the facility failed to provide care and services appropriate to the needs of 2 of 10 sampled residents (#3 & 14).

Findings:

1. Resident #14's record revealed a facility admission date of . A health assessment form 1823, dated on , indicated she had a diagnoses of Parkinson's , and Dystonia. The form indicated she experienced frequent , she had an unstable gait, generalized , and rigidity. Precautions were for and choking.

On , resident #14 was on the floor in front of her recliner.

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

On , she was observed on her knees at her bedside with her upper body lying on her bed. The back of her left leg was wedged under her walker. She said she leaned over and rolled out of bed.

On , she in the the gym.

On , she while trying to get clothing from her closet. A caregiver was present in the the time. She was educated on safety, use of her call bracelet, and to call for assistance.

On , she was observed on her knees on the floor after losing her balance and falling.

On , she slid out of her bed onto the floor while attempting to get up without assistance. , was ordered for a positive Urinalysis.

On , she out of her chair in her apartment.

On , she had a in her unattended.

On , she was found on her kitchen floor in her apartment attempting to do her medications. She was seen by physical , on .

Resident #14's record contained no documented interventions following the she had on , , , , and .

On at 12 PM, the memory care director confirmed the findings.

2. Review of the record for resident #3 revealed a health assessment (1823), dated , completed following insertion of a tube. Diagnoses included , ( ) and . Physical limitations read, "needs assistance with transfers, feeding & medications due to caused by ." The 1823 reflected "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.

Resident #3 was admitted to hospice care on . She was discharged from hospice on when she went to the hospital for a planned tube placement. The hospice nurse stated on at 2:45 PM, she was discharged because she was going outside of their service area for a , endoscopic , ( ) tube insertion, and they would re-evaluate her when she returned. The

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

resident was readmitted to facility on . Hospice not restarted until .

An note on at 3 PM reflected the resident returned to the facility.

There were no notes in the resident's record from to present documenting flushing or care of the tube. Notes did document that the tube area dressing was dry and intact.

On , a 7 AM-3 PM shift note documented a call to hospice to come see the resident. Hospice care not was restarted as of this date according to hospice nurse.

On , a 3-11 PM shift note, signed by a facility licensed practical nurse (LPN), reflected that she contacted hospice. The resident had pain and redness at the insertion site and a small to medium marble sized lump was observed to the right of the tube insertion site.

According to the hospice nurse at 1:20 PM on , resident #3 went back on hospice on . The nurse stated the family was looking for another private caregiver to provide the daily flushing/care of the tube. At that time, they would discontinue hospice. The hospice nurse provided an Integrated Plan of Care dated . Resident #3 was discharged from hospice on . There was no new plan of care.

On at 3:05 PM, the hospice nurse told LPN I that she did not have orders for the care and treatment of the / tube area.

On at 3:08 PM, LPN I confirmed the resident returned to the facility on around 3 PM. Her understanding was that the facility received orders yesterday, , for care of the tube. She did not confirm that the facility was or was not providing care and flushing of the tube for 5 days post hospital discharge from to . She did confirm that there was no documentation as to what care was provided to resident #3 after her discharge from the hospital

The facility was unable to provide documention of the care provided to resident #3 for 5 days post-op for a tube insertion. The facility did not have discharge and care orders from the hospital, and the resident was not receiving hospice care.

Class II

**Z803 - License Required; Display - 408.804 FS**

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on review of the Florida Health Finder website, record reviews and interview, the facility provided an unlicensed service to 2 of 10 sampled residents (#3 & 7) who had Endoscopic , ( ) tubes.

Findings:

1. Resident #3's health assessment (1823) dated , had the completed section for a tube. Diagnoses included , , ( ) and . Physical limitations reflected the reisdent "needs assistance with transfers, feeding & medications due to caused by ." The 1823 read, "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 assessed as being appropriate for an Assisted Living Facility. The insertion of the tube was not noted on the 1823.

Resident #3 was admitted to hospice care on and discharged from hospice on when she went to the hospital for a planned tube placement. The hospice nurse stated on at 2:45 PM that she was discharged because she was going outside of their service area for the tube insertion and they would re-evaluate her when she returned. The resident was readmitted to facility on . Hospice was not restarted until .
An observation note on at 3 PM reflected that the resident returned to the facility.

There were no notes in the resident's record from to present documenting flushing or care of the tube. Notes did reflect that the dressing was dry and intact.

On , a 7 AM-3 PM shift note relected that hospice was called to come see the resident. Hospice care was not restarted as of this date, according to hospice nurse.

On , a 3-11 PM shift note, signed by a facility licensed practical nurse (LPN) documented that she contacted hospice. The resident had pain and redness at the insertion site and a small to medium marble sized lump was observed to the right of the tube insertion site.

According to the hospice nurse at 1:20 PM on , resident #3 went back on hospice on .
The nurse stated the family was looking for another private caregiver to provide the daily flushing/care of the tube. At that time, they would discontinue hospice. The hospice nurse provided an Integrated Plan of Care dated . Resident #3 was discharged from hospice on . There is no new plan of care.

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

On at 3:05 PM, the hospice nurse told staff I that she did not have orders for the care and treatment of the and .

On at 3:08 PM, LPN I confirmed the resident returned to the facility on around 3 PM. Her understanding was that the facility received orders yesterday, , for care of the tube. She did not confirm that the facility was or was not providing care and flushing of the tube for 5 days post hospital discharge from to . She did confirm that there was no documentation as to what care was provided to resident #3 after her discharge from the hospital

The facility was providing Extended Congregate Care (ECC) services they were not licensed to provide for 5 days by providing post op care to a tube and . The facility did not have discharge and care orders from the hospital or physician, and the resident was not receiving hospice care.

2. 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.

On at 9:30 AM, LPN I identified resident #7 and said the resident received home health services for a at the site of her tube.

Resident #7's record revealed a facility admission date of . On , she had a temperature of 103.8 degrees and was sent to the hospital. On , she returned from the hospital with a tube.

A health assessment form 1823, dated on , indicated she was to receive home health care for evaluation, treatment, and management of her tube.

A facility note, dated on , indicated the nurse obtained consent from the resident's family to remove the soiled tube dressing, cleanse the skin around the tube with normal , and apply a clean 4x4 gauze around the tube. However, nursing services can only be provided to a tube when the facility holds an Extended Congregate Care (ECC) specialty license.

Resident #7's record did not contain documentation to indicate she was admitted to hospice services.

On at 12:45 PM, the memory care director confirmed the findings.

Unclassified