STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968715	**12/03/2018**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT SUN CITY CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1320 33RD ST SE** **SUN CITY CENTER, FL 33570**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint (CCR#2018017527) survey was conducted on at Inspired Living at Sun City Center Assisted Living Facility. The facility had deficiencies at the time of the visit.

(License #12603)

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

Based on observation, interview and record review, the facility failed to provide the level of oversight, supervision and care and services required to address aggressive behavior for three residents (#1, #2, #3) who required a higher level of personal supervision due to ongoing physical and aggression toward other facility residents and facility staff. Additionally, the facility failed to document and provide ongoing assessment of the facility residents, as required under the facility's own policy and failed to notify the responsible parties for victims following incidents involving resident on resident for one sampled resident (#4).

Findings included:

During an observation throughout survey at the facility on between the hours of 9:00 AM and 4:00 PM, Resident #1 was observed moving freely throughout the facility in his wheelchair. On multiple occasions during the hours of survey, Resident #1 was observed running his wheelchair into other residents' wheelchairs, into residents walking in the hallways and grabbing or attempting to grab other residents as they wheeled or walked by Resident #1.

A record review for Resident #1 conducted on revealed documentation of a -to- health assessment conducted by a health care provider on , indicating a diagnosis of . Further review of Resident #1's record revealed ten documented incidents of aggressive behaviors toward other unnamed facility residents between - , including the following:

- Punched a resident and ran over another resident's on ,
-Agitated, yelling banging doors, "touching other residents" on ,
-Grabbing other residents' wheelchairs and attempting to strike female resident on ,
-Hospitalized on and ,

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-Meds changed ,
-Agitated, yelling and banging on doors on and and ,
-Med changes ,
-Approaching and grabbing residents and staff on ,
-Attempted to punch another resident on ,
-Kicking a resident on ,
-Ran his wheelchair into another resident and hit a resident in the on .

The record contained no additional documentation for the rest of or , although during staff interviews, facility staff (including the Executive Director and Health and Wellness Director) stated Resident #1 is still displaying aggressive behaviors towards other residents.

During an interview with the Health and Wellness Director on at 10:16 AM, when asked about resident behaviors, the Health and Wellness Director indicated Resident #1 had aggressive behaviors and his last hospitalization was due to his behaviors.

During an interview with the Executive Director (ED) on at 4:36 PM, the ED also stated Resident #1 is still displaying aggressive behaviors.

During an observation on at 1:50 PM, Resident #1 was observed in the "aquarium room" in the facility, sitting in his wheelchair behind Resident #4 who was in their wheelchair. Resident #1 grabbed Resident #4 by the right and yanking Resident #4 backwards, shaking Resident #4 and hitting Resident #4 on the . Resident #4 was screaming, "Let go of me." "Get off of me." "Ouch, you are hurting me." No staff were observed supervising the situation or available to intervene. Two Agency employees were present and pulled the wheelchair of Resident #4 forward and called for staff assistance. Staff F arrived and intervened, stating, "Where are the floor staff, this always happens." Following the incident, Staff F stated, "This happens frequently and the floor staff are never around."

During a record review for Resident #2 on , it revealed a history of touching other residents inappropriately, exposing himself and around the facility naked. It revealed six specific documented incidents of on Resident #4 between and , including as follows:

-Walking around naked or partially dressed ,
-Attempting to hit a resident on ,
-Touching and rubbing female resident's on and after being redirected, went and did it again.

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-Walking naked in hallway on , , , and ,
-Rubbing female's on ,
-Physically aggressive to another resident on ,
-Walking naked on ,
-Exposed himself to female resident on ,
-Walking naked on ,

-Staff was busy with other resident, resident makes way to female resident and fondled her under her shirt, staff redirected, later had another altercation with male resident saying "hey watch out now", the other resident got too close, punches were thrown on

-Had physical altercation with male resident on and .

During an observation on at 11:15 AM, Resident #2 was observed in the dining room standing behind Resident #4, who was sitting in their wheelchair at the table. Resident #2 had their extended down between Resident #4's and the wheelchair by their waist/ area.

During an observation on at 1:55 PM, Resident #2 was observed reaching out and trying to grab Resident
#4 as they were passing by.

During a record review for Resident #4 on , it revealed a Health Assessment conducted by a healthcare provider dated , indicating a diagnosis of 's. The record revealed one documented incident of by Resident #2 on . No other incidents were documented in Resident #4's record of by Resident #2. Resident #4's record only included one documentation of notification of the responsible parties following the incident noted in Resident #4's chart involving Resident #2 as the victim of .

During an interview with Staff E on at 11:15 AM, Staff E stated there have been incidents with Resident #2 touching residents inappropriately and added that they have only witnessed Resident #2 touching Resident #4 and no other female residents.

During a family interview for the family member of Resident #9 conducted on at 12:03 PM the family member stated, "I have seen inappropriate touching right out in the open. Resident #2 was touching Resident #4 and I reported it. It happened a couple weeks ago. I reported it to the Health and Wellness Director."

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During an interview with Staff D on at 11:40 AM, Staff D stated, " (Resident #2) harass (Resident #4). He goes to her when staff are not around. I don't know if they tell the daughter (of Resident #4). It has been told to management many times. They have not done anything about it."

During an interview with the Health and Wellness Director on at 3:00 PM, the Health and Wellness Director stated Resident #2 was inappropriate with Resident #4. The Health and Wellness Director confirmed the documentation of the multiple incidents of toward Resident #4 documented in Resident #2's chart to be accurate. The Health and Wellness Director confirmed Resident #2 and Resident #4's rooms are in the same hallway, adjacent to one another and Resident #2 and Resident #4 share the same common and dining areas.

The facility did not provide any documentation of any interventions provided to protect Resident #4 from Resident #2 frequently seeking Resident #4 out and harassing and abusing Resident #4.

Resident #4's record only revealed one documented incident of by Resident #2 and only one notification to the responsible party for Resident #4 following the incidents.

During an interview with Staff A on at 9:37 AM, Staff A stated Resident #3 was inappropriate with staff and other residents, making expressions, touching staff, touching female residents, and grabbing and playing with Resident #3's own in the common areas in front of female residents.

During a record review for Resident #3 on , it revealed documentation of a -to- health assessment conducted by a healthcare provider dated , indicating Resident #3 had a diagnosis of frontal . The record review further revealed a evaluation dated due to Resident #3 having an increased drive and inappropriate behaviors toward female residents. Between the dates of and , there were five documented incidents of aggressive or inappropriate behaviors with unidentified female residents or facility staff, as follows:

-Inappropriate touching and exposure of penis to female residents on ,
-Aggressive toward staff and exit seeking on and ,
-Meds changed on ,
-Acted out and exposed himself to staff on ,
-Made a gesture to a female resident on

There was no documentation by the facility of notification of the incidents to the female residents'

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(victims) responsible parties noted.

During an interview with the Executive Director on at 4:39 PM, the Executive Director (ED) acknowledged and confirmed the occurring between Resident #4 and Resident #2. The ED stated if it is not documented in Resident #4's chart or notes, then the responsible parties were not notified following the incidents of . The ED acknowledged Resident #1 is still displaying aggressive behaviors and Resident #3 displays inappropriate behaviors to and in front of female residents. The ED further stated the interventions taken for these behaviors were medication changes. The ED stated if there is no documentation, then the residents' responsible parties must not have been notified.

Class I

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, record review, and interview, the facility failed to honor resident rights to live in a safe environment, free from and neglect. Specifically, they failed to ensure all residents who reside in the facility were free from resident-to-resident and , from three sampled residents (#1, #2 and #4) displaying aggressive behavior and failed to follow the facility's own policy. Additionally, the facility failed to ensure resident rooms were clean and free of hazards for one Resident (#2) who was identified as a risk.

Findings Include:

On , at 11:15am, Resident #2 was observed in the dining room standing behind Resident #4 who was sitting in a wheel chair at the dining room table. Resident #2 had a extended down between Resident #4's and the wheel chair by the waist/ area of Resident #4. Staff E witnessed the incident and stated that there have been incidents with Resident #2 touching other facility residents inappropriately. When asked if Resident
#2 touched others, Staff E stated that they have only seen Resident #2 touch Resident #4.

At 1:55pm, while passing Resident #4, Resident #2 was observed reaching out and trying to grab Resident #4.

A resident record review conducted on , for Resident #2 revealed multiple incidents of touching other residents inappropriately, exposing self, and naked in the facility. The

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following events were documented in Resident #2's chart:

- This AM was coming out of apartment naked after a care staff had already been in to get them dressed
- Resident walked into dining room with only brief and t-shirt
- Approximately 1:10pm had to be directed away from another resident as they struck out with their and hit another resident that was passing by in their wheelchair
- Touching and rubbing another female resident's . Quickly stopped and redirected. Writer was helping another resident and they walked over and grabbed the same resident's again
- Walking naked in hallway
- Walking naked in hallway
- Seen by family member of another resident walking out of room naked with brief around ankles
- Came out of apartment naked
- Resident continues to be very aggressive by screaming and yelling
- Walking without clothes and walker
- , hallway naked
- Rubbed on a female's
- Resident very aggressive and violent to another resident by kicking and punching them
- Walking around naked
- Pants down, and front private area showing standing in front of female resident, care staff redirected, female resident unable to convey what happened
- 12:00 PM , hallway naked
- Staff was busy with other resident, resident makes way to female resident and fondled her under her shirt, staff redirected, later had another altercation with male resident saying "hey watch out now", the other resident got too close, punches were thrown, families and doctor aware
- , Came out of apartment naked
- Altercation with another resident, hitting each other.

The Health and Wellness Director was interviewed at 3:00pm on , and stated that "(Resident #2) doesn't seem , inappropriate with staff, but with residents, it's just with (Resident #4)."

An observation of the layout of the facility on , beginning at 9:16 AM revealed there were two separate dining areas and two separate common areas separated by a long hallway where administrative offices were located. Resident #2 and Resident #4's rooms were on the same hallway

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across the hall from each other and shared the same dining area and common seating area.

During a family interview with the family member of Resident #9 conducted on at 12:03 PM the family member stated, "I have seen inappropriate touching right out in the open. (Resident #2) was touching (Resident #4) and I reported it. It happened a couple weeks ago. I reported it to the Health and Wellness Director."

A resident record review for Resident #4 revealed that per the health assessment dated , they have . A care note dated stated "resident sitting in hallway and was approached by male resident who attempted to touch her between , staff immediately separated them, Advanced Registered Nurse Practitioner (ARNP) and family notified." The Health and Wellness Director was asked for additional documentation regarding other incidents between Resident #2 and Resident #4, and the notification of Resident #4's family, but no additional documentation was provided.

The Executive Director (ED) was interviewed on , at 4:39pm at which time the ED acknowledged and confirmed the multiple incidents of between Resident #2 and Resident #4 that were documented in Resident #2's record. When requested, the ED did not provide any documentation for Resident #4, who was the victim of the from Resident #2, indicating any further details of the incidents, if an investigation was conducted or if Resident #4's responsible party was notified. The ED also did not provide any documentation of any type of assessment of Resident #4 following the documented incidents of in Resident #2's record.

During an interview with Staff A on , at 9:37am, Staff A stated that Resident #3 is , inappropriate with staff and with other residents. According to Staff A, Resident #3 has made expressions with their and and Resident #3 touched other care staff and Staff A. Resident #3 also touched a female resident on the , and Resident #3 has grabbed himself, and "plays with" himself in the common area.

A resident record review for Resident #3 on , revealed the following events documented in the record:

- 12:57 PM , inappropriate behaviors, sat next to a female resident and with rubbed up her and asked her "what do you want to do"
- 1:01 PM late entry for at 11:00 AM Pulled penis out of shorts in the common area and was trying to get the attention of a female resident, redirected
- Confrontational with staff
- Medication changes for behaviors

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- late entry for Resident asked staff to sit next to them, as they needed a female to help them. While they were doing this they were grabbing their penis with their and rubbing them up and down
- Made a , inappropriate gesture to another female resident. Explained to the resident it was inappropriate.

On , during the hours of 9 AM and 4 PM, Resident #1 was observed in a wheelchair moving around the facility banging into other residents and screaming at them.

On , at 1:50 PM, Resident #1 was in their wheelchair behind Resident #4, who was also in a wheelchair. Resident #1 reached out and grabbed Resident #4 by the right and , and shook and hit her, pulling her backwards. Resident #4 was screaming for Resident #1 to stop. There were no staff observed in the area. Two Agency employees had to attempt to separate the wheelchairs and notify staff.

A resident record review for Resident #1 was conducted on , . The following documentation was in Resident #1s record:

- 1:45 PM Punched another resident in the . The other resident grabbed (Resident #1's) arms to avoid being hit. Residents were separated, 3:35 PM Ran over another residents with his wheelchair in the west wing. The other resident slapped him on his arm. (Resident #1) slapped the other resident in the .
- The past week has been agitated, yelling, screaming, banging on doors grabbing and shaking doorknobs, the hallways touching other residents, and showing aggression. Trying to redirect, not working. ARNP and wife notified
- 1:38 PM Noted to be extremely agitated, ambulating in rolling walker, grabbing other residents wheelchairs and yanking them. Attempted to strike a female resident, staff intervened and got hit. Tried to redirect, wife notified
- 1:35 PM Extremely agitated and combative, hitting with , grabbing objects projecting them at staff and residents. , sent to hospital.
- 3:44 PM Agitated, kicking and banging on other resident doors, was eventually redirected
- Extremely , the community, yelling out, knocking on doors
- Banging on resident doors
- 2:02 PM the community restlessly, worked up yelling out random words, refusing care
- Order for as needed medication for increased agitation. the community yelling and difficult to redirect. Approaching other residents and staff grabbing/pulling on them.

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- 5:41 AM Combative and
- 6:41 AM Awake with aggressive behaviors and restless, as needed medication administered.
- 2:00 AM Awake, restless, and combative, redirected multiple times
- Attempted to punch another resident in the with fist
- 10:23 PM Found by staff in another residents bed only wearing a brief, resisted staff
- 2:41 PM Banging and shaking resident doors, kicking the of another residents while sitting, resisted care
- 4:19 PM Resident agitated, banging on other resident doors, up and down the hallways in wheelchair bumping into other residents. Backed wheelchair into another resident, ran over the other residents twice and hit them in the . Separated by staff and redirected

On , a review of the Facility's /Neglect policy dated 2014, modified , ; revealed that the policy required that any witnessed is to be reported to the Executive Director and the Regional Director of Operations, an incident report will be filled out, the Executive Director will do an investigation, and enlist Adult Protective Services, the state licensing agency, and/or the local Ombudsman's office. The resident's responsible party will be notified by the Executive Director, and local law enforcement will be called.

The Executive Director was interviewed on , at approximately 4:39pm at which time they acknowledged and confirmed that the facility did not follow their /Neglect policy in reporting, investigating and notification. The Executive Director also did not produce any documentation or evidence of notification to the agencies outlined in the Facility's /Neglect policy. The Executive Director also did not produce any documentation indicating that any of the residents physically assaulted by Resident #1 received any assessment or follow-up after the documented incidents.

During a tour of the facility on , at 9:16am, a substance that appeared to be feces was observed in the shower and on the shower mat in . During an additional observation of at 2:10pm, feces was still in the shower and on the shower mat (photo evidence obtained). During a continued tour at 1:40pm, in , observed two white , one of which was stretched across the room from the cable connection to the television, and a walker sitting in the middle of the room (photo evidence obtained). A resident record review for Resident #2, resident who resides in that room, revealed they are a risk, have a history of , unsteady gait, and noncompliance using a walker to ambulate.

The Executive Director was interviewed on , at 4:39pm and acknowledged and

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confirmed the feces in the shower area and the unsafe cable in .

Class I

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on observation, record reviews, and interviews, the facility failed to ensure the facility Administrator supervised the operation of the facility as required to ensure the facility was a safe environment, free of and neglect and provided the required level of , including the management of care and supervision to all residents. Additionally, the facility Administrator failed to ensure the facility's and neglect policy and procedure was being followed.

Findings Included:

A record review of the facility's and Neglect Policy Dated 2014 Modified: , conducted on revealed the following:

Reporting:
9. Any employee witnessing, suspecting, or having knowledge of is required to report it immediately to the Executive Director and Regional Director of Operations (RDO).
10. The Executive Director will ensure that appropriate procedures are followed, forms are submitted, and specified timelines are followed per state regulations.
11. An incident report will be filled out as needed.
14. The Executive Director will investigate the allegation and enlist the services of Adult Protective Services (APS), the state licensing agency and/or the local Ombudsman for assistance.
15. The Executive Director will notify the Resident's Responsible Person of a report of alleged or neglect involving the Resident.
17. Local law enforcement authorities will be contacted when involving physical injury, , a crime, or when other than by processes occurs to a Resident because of alleged actions by a staff member, visitor, or other resident.
Action:
23. In the event the , is a fellow Resident, the Resident's condition will immediately be evaluated to determine the most suitable action and placement for the Resident considering the safety of the Resident as well as the safety of other Residents and employees of the Community.

During observations on during the hours of 9:00 AM and 4:00 PM, Resident #1 was observed moving around freely in the community running their wheelchair into other residents and grabbing them.

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On at 11:15 AM, Resident #2 was observed with their down the of Resident #4's wheelchair between Resident #4's and the wheelchair, near their area.

During a family interview with the family member of Resident #9 conducted on at 12:03 PM the family member stated, "I have seen inappropriate touching right out in the open. (Resident #2) was touching (Resident #4) and I reported it. It happened a couple weeks ago. I reported it to the Health and Wellness Director."

During a record review on for Resident #2, there were multiple documented incidents of inappropriate behaviors to include on Resident #4 noted in Resident #2's record. During a record review on for Resident #4 there was no documentation to indicate that the facility notified Resident #4's responsible party, APS, the local Ombudsman or the local police following the documented behaviors and by Resident #2 to Resident #4.

A record review for Resident #1 on revealed multiple incidents of resident-to-resident , on unidentified residents. No documentation of notification to responsible parties of the victims, APS, local Ombudsman or the local police was noted in the record.

A record review for Resident #3 on revealed multiple incidents of resident-to-resident to other residents, including Resident #3 exposing their , making gestures to other residents and touching other residents inappropriately. There was no documentation to the responsible parties of the victims, APS, the local ombudsman or local law enforcement in Resident #3's record.

During an interview with the Executive Director (ED) on , the ED confirmed that the , policy and procedure was the policy and procedure the facility currently follows. The ED stated if there were no documentation in the resident charts of notification to their responsible parties following incidents of or , , then the responsible parties were not notified. The ED also did not produce any documentation of investigation of any of the incidents documented regarding Resident #1, Resident #2 or Resident #3 nor any documentation of the assessment of the victims of the documented in Resident #1's record, Resident #2's record or Resident #3's record.

Regarding Resident #1, the ED confirmed the only documented continued action taken was to redirect the resident during the documented incidents and no reports were made to the required local agencies.

Class II