STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968822	**12/06/2018**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5130 KELLY RD** **TAMPA, FL 33634**	

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

0000 - Initial Comments

Assisted Living Facility

A Complaint investigation (CCR#2018014967, #2018015562 and #2018017243) was conducted at Inspired Living at Tampa on 12/6/18. Inspired Living at Tampa had deficiencies at the time of the investigation.

License (#12689)

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on interview and record review the facility failed to ensure that a health care provider's order related to providing a nutritional supplement three times a day with meals was followed for one (Resident #1) out of three sampled residents reviewed.

Findings included:

On 12/06/2018, a medical record review was completed for Resident # 1. A health care provider order was located in the chart and included: Healthcare Provider Fax Order Sheet. Problem: Dietary needs. Physician Response/Order: Patient to be downgraded to with magic cup at each meal. Licensed Practical Nurse (LPN) F received the telephone order on . The Healthcare Provider Signature was by the Advanced Registered Nurse Practitioner (ARNP).

The Medical Observation Record (MOR) was reviewed. The magic cup supplement was not present on the MOR.
The Dining Communication Form signed by the Dining Services Director was signed on . The form included: Diet ordered: Regular and Consistency: .
No supplements including the magic cup were listed on the form.

An interview was conducted with the Dining Services Director at 2:27 pm. The Director said that the Resident #1's family came to her and requested the magic cup supplement. She said that she mixed the magic cup in a shake because it was easier for Resident #1 to drink it. The Director was asked how often the resident received the magic cup. She stated that the resident was provided the supplement everyday with the lunch and dinner meals. She said if there was a physician order or nursing request, then it would be on the Dinning Communication Form. She said that the nursing department never came to her about adding the magic cup. She said that it was the family who came to her and requested the

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supplement. The Dinning Communication Form, completion date . . . . . was the only form that she had seen. She confirmed that she had not received another more current form that included the magic cup.

At 2:45 pm, an interview was conducted with the Executive Director. He stated, if a doctor ordered a magic cup, then it should be on the MOR. He said that Resident #1 was receiving a magic cup because of a poor appetite. He said that probably the reason the family asked for it was because they saw other residents receiving it. He was shown the telephone physician order for the magic cup to be provided at each meal. He acknowledged that the magic cup should have been on the MOR.
At 3:15 pm, an interview was conducted with LPN F. She was asked about the telephone order for the magic cup to be provided at each meal. She said that when she received a telephone order it then went into the ARNP's folder. The ARNP then signs the order when she came to the facility. The nurse said she would have faxed a dietary sheet to pharmacy so that the magic cup would be included on the MOR. A copy of the dietary sheet would have then went to kitchen. She confirmed that the magic cup should go on the MOR. She stated that then the kitchen would know to provide it with all meals, including breakfast, lunch and dinner. She said that there should have been another more current Dinning Communication Form that included the magic cup. The nurse acknowledged that they were not documenting that the resident was receiving the supplement.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on records review and interviews the facility failed to ensure that all staff who provide direct care to residents receive the required in-service training for 2 of 3 staff whose records were reviewed (Staff B and Staff D).

Findings included:

During a review of Staff B's employee training records on 12/6/18, it was noted that Staff B's records did not include a certificate for the required 3-hour in-service training, within 30 days of employment for Activities of Daily Living (ADL) training. Staff B began employment with the facility on 4/30/18 and appeared on the December 2018 schedule.

During a review of Staff D's employee training records on 12/6/18, it was noted that Staff D's records did not include a certificate for the required 1-hour in-service training, within 30 days of employment, for

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reporting incidents. Staff D began employment with the facility on 4/16/17 and appeared on the December 2018 schedule.

In an interview with the Executive Director at 2:10pm, the Executive Director stated the certificates should be in the staff members' records, but could not explain why they were not.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on records review and interview, a memory-care facility that provides care to residents with Alzheimer's Dementia Related Diseases (ADRD), failed to ensure that a staff member who provides direct care to residents, received ADRD training within 9 months of employment for 1 of 3 staff members (Staff C).

Findings included:

During a record review of Staff C's training records on 12/6/18, it was noted that Staff C's records did not include ADRD Level 1 or ADRD Level II training certificates. Staff C began employment with the facility on 12/21/17, having worked at the facility for over 11 months, and appeared on the December 2018 schedule.

In an interview with the Executive Director at 2:10pm, the Executive Director stated the certificates should be in the staff member's records, and could not explain why they were not there.

Class III

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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on records review and interview, the facility failed to ensure that personnel, subject to a Level II Background Screening, were listed with the clearinghouse on the facility's employee roster for 1 of 3 employees whose records were reviewed (Staff B).

Findings included:

During a review of Staff B's employee records on 12/6/18, it was noted that Staff B did not appear on the facility's background screening clearinghouse roster. Staff B's records revealed that Staff B's employment with the facility began on 4/30/18 and Staff B's name appeared on the staffing schedule for December 2018 on the 10:00pm to 10:00am shift. Staff B had a Level II Background Eligibility date of 6/26/17 and had signed an Attestation on 4/20/18.

In an interview with the Executive Director at 2:10pm, the Executive Director acknowledged that the facility overlooked adding Staff B to the roster.

Unclassified