STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968716	12/06/2018
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT PALM BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE **350 MALABAR RD SW** **PALM BAY, FL 32907**	

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

0000 - Initial Comments

The re-licensure survey including Limited Nursing Services was conducted on . Inspired Living at Palm Bay Assisted Living Facility, License #12617 had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, record review and interview, the facility admitted a resident who did not meet admission criteria who had an on her left heel (#13).

Findings:

Observations during a tour of the facility revealed resident #13 seated in a wheelchair with an inflatable on her left .

Review of the record for resident #13 revealed she was admitted to the facility on . Her admission health assessment (form 1823) was dated . Diagnoses included and , . Nursing requirements documents "skin prep to left heel ." There were no , documented.

An admission note dated documented the resident had a " noted to left heel, red area noted to right heel." The resident evaluation, dated , documented "left heel dark and intact."

An updated 1823 dated documented diagnoses of , , , and , . She required assistance with all Activities of Daily Living. Nursing requirements listed " care." Page 2 of the form indicated "yes" to the questions "any , 3 or 4 , ?" There were no comments documented.

On at 3:00 PM, the Health and Wellness Director (HWD) stated she evaluated the resident prior to admission and noted the black area on her heel. She brought it to the attention of the hospital staff and they retained the resident a few more days. The HWD stated she accept the resident and the blackened area on her left heel was still there, but was closed. She said "sometime later, an aide was changing her socks and the black scab off. It was pretty thick and the area underneath was now open and had some drainage." She said they bandaged the open and notified the nurse practitioner. She was examined on by the ARNP who noted the resident had "a on her left heel that has now become open, with drainage and increased bogginess." She noted the resident was being treated by home health and was referred to a care , .

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The most recent note from the home health nurse, dated , documented the to be " DTI (, ,)" with an onset date of . The did not heal within 30 days as required and is still, over 2 months later, classified as .

The Health and Wellness Director stated on at 3:30 PM that the was present on admission, but since it was covered by the black eschar, they did not know what was."

Class III

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

Based on record review and interview the facility did not obtain a complete and accurate Resident Health Assessment form (AHCA form 1823) for 1 of 5 sampled residents (#4).

Findings:

Resident record review for resident #4 revealed an updated health assessment report (AHCA form 1823) dated that did not address the resident's need regarding medications. The form did not indicate if the resident was able to self-administer medications or whether or not he needed assistance or administration of medications. The portion of the assessment was blank.

In an interview on at 3:15 PM with the Wellness Director, who offered no comment.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed did not have evidence that 1 of 1 sampled resident (#12) who received hospice services had an developed an interdisciplinary care prior to or at the time of admission to hospice service in order to determine if his physical needs could be met at the facility.

Findings:

On at 9:30 AM, the health and wellness director stated resident #12 received hospice services.
Resident record review for resident #12 revealed he began hospice services on . Continued

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review revealed no evidence to confirm that the facility obtained an hospice interdisciplinary plan that was developed and implemented by a licensed hospice in consultation with the facility prior to the hospice admission in order to specify the services being provided by hospice and those being provided by the facility to determine the physical needs of the resident could be met. There was integrated plan of cares located in the record with no dates, there were others with the month and year only that were completed after the hospice admission date.

On ... ... at 1 PM, the health and wellness director confirmed there was no evidence of a hospice interdisciplinary plan completed prior to or at the time of the hospice admission in the record.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations and interview the facility failed to ensure the unlicensed staff (B) who assisted 2 of 2 residents (#2 and #14) with self-administration of medications followed the correct procedure.

Findings:

Observation during the medication pass on at 1:10 PM noted unlicensed staff B (med tech), assisted resident #2 with self-administration of medications in the following manner: He checked and signed Medication Observation Record (MOR), retrieved the medication from medication cart, put one pill in the cup handed the cup to resident and observed the resident take the medication.

Continued observation during the medication pass at 1:15 PM noted unlicensed staff B (med tech), assisted resident #14 with self-administration of medications in the following manner checked and signed the MOR, retrieved the medication from medication cart, put one pill in the cup, crushed it, mixed it with 1 spoon of yogurt, brought cup to resident and observed her take the medication.

The staff did not in the presence of the resident, read the label, opened the container, removed a prescribed amount of medication from the container, and closed the container. The staff signed the MOR before the residents took the medication.

In an interview on ... ... at 3 PM with the Wellness Director, who offered no comment.

Class III

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0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observations, dietary record review and interview, the facility failed to maintain dietary records and did not maintain a sufficient supply of water for use in the event of an emergency as required by 58A-5.020(2) FAC.

Findings:

Observations during a tour of the facility on found daily menus posted in the common hallway. The menu for "Thursday" was posted, but not dated. The menu for lunch was to be a tossed salad with , choice of smothered steak with grilled onions or marinated pork, rice, garlic button mushrooms and a dinner roll. Dessert was sugar cookies.

Observations during lunch found the meals served followed the posted menu except for the vegetable was green beans instead of mushrooms.

On at 12:30 PM, the dietary manager provided the facility's menu. The weekly menu was not dated, did not contain portion sizes, and was not signed by a licensed dietician. It had "week 3" written in pen along the top. When asked if the manager had an original, signed and dated menu, he replied he did not.

When asked if he had a substitution log that included the vegetable substitution observed, he said, "I don't have one. I will start one soon." He confirmed he did not have a 6 month record of substitutions made to the menu.

When asked if he had 6 months of dated menus on file, the manager said, "No. I just throw them away when the week is over."

When asked if he had a menu with portion sizes indicated, he said no. He showed there was a white board outside his office with the current day's menu written on it and portion/ladle sizes indicated. The manager stated he did not know where those measurements were obtained, but they erased it and wrote a new menu every day.

When asked if he had the dietician's name and a copy of their license, the manager said the menu came from US Foods and he did not know anything about the dietician. A copy of a dietician's license and credentials was observed posted on the bulletin board in his office. When asked whose license that was, he replied, "I don't know. It was there when I came to the job. I never changed the office." The manager

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said he came to this position in of 2017.

When asked to show the surveyor the water for use in an emergency, he opened a cooler in the hallway that contained a number of collapsed water . He picked up a small post-it from the cooler and said there were 31 5 gallon containers and 12 2.5 gallon containers. In the event of an announced emergency, he said they would fill them. That would provide 185 gallons of water. The facility had 70 residents on the date of the survey, and a capacity of 78 residents. The requirement on the survey date was 210 gallons of water. When asked he they had a supply of bottled water if said they did not have any in the facility that day.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on observations, fire inspection report and interview, the facility failed to maintain a satisfactory fire inspection report issued within the last 2 years.

Findings:

Observations on at 9:15 AM, revealed the fire department staff were present in the facility.

Review of facility records revealed the last fire inspection report was dated (due).

On at 1 PM, the plant operations director said the fire inspection was completed on (day of the survey) and the inspectors did not provide a report.

Class III