STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968715	02/28/2019
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

On , , a Complaint Survey (CCR#2019001024 and CCR#2019001197) was conducted at Inspired Living at Sun City Center. At the time of the survey, the facility had deficiencies.

(License #12603)

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

Based on record review and interview, the facility failed to honor residents rights to live in a safe environment, free from and neglect. Specifically, the facility failed to follow their internal policy to ensure all residents who reside in the facility were free from resident on resident and neglect for Resident #1 who was displaying aggressive behavior toward other residents.

Findings included:

A Resident record review conducted on for Resident #1 revealed multiple incidents of Resident #1touching other residents inappropriately. The following events were documented in Resident #1's chart:
(photographic evidence contained)

-Approximately 6:30am (Resident #1) had his in the front part of another residents pants. Care-staff separated and brought (Resident #1) to the nurse. This nurse explained that touching other Residents is inappropriate. I asked if (Resident #1) could tell me what happened and (Resident #1) sighed and put his down and stated "It won't happen again." This writer did 15 minute checks for an hour and reminded staff this is a Memory Care facility that we have to do lots of reminding and lots of repeating everyday. Advanced Registered Nurse Practitioner (ARNP) was notified and She will see the resident on Thursday and said she will look over his medication and make some changes. Family was notified and is aware ARNP will see (Resident #1) on Thursday.

-1:43pm Staff noticed (Resident #1) had his placed on another resident's and she began to walk and then (Resident #1) removed his and placed it on her upper / area.

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Resident #1 was separated away from, staff got the nurse and I asked him what had happened and (Resident #1) said "I don't remember." I asked if (Resident #1) touched someone and (Resident #1) said "I Can't remember." I explained to (Resident #1) that it was witnessed that (Resident #1) touched someone and I explained to him it's inappropriate to touch anyone else. (Resident #1) said "I'm sorry, it won't happen again." Care partners were notified to keep reminding, repeating and redirecting if need be in regards to the residents as its a Memory Care community.

-7:06pm A family member notified writer about seeing (Resident #1) next to a female resident and touching her left arm. Family stated she was sitting on the sofa in the west wing common area near the dining room, when she noticed the female resident sitting in her wheelchair at a table. (Resident #1) approached her and began to touch her on her left arm. Care Partner who was in the dining room near the two residents instructed Resident #1 to not to touch the female resident. (Resident #1) was then redirected away from the female resident. Care Partners were instructed to redirect resident if were to re-approach the female resident.

-2:36pm (Resident #1) was in the main living room and activities just ended. Residents were being moved out and a Care Partner approached main living room and saw (Resident #1) touching a female's . Care Partner immediately intervened and separated the second the Care Partner saw it and explained to (Resident #1) he cannot be touching other residents. Family and ARNP notified.

On a review of the Facility's /Neglect -Florida Policy Date 2014 modified , revealed the following:
Executive Director has the overall responsibility and accountability for implementing the Resident Protection and Prohibition Policy and is assisted by: Regional Vice President of Operations and the Health and Wellness Director: Attends to resident needs during the investigation with assistance from the attending physician and resident care staff. Associates, residents and/or families who express concerns receive a follow-up report within 5 days. The Health and Wellness Director and team will assess, create care plans and monitor residents with needs and behaviors which might lead to conflict or .
(photographic evidence obtained)

During an interview conducted on at 2:26pm, the Interim Executive Director/ Regional Vice President of Operations acknowledged and confirmed that the facility did not follow their /Neglect - modified in accountability, prevention and assessment. The Interim Executive Director/Regional Vice President of Operations stated regarding the multiple inappropriate incidents with Resident #1 "I just found out about this today." "The Nurse should have notified me immediately." During an interview at 3:12pm, the Interim Executive Director/Regional Vice President of Operations stated "We didn't follow

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our own policy."

During and interview conducted on at 3:22pm, the Assistant Health and Wellness Director acknowledged and confirmed that the facility did not follow their /Neglect - modified in accountability, prevention and assessment. The Assistant Health and Wellness Director stated regarding the victims being assessed "We should have."

During an interview conducted by phone on at 3:44pm, the Regional Health and Wellness Director acknowledged and confirmed that the facility did not follow their /Neglect - modified in accountability, prevention and assessment. The Regional Health and Wellness Director stated regarding who staff should contact when incidents occur "The Regional Vice President of Operations is the interim Executive Director and so they would be the person the staff would inform of the incident."

Class III