

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/30/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

INSPIRED LIVING AT BONITA SPRINGS

**27221 BAY LANDING DR
BONITA SPRINGS, FL 34135**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revisit survey and limited nursing services (LNS) survey was conducted on at Inspired Living, an assisted living facility in Bonita Springs. This was a follow-up to the complaint survey completed on . The following is description of deficiency found at the time of the visit.	{A 000}		
AN278	58A-5.031(3) FAC; 429.07 (3)(c)2, FS LNS - Records 58A-5.031(3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to have monthly assessments for _____ done by a registered nurse (RN) for limited nursing services (LNS) for 3 (Resident #3,	AN278		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER INSPIRED LIVING AT BONITA SPRINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 27221 BAY LANDING DR BONITA SPRINGS, FL 34135			
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	Continued From page 1 #4, and #5) out of 3 resident records sampled. The findings included: Record review of LNS Residents #3, #4, and #5 revealed no monthly assessments were done by an RN for _____, 2019. During an interview with the Wellness Director on _____ at 1:50 p.m., he reported he was not aware the monthly assessments for _____, 2019 were not done. Record review of the facility contract with the outside vendor to provide LNS services revealed the RN from the home care company signed the contract on _____. During an interview on _____ at 2:10 p.m., with the Executive Director, she reported the facility has had a contract with a RN from a home care company to provide monthly assessments to LNS residents. She reported she was not aware the services were not done in _____, 2019. Class III	AN278			