STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969074	R 07/09/2018
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1061 TOMYN BLVD** **OCOEE, FL 34761**	

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

0000 - Initial Comments

A second revisit to Complaint Investigation #2018000434 was conducted on . Inspired Living Assisted Living Facility License #12906 had deficiencies at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

DEFICIENCY REMAINED UNORRECTED

Based on interviews and the call log, the facility failed to ensure the residents were treated with consideration for their needs, and did not timely answer calls for assistance for 3 of 3 samples residents who requested help through the call light system used by the facility.

Findings:

Through resident interviews on , it was revealed that they were provided a pendant to use to call when they required assistance from the facility staff. The residents said that when they pressed their pendants for assistance they did not always get assistance from staff in a timely manner. Some said they had to wait for 30 minutes before a staff would come to check on them. The residents said the staff would sometimes clear the pendant from their IPads without coming to the assist them until a later time.

The residents said on the call light system was not working at all and the administrator could not reach the company to have it repaired until the next day.

Review of the call light log form 7/1/8 through revealed there were delays in clearing the pendant at times, some examples include the following:

On call for assistance at 5:08 PM and was not cleared until 5:39 PM
On call for assistance at 6:16 PM and was not cleared until 6:39 PM
On call for assistance at 6:40 AM and was not cleared until 7:34 AM
On call for assistance at 4:31 PM and was not cleared until 5:27 PM
On call for assistance at 6:14 PM and was not cleared until 7:10 PM
On call for assistance at 1:18 PM and was not cleared until 1:48 PM
On call for assistance at 12:45 PM and was not cleared until 1:17 PM

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On call for assistance at 5:56 PM and was not cleared until 6:43 PM
On call for assistance at 8:04 PM and was not cleared until 8:46 PM
On call for assistance at 8:38 PM and was not cleared until 9:32 PM

On call for assistance at 11:03 AM and was not cleared until 12:41 PM
On call for assistance at 4:49 PM and was not cleared until 5:38 PM
On call for assistance at 5:32 AM and was not cleared until 7:00 AM
On call for assistance at 2:19 PM and was not cleared until 2:58 PM

On at 1:45 PM, the administrator confirmed there was a problem with the system on and the company could not be reach. He said the residents were told to use their telephones to call the desk for assistance.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on medication observation and interviews, the facility failed to ensure a licensed nurse provided medication administration for 1 of 1 sampled residents (#1) and allowed unlicensed staff to administer medications.

Findings:

On at 11:45 AM, Resident #14 was observed sitting in a wheelchair next to the the medication carts was waiting for her medications. She was unable to communicate and used an IPad to communicate by typing her answers. The nurse present informed Staff A that the agency staff was waiting to talk with resident #14. Staff A was observed bringing a cup with applesauce to the resident; further observations revealed there were pills inside of the applesauce. Staff A used a spoon and fed/administered the medication to resident #14 without the resident assisting. Staff A was asked at the time if she was a nurse and she stated she was not. Unlicensed staff cannot administer medications. When asked if resident #14 could take her own medications without being fed. Staff A said she could but she fed the medication to resident #14 because the agency staff was waiting to speak with the resident.

Class III

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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SUMMARY STATEMENT OF DEFICIENCIES
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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on medication observation record (MOR) reviews and interview, the facility failed to make every reasonable effort to ensure prescriptions were refilled in a timely manner for 1 of 1 sampled residents (#1) who received assistance with self-administered medications.

Findings:

On . at 10:45 AM, resident #1 said he received assistance with the self-administration of his medication and he was without one of his medications for about 10 days and another for several days in . He said he was told the health care provider was out of town and the facility could not get a refill prescription.

Review of the MOR for . revealed the following medications had staff initials with a circle on the following dates as follows:

80 milligrams (mg) give 1 every evening at 8 PM on . through . and through . and .
12.5 mg give 1 twice a day at 8 AM and 8 PM on through .
The staff noted for each of the above dates "waiting on pharmacy delivery."

On . at 1 PM staff B, a Licensed Practical Nurse (LPN) said the med tech (an unlicensed staff) was marking the medication as not given and did not inform the nurses that the medication was running out. She said they were to pull the sticker off the medication card and fax to the pharmacy to refill. Staff B said sometimes that they would receive a fax back from the pharmacy letting them know there were no refills available; the nurses would then have to call the health care provider for a new prescription. She explained the med techs would have to let the nurse know when refills are due. She said in this case, the med tech did not inform the nurses of the refills and new prescriptions were required.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

DEFICIENCY REMAINED UNCORRECTED

Based on interview, the facility did not have evidence that the comprehensive emergency management plan (CEMP) was approved by the local emergency management agency.

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Findings:

On [redacted] at 10 AM, the memory care director said the facility's CEMP was submitted on [redacted] and the facility had not received the approval letter from the emergency management agency.

Class III