Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969074	A. BUILDING: _____ B. WING _____	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

(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 A re-licensure survey, two Complaint Investigations #2026007937, #2026007989 and a generator monitoring was conducted at Inspired Living Ocoee Assisted Living Facility & Memory Care on and . The facility had deficiencies at the time of the survey visit.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on review of facility's documentation, resident record review and interview, the facility failed to [1] to provide appropriate supervision for 1 of 6 sampled residents (#2) that had aggressive behaviors and had multiple without any intervention applied and documentation; [2] the facility failed to ensure that resident #8 received , , , , after a that resulted hospitalization; and [3] the facility failed to notify the healthcare provider for resident #1 of a change in condition as required. Findings:	A 025		

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A 025	Continued From page 2 1. A review of Resident #2's record revealed an admission date of . The last 1823 Health Assessment dated listed medical history of , post- stress ( ), and ( ). He was a precaution and needed at least one person to assist with all his activities of daily living (ADLs) and is with and . He needs assistance ambulating his wheelchair, he cannot propel alone. He needs assistance with self-administration of medications. A review of the incident report and 24-hour communication log documented that Resident #2 had 8 and 2 of the resulted in injury. The resident was sent to the hospital for aggressive behaviors hitting, punching and kicking staff members when he was being assisted with activities of daily living (ADLs). In further review, the facility did not document interventions to mitigate the and the facility did not have a meeting with the family or legal representative for a care plan of the aggressive behaviors displayed for the past year (2025-2026). 1. On , Resident #2 last night, early in the morning at 1 AM; he was in and could not raise his arms. Called 911 and transported to the hospital, the daughter notified. There was no documentation if Resident #2 had his arm and any discharge instruction documentation when he returned to the facility from the hospital.	A 025		

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A 025	Continued From page 3 2. On , Resident #2 and was lying on the floor with a blanket over his body and shaking uncontrollably all over. Resident #2 could not communicate verbally. Called 911, and daughter requested that Resident #2 be taken to Veterans Administration (VA) hospital instead. The emergency medical transportation (EMT) could not transport Resident #2 to the VA hospital, so they took him to local nearest hospital. There was no documentation of Resident #2's condition or discharge instructions upon his return to the facility. 3. On , Resident #2 was getting ready for bed. Resident #2 lost his balance and on the carpet. Assessed Resident #2 and body and no injuries. He was unable to communicate to give a description of what happened. Resident #2 was assisted off the floor, cleaned up and put to bed. There was no documentation that Resident #2's family and physician was notified of this . 4. On , Resident #2 was found sitting on the floor in his bedroom. Resident #2 was unable to explain what happened. He was not taken to hospital. The physician and family notified. No complaints of , /discomfort. There was no intervention put in place for already four (4) at this point. 5. On , Resident #2 was in activities and was picking up something from the ground, stood up and took two steps backwards, stumbled and on his bottom on the floor. DHW assessed Resident #2 for range of motion. No complaints of , /discomfort. No injuries noted.	A 025		

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A 025	Continued From page 4 There was no documentation that Resident #2's family and physician was notified and still no intervention put in place for the multiple . 6. On , Resident #2 on his because he was trying to put his in his walker. Assessment done, no injuries. Notified the daughter. 7. On , Resident #2 out of his wheelchair to the floor at 1 PM, he kept trying to get up several times. Tried to catch him before he . No injuries. Resident #2 was unable to explain details. There was no documentation that Resident #2's family and physician was notified and still no intervention put in place to mitigate the multiple . 8. On at 12 PM (noon), Resident #2 was observed sitting upright on his apartment floor. Vitals and assessment completed, no visible injuries. Resident #2 did not complain of any , or discomfort. There was no documentation that Resident #2's family and physician was notified and still no intervention put in place to mitigate the multiple . A review of the service plan was initiated on (last year) and updated on but did not indicate and did not document the interventions put in place to mitigate the . On , the Director of Health Wellness (DHW) provided a service plan handwritten dated that did not document interventions that were not relevant to Resident #2's multiple	A 025		

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A 025	Continued From page 5 listed below: a) toilet resident #2 every hours; b) offers snacks and hydration drinks throughout the day; c) allow resident #2 to rest after every meal. The facility's policy and procedures dated documented should a resident experience a , staff will provide immediate care and follow through with service planning. In addition, it documented that a risk assessment and a risk analysis to be completed to identify progressive measures to help avoid future . Behaviors- 1. On , Resident #2 approached a Med Tech on punched her on the left side of the jaw. Resident #2 was yelling in Spanish. Resident #2 was redirected to his room and given space. Med Tech completed workmen's compensation paperwork and seeking medical attention. Med Tech's jaw was locked and ice applied. 2. On , Resident #2 was walking without assistance of his walker, he was redirected to use his walker, and he punched a staff member in the , causing her to and swell. The prior DHW explained to the staff member about the workmen's compensation protocol and called both daughter and the VA hospital physician but did not get a returned call. 3. On at 12:42 PM, (altercation/behavior) Unlicensed Caregiver F and Caregiver G were assisting Resident #2 out of bed, initially he was doing well however when he was being transported out of his room to the dining room for lunch, Resident #2 became combative. Resident #2 grabbed Caregiver G's arm and struck her in	A 025		

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A 025	Continued From page 6	A 025		

the with a closed fist. Resident #2 subsequently kicked Unlicensed Caregiver F in the left . Both staff members tried to redirect and distract resident #2 but was not working. Called 911, Resident #2 was combative with the first responders and refused to allow them to take his vitals. Notified ADHW of the incident. No injuries to Resident #2 and currently at the VA hospital.

A review of the behavior service plan dated (last year) and there was no documentation of an updated service plan and no documented evidence of meeting or conference with the family about the behaviors.

On at 8:30 AM, an interview with the family stated that she had hired a nurse and private sitter to work every evenings to assist with Resident #2's showers and medications. Furthermore, the family member said that the nurse and private sitter speaks Spanish that Resident #2 language familiar and native language. Resident #2 do not speak or do not understand English and she thinks this was the problem with him wanting to fight the staff members because he did not understand them speaking English and they are coming at him always trying to change him or shower him. The family member also stated that Resident #2 has and and that was the reason for putting him in Memory Care where they specialize with these medical diagnosis. The family member said that no one has ever called her to have a meeting about his behaviors.

On at 10:16 AM, an interview with Unlicensed Caregiver F confirmed that Resident #2 was wearing adult briefs and it takes at least 3 to 4 staff members to assist him

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A 025	Continued From page 7 because one staff holds each of his arms , and one staff hurry up clean him and change his adult briefs, sometimes we must change his pants if soiled. Resident #2 recently started kicking the staff member when changing his adult briefs and pants, so a fourth staff member needed to hold his ˇ down from kicking. She further said that he was always combative anytime he must be changed, dressed and showered. Unlicensed Caregiver F said that just recently 2 days ago on , Resident #2 kicked her in the left ˇ and punched Caregiver G in the . On at 10:30 AM, an interview with Unlicensed Caregiver I said that Resident #2 is always combative and aggressive with staff anytime you change, dress or shower him. He does not like this. It always take at least 3 to 4 people to assist him because he will fight and kick them. Unlicensed Caregiver I stated when she must assist him, and knows he starts his fighting behavior, she will just jump and let him calm down for a few minutes and then attempt again. On at 10:37 AM, an interview with Unlicensed Caregiver E said that she noticed that since the daughter has hired a sitter for him in the evenings, he does not fight the sitter because she is Spanish. Resident #2 only speaks Spanish. She said that maybe he do not understand why it takes all of us to change him, dress or shower him. He thinks we are ganging up on him. Resident #2 always fights when he must be changed, dressed or showered. He does not like it at all. Because he always hurts us (staff members), we try to keep him clean and help him with bathroom and you cannot do it alone. Resident #2 need 2 to 3 people to assist at minimum. It was asked if there were any staff	A 025		

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A 025	Continued From page 8 members that speak Spanish working in the Memory Care? Unlicensed Caregiver E said no. Only one staff (Unlicensed Caregiver J) but she works mostly on the ALF side that speaks Spanish. Sometimes when she works over here in Memory Care, resident #2 does not give her a hard time with changing, , or showering. She said that maybe the supervisor should let her work more on this side (Memory Care) or hire more bilingual staff to assist Spanish only speaking residents. Unlicensed Caregiver E said that she understands why resident #2 is so aggressive because of his and he cannot help it. Unlicensed Caregiver E said that she just do her job and do not complain about it. On at 11:35 AM, an interview with the DHW about the multiple and behaviors that Resident #2 have presented since admission in 2025. It was explained that Resident #2 has had behaviors since he came last year and the facility did not put any interventions in place. The DHW confirmed that she did not have a sit-down conference with the family for Resident #2 to discuss a resolution for the behaviors and . The DHW stated that she was employed at the facility in (three months ago) and had no knowledge of the extensive behaviors and multiple by Resident #2. On at 3:20 PM, an interview with the Administrator confirmed the findings. (Photographic Evidence Obtained) 2. On at 11:20 AM, Resident #8 said she wanted to get up and walk and said she was not receiving , , , like she was supposed	A 025		

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A 025	Continued From page 9 to. Review of resident #8's health assessment 1823 form, dated , revealed the resident had a history of . The form showed an order for . Reviews of the resident's record revealed there was no documentation to show the resident received . On at 9:51 AM, the findings were discussed with the Director of Health and Wellness. On at 12:03 PM, the Director of Health and Wellness explained that the provider did not receive an order from the hospital. The Director of Health and Wellness was unable to provide documentation to show the facility tried to facilitate the initiation of . 3. Review of Resident #1's record revealed a medical history of 's. During an interview on at 3:45 PM, Resident #1's family said on , the Resident after the evening meal. The family added, a caregiver said Resident #1 will be checked every 15 mins. During an interview on at 4:35 PM, Resident #1's family identified Caregiver L as the caregiver who informed them that Resident #1 would be checked every 15 mins due to after her meal. During an interview on at 4:54 PM, Caregiver L said another staff person informed her Resident #1 on , she was not present when the resident , and another	A 025		

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A 025	Continued From page 10 staff person assisted the resident that night. During an interview on at 8 AM, Unlicensed Caregiver F said, when there is a change in condition with a resident it is documented in the 24-hour book. The Unlicensed Caregiver said approximately 1 week prior to , Resident #1 after dinner time. Unlicensed Caregiver F added, Resident #1's family was present. The Unlicensed Caregiver said she assisted Resident #1 with a shower 20 mins after dinner and the Director of Health and Wellness was informed. Review of the , progress notes and 24hour documentation did not reveal information of Resident #1 , or documentation of a health care provider being notified. During an interview on at 11:35 AM, the findings were discussed with the Assistant Director of Health and Wellness. The Assistant Director of Health and Wellness said she was not aware that Resident #1 . During an interview on at 1:19 PM, the findings were discussed with the Director of Health and Wellness, who said she did not get any calls and the health care provider was not informed of the resident , either time. The Director of Health and Wellness added there was no documentation in the 24-hour report. During an interview on at 2:18 PM a Physician Assistant said she did not remember hearing anything about Resident #1 . (photographic evidence obtained) Class III	A 025		

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A 040 SS=D	429.55(2) F.S. Resident Education- (V (2) VTE CONSUMER INFORMATION.- (a) The Legislature finds that many (PEs) are preventable and that information about the prevalence of the could save lives. (b) The term " " means a condition in which part of the clot breaks off and travels to the , possibly causing (c) The term " " means , which is a clot located in a deep , usually in the or arm. The term can be used to refer to , or both. (d) Assisted living facilities must provide a consumer information pamphlet to residents upon admission. The pamphlet must contain information about including risk factors and how residents can recognize the signs and symptoms of This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to provide upon admission, the facility's pamphlet regarding education about ( ) clot consumer information provided to the resident and/or legal representatives for 2 of 2 sampled residents (#8, #13) as required, effective on . Findings: 1. A review of Resident #8's record revealed date of admission on . 2. A review of Resident #13's record revealed date of admission on .	A 040		

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A 040	Continued From page 12 There was no documented evidence provided by the facility that both residents and/or legal representatives received the / clot consumer education pamphlet at admission. On at 9:35 AM, an interview the Administrator confirmed the findings Class III	A 040		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take	A 054		

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A 054	Continued From page 13 medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to maintain Medication Observation Record (MORs) as required for 1 of 6 sampled residents (#11) that needed assistance with self-administration of medications. Findings: A record review for Resident #11 revealed date of admission . The last 1823 Health Assessment dated completed by the healthcare provider documented the resident needs assistance with self-administration of medications. In further review, there was no separate physician order on file allowing Resident #11 to do her own medications and there were no MORs provided. On at 10:47 AM, an interview with Resident #11 said that she does her own medications and did not need any help from staff. She has been doing her own medications for years. On at 11:12 AM, an interview with the Assistant Director Health Wellness (ADHW) said that Resident #11 does her own medications and there was no MORs for her when it was requested. Also, the ADHW provided a list earlier of all seven residents that do their own medications in the facility, and it was pointed out	A 054		

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(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 054	Continued From page 14 that Resident #11 was not on the list. On at 11:35 AM, an interview with the Director Health Wellness (DHW) said that she reviewed orders received by the physician for Resident #11 and could not find any orders that Resident #11 can do her own medications. The DHW provided an older 1823 Health Assessment dated that documented Resident #11 can administer her own medications. On at 1:32 PM, an interview with the DHW confirmed that she did not have a MOR for Resident #11 and will complete another assessment to see if Resident #11 can continue to do her own medications and reach out to the healthcare provider for a new order. (Photographic Evidence Obtained) Class III	A 054		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.	A 081		

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	AL11969074	A. BUILDING: _____ B. WING _____	06/02/2026

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A 081	Continued From page 15 (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by	A 081		

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A 081	Continued From page 16 the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , , . The facility must use its	A 081		

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A 081	Continued From page 17 prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 4 sampled staff (C) received 1-hour training in control, 1-hour training in recognizing and reporting resident , neglect, and , , and 1-hour training in the facility's emergency procedures.	A 081		

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A 081	Continued From page 18 Findings: Review of caregiver C's personnel record revealed a hire date of . The record contained a certificate of training, dated , that covered control, resident , and emergency procedures however, the duration of the training was not documented to show the minimum requirements were met. On at 12:08 PM, the Assistant Director of Business and People confirmed the findings. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 4 sampled staff (C) received 1-hour training in the facility's	A 090		

Agency for Health Care Administration

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A 090	Continued From page 19 order ( ) policy. Findings: Review of caregiver C's personnel record revealed a hire date of . The record contained a certificate of training, dated , that covered advanced directives however, the duration of the training was not documented to show that the minimum requirement was met. On at 12:08 PM, the Assistant Director of Business and People confirmed the findings. Class III	A 090		