

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Aspire at Saint Lucie		STREET ADDRESS, CITY, STATE, ZIP CODE 611 S 13th St Fort Pierce, FL 34950	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137</p> <p>Based on interview and record review, the facility failed to provide showers as per schedule and resident request for 1 of 6 sampled residents, Resident #2.</p> <p>Finding included:</p> <p>Review of the record revealed Resident #2 was admitted to the facility 02/19/24. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact.</p> <p>Review of the care plan dated 03/11/2025 documented The resident has an Activities of Daily Living (ADL) self-care performance deficit related to disease process, impaired balance and weakness with interventions including: Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated and Bathing/Showering: The resident requires max assist with bathing.</p> <p>Review of Resident #2's tasks revealed the shower/bed bath schedule as following: Tuesday, Thursday, and Saturday on morning shift. On a 30-day look back period, there was no shower documentation for the following dates: 02/25/25(Tuesday) and 03/01/25 (Saturday). A shower was last documented for Resident #2 by Staff B, Certified Nursing Assistant (CNA) on 03/18/25.</p> <p>During an interview on 03/17/25 at 09:52 AM, when asked if the staff honor the Resident's choices, he stated he does not receive a shower as often as he would like; I would like to receive a shower twice a week. Resident #2 stated I receive bed baths instead and don't feel clean afterwards. When asked if he had told anyone about his preferences, he stated he had but the staff hadn't done anything about it.</p> <p>During an interview on 03/19/25 at 10:30 AM, when asked when Resident #2's last shower was, Staff B stated he got a bed bath yesterday. When asked why she documented on the electronic record she provided a shower to the Resident yesterday, she stated because it was a full bed bath; I gave him a shower in bed.</p> <p>During an interview on 03/19/25 at 10:40AM, when asked if he had received a bed bath yesterday, Resident #2 stated he had not received one.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>33103</p> <p>Based on record review and interviews, the Facility failed to notify the family in a timely manner that Medicare Part A was going to be ending for 1 of 3 residents reviewed, Resident #87.</p> <p>The findings included:</p> <p>A review of a document called SNF Beneficiary Protection Notification Review that is given to the skilled nursing facility to fill out on Resident #87 revealed that Medicare Part A skilled services start date was 11/25/24. The last covered day of Part A service was 12/16/24, which was facility initiated. A SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice) of Non-Coverage and the Notice of Medicare Non-Coverage (NOMNC) was signed by the son on 12/16/24, which was the last day of covered services.</p> <p>During an interview on 03/20/25 at 10:15 AM with the Social Service Director she acknowledged that the resident or family should have been notified at least 2 days prior to the coverage ending and was unable to find any documentation that the family was notified prior to 12/16/24.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103</p> <p>Based on observations and interviews, the facility failed to provide personal privacy which includes his personal space, accommodation and personal care related to the bedroom door not closing for 3 of 3 sampled residents (Residents #242, #64, and #76).</p> <p>The findings included:</p> <p>Observations on 03/18/25 at 08:49 AM revealed that Resident #242 main door to the bedroom does not close completely because the bed is sticking out from the end of the wall into the door space. The privacy curtain is in a knot not giving the resident any privacy during personal care or any personal privacy. Resident #242 stated that the door has been this way since he was admitted on [DATE].</p> <p>On 03/18/2025 at 2:00 PM, the Surveyor showed the DON (Director of Nursing) and the Executive Director the bed sticking out from the wall preventing the main door to room from closing. The DON stated to the resident we will have to change your room and the resident stated he does not want to change rooms. The Executive Director looked at the head of the bed and stated that the bumpers are preventing the bed from getting closer to the wall.</p> <p>Observations made on 03/19/25 at 2:45 PM revealed that the door to the rooms of Residents #76 and Resident #64 could not close due to the bed-A stuck out from the wall into the path of the doorway. The Executive Director was notified of the concern at that time.</p> <p>On 03/19/25 at 8:13 AM, Resident #242 stated to the Surveyor that he was so happy last night and had a good night's sleep since they fixed the door yesterday. He said that it was so quiet, he did not have to listen to the carts going up and down the hallway, listening to the staff chatting all night, or the lights blaring in his eyes.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167</p> <p>Based on observation, interview, and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment related to the discharge and transfer of Resident #139; Limited range of motion for Resident #5; Unnecessary medication for Resident #107 and Resident #64; and medication inaccuracy related to anticoagulant use for Resident #32.</p> <p>The findings included:</p> <p>1. A review of the clinical records indicated that Resident #5 was first admitted to the facility on [DATE], and returned on [DATE], with a diagnosis of hemiplegia, which is characterized by unilateral weakness. The care plan, last revised on [DATE], noted that Resident #5 had impaired mobility due to weakness on the left side.</p> <p>A review of the quarterly comprehensive assessment dated [DATE], specifically within the section GG, pertaining to functional limitations in range of motion, indicated no impairment in the upper extremities, including the shoulder, elbow, wrist, and hand.</p> <p>Observations conducted on [DATE] at 9:54 AM; [DATE] at 7:44 AM; [DATE] at 10:42 AM and 1:13 PM; and [DATE] at 9:47 AM, revealed that Resident #5 exhibited a contracture of the left hand, with her left wrist and hand positioned in a bent posture and her fingers tightly closed.</p> <p>On [DATE], at 12:41 PM, the surveyor interviewed the rehabilitation director. She confirmed that Resident #5 had a left-hand contracture and stated that Resident #5 previously utilized splints for the contracture; the resident has since refused to wear them.</p> <p>Additionally, on [DATE], at 10:19 AM, the surveyor interviewed Staff A, the MDS coordinator. During this discussion, Staff A reviewed the clinical records and acknowledged a lack of documentation reflecting Resident #5's status of contracture.</p> <p>2. A review of the clinical record indicated that Resident #107 was admitted to the facility on [DATE] with a diagnosis of non-Alzheimer's dementia. Further examination of the documents revealed a physician's order dated [DATE], prescribing Tramadol 50 mg to be administered orally as needed for pain, with a frequency of twice per day and a minimum interval of six hours apart. Tramadol is classified as an opioid.</p> <p>Additionally, the quarterly comprehensive assessment with a reference date [DATE], listed under section N about medication, subsection H addressing opioid use, indicated no regarding the utilization of opioids.</p> <p>On [DATE], at 10:15 AM, Staff A, the MDS coordinator, was interviewed. She reviewed the clinical records for Resident #107 and acknowledged the findings presented.</p> <p>25404</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the record revealed Resident #64 was admitted to the facility on [DATE]. Review of the Quarterly MDS assessment dated [DATE] lacked any documented use of an opioid. Review of physician orders revealed as of [DATE] the resident had orders for both oxycodone and Percocet, which are opioids, for pain. Review of the corresponding Medication Administration Record (MAR) for February 2025 revealed the resident took both of these medications during the seven-day look-back period of this MDS, between [DATE] and [DATE].</p> <p>During a side-by-side record review and interview on [DATE] at approximately 11:30 AM, Staff A, MDS Coordinator, agreed with the inaccurate assessment.</p> <p>51137</p> <p>4. Review of the record revealed Resident #139 was initially admitted to the facility [DATE] and discharged [DATE]. The Resident had a primary diagnosis of acute and chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues.)</p> <p>Review of the Transfer to hospital form dated [DATE] documented the resident was sent out to a local hospital due to shortness of breath.</p> <p>Review of the last Minimum Data Set (MDS) assessment dated [DATE] titled Death in facility revealed Resident #139's discharge status as deceased .</p> <p>During an interview on [DATE] at 2:39 PM, when asked to explain what happened to Resident #139, Staff A, MDS Coordinator stated the Resident was transferred to the emergency room . When asked if the Resident died at the facility, Staff A replied no. When asked why the MDS was coded as death in facility, the Regional MDS nurse stated Resident #139 had not been admitted to the hospital, so the death counted as a facility death. When asked to provide evidence of that information, the Regional MDS nurse stated it was documented on Resident #139's medical record.</p> <p>Further review of the record did not reveal any documentation of the Resident's status after being transferred to the hospital.</p> <p>33103</p> <p>5. Review of Resident #32's medical records revealed Resident #32 was admitted to the facility on [DATE] with a readmission from hospital on [DATE]. Review of the current MDS (Minimum Data Set) assessment dated [DATE] documents under Section N that the resident is on an anticoagulant. Review of the current physicians' orders as well as discontinued physician orders, the Surveyor was unable to find any evidence that Resident #32 had ever been on an anticoagulant.</p> <p>During an interview on [DATE] at 10:35 AM with the MDS Coordinator she was asked to review the resident's medication orders and MDS section N. She acknowledged that she was unable to find any anticoagulant medication that the resident is currently on or was on. She only sees Plavix and aspirin and acknowledged the coding is incorrect.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on record review and interview, the facility failed to obtain a PASARR (Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability) Level II in a timely manner for 1 of 2 Residents reviewed for PASARRs (Resident #86).</p> <p>The findings included:</p> <p>Resident #86 was admitted to the facility on [DATE]. A review of a PASARR Level 1 dated 01/28/25 indicated a Level 2 should have been completed.</p> <p>An interview was conducted with Regional Social Services Director (SSD) on 03/19/25 at 8:40 AM. The SSD stated a Level 2 was submitted for Resident #86 on 01/28/25. The SSD further stated the Level 2 was closed on 02/04/25 due to an incomplete signature for the resident. The SSD stated the Level 2 had not been resubmitted with the missing information.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103</p> <p>Based on record review and interviews, the facility failed to ensure that baseline care plans are completed within 48 hours of admission for 3 of 38 residents reviewed (Resident #32, #117 and #103).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1) Resident #32 was admitted to the facility on [DATE] with readmission from hospital on 03/12/25. Review of a baseline care plan dated 11/05/24 (Monday) revealed this is 8 days after the resident was admitted . 2) Review of Resident # 103 medical records revealed Resident #103 was admitted on [DATE]. The surveyor or the facility was unable to locate a baseline care plan. 3) Review of Resident #117 medical records revealed Resident #117 was admitted on [DATE]. The Surveyor or the facility was unable to locate a baseline care plan. <p>During an interview on 03/20/25 at 10:10 AM with the Social Service Director, she was asked where the baseline care plans are kept. She stated the Minimum Data Set (MDS) Coordinator has them or if not, they are in a binder at the nurse's station.</p> <p>During an interview on 03/20/25 at 10:40 AM, with the MDS Coordinator she was asked where the baseline care plans are. She stated that they are in the residents' record under the task bar and if not there then they would be in the Medical Records. The surveyor then stated what the Social Service Director said, and she said, I miss understood you, I have them all in a binder here in the office. She pulled out a binder but was unable to locate Resident #103 or Resident #117. She then stated they might be in medical records.</p> <p>On 03/20/25 at 11:05 AM, Regional Nurse Consultant asked the surveyor if there was anything else she needed. Surveyor stated that she cannot find 2 baseline care plans. She stated she will look.</p> <p>The surveyor asked the Regional Nurse Coordinator on 03/20/25 at 12:25 PM if she was able to locate the baseline care plans for Resident #103 and Resident #117. She stated that she was unable to locate them, but medical records was still looking and if I don't hear back from her then they did not find any and they don't have it. Surveyor did not hear back from her.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>33103</p> <p>Based on observation, record review and interview the facility failed to offer and provide services of dental care and getting resident out of bed at his request for 1 of 1 resident reviewed for ADL's (Activities of Daily Living), Resident #32.</p> <p>The findings included:</p> <p>Observations were made on 03/17/25 at 12:26 PM with Resident #32 lying in bed. There is no wheelchair observed in his room or outside of his room.</p> <p>Observations were made on 03/18/25 at 11:15 AM Resident #32 lying in bed.</p> <p>Observations were made on 03/18/25 at 2:45 PM Resident #32 lying in bed.</p> <p>During an interview on 03/17/25 at 12:26 PM with Resident #32 he stated to the Surveyor that he has been asking to get out of bed when they get his roommate up. He stated they would state that they would get him up but then they do not. He says he has been in the facility since 10/24 and maybe has been up twice. The surveyor observed resident's teeth having food caked between his teeth and asked the resident if they ever brush his teeth for him. He stated no. He cannot brush his own teeth, and his thumbs are the only digits on the hand that function, he cannot move the other fingers, he thinks because of his diabetes.</p> <p>Review of Resident #32 medical records revealed he was admitted to the facility 10/28/24 and readmitted after a brief hospital stay on 03/12/25. He has a diagnosis to include Type II Diabetes Meletus with Polyneuropathy, COPD (Chronic Obstructive Pulmonary Disease), Atherosclerotic Heart Disease, Osteoarthritis, Weakness, and Major Depressive Disorder. A review of the quarterly MDS (Minimum Data Set) dated 02/04/25 documents he has a BIMS (Brief Interview for Mental Status) score of 13 of 15 which means his cognition is intact. A review of Section GG Functional Limitations documents that he has impairment to his upper body on both sides. Oral Hygiene is set up or clean up assistance, he is dependent on toileting, showering; putting on and taking off footwear and personal hygiene; and chair to bed to bed to chair transfers. He is Substantial/Maximal Assistants for upper and lower body dressing. His Care Plan dated 11/13/24 documents resident performance of oral hygiene is Substantial/Maximal assist with 1 staff assist.</p> <p>Review on 03/19/25 at 7:55 AM of Resident #32 Care Plan it was observed on the Care Plan that the MDS Coordinator added documentation on 03/18/25 after it was brought to their attention about resident wanting to get out of bed and to have someone brush his teeth. It documents The resident does not cooperate with care related to Personal choice. Refuses to get out of bed. Date Initiated: 03/18/2025 by the MDS Coordinator and Resident chooses not to get out of bed at times. Dated 03/18/25 by the Regional MDS Coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/18/25 at 2:58 PM with Staff G, CNA (Certified Nursing Assistant) she was asked if she got this resident up out of bed. She stated only on Fridays, Thursdays and Sundays. The surveyor asked what about the other days, she said no. She was asked if she asks him on the other days and she stated no. She was asked where his wheelchair was and she stated, we keep them in the Rehab unit since we do not have room. She was asked if she brushes the resident's teeth, and she said yes. She then said I only brush his teeth when he asks. These questions were asked in front of the resident. The resident began getting frustrated with CNAs answers and stated, I don't want you to get me up only Thursday, Friday, Sunday, I want to get up everyday. He said he disagreed that she offered to brush his teeth. He then said he acknowledged that he does not ask her.</p> <p>During an interview on 03/18/25 at 3:05 PM with Staff K, OTR (Registered Occupational Therapist) she was asked if they store resident's wheelchairs in rehab if not in use. She stated no, we do not do that, we do not have the room.</p> <p>On 03/19/25 at 11:00 AM the Surveyor went into Resident's #32 room and observed him sitting in his wheelchair. He stated he was so excited that he was sitting in his chair and out of bed. The surveyor asked if CNA came in to brush his teeth and he stated no. He was not happy.</p> <p>On 03/20/25 the Resident is sitting in W/C, he is smiling and thanked the surveyor for getting them to get him up yesterday and today. The surveyor asked him if he had his teeth brushed, he said yes it felt so good.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103</p> <p>Based on observations, record reviews and interviews, the facility failed to encourage and assist the residents to participate in Activities for 2 of 2 residents reviewed for Activities. (Resident #32 and Resident #243).</p> <p>The findings included:</p> <p>1) Observations were made on 03/17/25 at 12:17 PM, Resident #32 is in his bed playing on his phone.</p> <p>Observations on 03/18/25 at 11:15 AM, Resident is in his bed doing nothing.</p> <p>Observations on 03/18/25 at 2:45 PM resident in bed.</p> <p>Resident #32 was admitted on [DATE] with a readmitted after a brief hospital stay on 03/12/25. A review of his care plan dated 12/06/24 for Activities revealed the resident has little or no Community Life involvement related to disease process Aortic Stenosis, Type 2 diabetes, pulmonary disease, Heart failure, Reflux disease, Hydronephrosis, Anemia, Restless leg syndrome, kidney disease. Resident #32 is alert and oriented able to make his needs and wants known he is self-regulated in daily activities of his choice he likes to watch television in his room, play the Harmonica and listen to classical music, love all animals and bible study, socializing with staff and peers. Interventions included: The resident needs assistance/escort to Community Life functions; Invite/encourage the resident's family members to attend activities with resident in order to support participation; Remind the resident that the resident may leave activities at any time and is not required to stay for entire activity.</p> <p>Review of Resident #32 Admission MDS (Minimum Data Set) dated 11/04/24 Section F Preferences for Customary Routine and Activities interview with resident documents it is very Important to have books, newspapers, magazines to read; It's very Important to listen to music; very important to be around animals; It's very important to get fresh air when weather is good; and very important to participate in religious services.</p> <p>Review of the task sheet for Activities for Resident #32 documented only 2 days of the last 30 days 03/18/25 and 03/19/25 for activities. On 03/18/25 at 4:21 PM documented Resident refused and on 03/19/25 at 3:37 PM documented religious services.</p> <p>During an interview on 03/17/25 at 12:17 PM, with Resident #32, he was asked if he goes to activities.</p> <p>He stated they do not get him up to go to activities. He was asked if they brought him activities to do in his room, he stated they do not bring him anything to do. He stated he would love to have a chaplain come talk to him.</p> <p>2) Observations on 03/17/25 at 12:10 PM Resident #243 is in his room having lunch.</p> <p>Observations on 03/18/25 at 8:20 AM, Resident #243 in his room having breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 03/18/25 at 2:35 PM, Resident #243 is in his room lying in bed.</p> <p>Observations on 03/19/25 at 3:00 PM Resident #243 is in his room in bed watching TV.</p> <p>Observations on 03/20/25 at 2:40 PM, Resident #243 is in his room lying in bed napping.</p> <p>Resident #243 was admitted on [DATE]. A review of Resident #243 care plan documents it was created on 03/18/25. The resident has little or no Community Life involvement related to disease process Acute Myocardial Infraction, Heart failure, Kidney failure, Hypotension, Anemia, Muscle weakness, Dysphagia Oropharyngeal phase, atrial flutter. Resident liked being social and loved animals, he enjoys listening to Rock & Roll and country music, watching the news and religious services. Resident loves to eat cupcakes. His goal is to walk again and get his left side back in motion, family and friend visits monthly. Interventions include Encourage the resident's participation by implementing activities the resident enjoys doing. A review of Resident #243 Admission MDS document that he has a BIMS of 12/15 which means his cognition is moderately impaired. Section F Preferences for Customary Routine and Activities interview with resident documented it is very important to have snacks between meals; very important to have family or close friend involved in discussion of care; very important to listen to music; very important to be around animals; very important to keep up with news; very important to do things with groups of people; very important to go outside for fresh air; very important to participate in religious services; somewhat important to have books, newspapers and magazines to read.</p> <p>Review of the task sheet for activities documented 03/13/25, 03/18/25 and 03/19/25 watching TV and 03/15/25 Napping.</p> <p>During an interview on 03/18/25 at 08:20 AM with Resident #243 he was asked if he goes to activities. He said he wanted to go to activities. He said he asked to go to church, and they did not get him up to go. Has not been out of bed for activities, and they do not bring him anything to do.</p> <p>During an interview on 03/20/25 at 9:20 AM with the Community Life Director. She was asked if she has documentation about when residents come to activities or when they bring activities to resident rooms. She stated yes, I record when they come and if they refuse, I document that. The surveyor gave her Resident #32 and Resident #243's names. She stated that Resident #32 refuses to come. She was asked if she brings items to his room and did not respond. Asked if she was aware that he wants to go to church and that he had a masters in bible study. She said they have a lot of different churches that come to do service, and was aware he had a masters in bible study. She said she inputs everything in PCC but does not know how to pull them up. The surveyor went to the Regional Nurse consultant, and she pulled them up under tasks. On 03/20/25 at 9:49 AM the Regional Nurse Consultant printed activity logs for Resident #32 and Resident #243, and it shows for the last 30 days 1 day that he came to religious service yesterday on 03/19/25 at 3:37 PM.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/20/25 at 2:30 PM residents are gathered in the activities room getting ready to play Bingo. Resident #32 is sitting in his chair playing on his phone, but Resident #243 is not in activities. During an interview on 03/20/25 at 2:35 PM the Surveyor asked the Community Life Director and Activities assistant if she asked Resident #243 if he wanted to go to Bingo, the Community Life Director did not respond, and the Activities Assistant stated no. She said she went into his room this morning, but he was sleeping. The Surveyor asked, have you asked him if he wants to go outside or to church, No. Asked if they looked at the preference sheet in MDS she stated the director probably does.</p> <p>The surveyor went to Resident #243 room on 03/20/25 at 2:40 PM, he is lying in bed. The surveyor asked him if he wanted to go to Bingo because they are having it in the activities room. He said yes, if someone would get me up. Surveyor advised his CNA that he wants to go to Bingo right now. She was hesitant in responding to get him up.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103</p> <p>Based on observations, record reviews and interviews, the facility failed to follow physician's orders related to blood pressure medication, for Resident #103, thyroid medication for Resident #242, spasm medication for Resident #66 and lab orders for stool sample for C-Diff for Resident #83.</p> <p>The findings included:</p> <p>1) Resident #103 was admitted to the facility on [DATE] with a diagnosis to include Essential Hypertension. Review of the current Physician's Orders revealed Metoprolol Tartrate Oral Tablet 25 MG to give 25 mg by mouth two times a day for hypertension, hold for systolic blood pressure less than 110 or pulse less than 60. Midodrine HCl Oral Tablet 5 MG to give 5 mg by mouth three times a day for hypotension hold for systolic blood pressure above 120.</p> <p>A review of the MAR (Medication Administration Record) for March 2025 revealed that the blood pressure (B/P) parameters were not followed.</p> <p>Metoprolol 25 MG for hypertension hold for SBP (systolic blood pressure) less than 110 or pulse less than 60, start 03/07/25.</p> <p>On 03/01/25 the 0900 dose documented B/P 120/79, had a code of 11 which means hold per parameters. The medication was not given but was not outside the parameters and should have been given. For the 1700 hour (5:00 PM) dose the B/P was 122/88 and had a code of 11, which means it was not given but should have been given.</p> <p>On 03/06/25 0900 documented a B/P 119/72 and had a code of 11 that the medication was not given and should have been given.</p> <p>On 03/12/25 0900 documented the B/P 112/98 with a code of 11 that the medication was not given and should have been given.</p> <p>On 03/16/25 0900 the B/P 100/75 check mark showed medication given when it should have been held.</p> <p>Midodrine 5 MG for hypotension hold for SBP (systolic blood pressure) above 120, start date 03/07/25. Previous order was to hold for SBP above 110, with an end date of 03/06/25.</p> <p>On 03/02/25 0900 documents the B/P 128/67 had a check mark indicating it was given but it should have been held.</p> <p>On 03/03/25 1700 (5:00 PM) documents the B/P 128/78 has a check mark indicating it was given but it should have been held.</p> <p>On 03/04/25 1700 (5:00 PM) documents the B/P 128/78 has a check mark indicating it was given but it should have been held.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/04/25 0900 documents the B/P 118/87 has a check mark indicating it was given but it should have been held.</p> <p>On 03/04/25 1700 (5:00 PM) documents the B/P 113/76 has a check mark indicating it was given but it should have been held.</p> <p>On 03/07/25 1700 (5:00 PM) documents the B/P 123/93 has a check mark indicating it was given but it should have been held.</p> <p>On 03/14/25 0900 documents the B/P 126/84 has a check mark indicating it was given but it should have been held.</p> <p>On 03/14/25 1300 (1:00 PM) documents the B/P 144/76 had a check mark indicating it was given but it should have been held.</p> <p>On 03/15/25 0900 documents the B/P 135/78 had a check mark indicating it was given but it should have been held.</p> <p>On 03/15/25 1300 (1:00 PM) documents the B/P 135/78 had a check mark indicating it was given but it should have been held.</p> <p>On 03/15/25 1700 (5:00 PM) documents the B/P 135/78 had a check mark indicating it was given but it should have been held.</p> <p>During an interview on 03/20/25 at 7:08 AM with the Director of Nursing (DON), she was asked to pull up this resident's orders and MAR. She stated that in February we noticed there was an issue with the nurses giving medications when there were parameters to hold and not documenting the parameters. It was 02/26/25 and 02/27/25 when the nurses were in-serviced on this. She reviewed the MAR for Resident #103 and acknowledged there is a concern that this is still happening after being in-serviced.</p> <p>2. Review of Resident #242 medical records revealed that Resident #242 was admitted to the facility on [DATE] with a diagnosis to include Adrenocortical Insufficiency. A review of the Physician's Order documented Levothyroxine Sodium 112 mcg Tablet 2 Tablets (224 mcg) by mouth in the morning for Hypothyroid, start date 03/05/25. Review of the March MAR (Medication Administration Record) revealed a check mark next to the medication that it was being given.</p> <p>During an interview on 03/18/25 at 08:15 AM with Resident #242, he stated that the nurse came in at 5:00 AM, woke him up to take his Thyroid medication which is supposed to be taken prior to a meal. He stated that she put the pill cup on his bed table and left. He said he did not take it because he is supposed to get two pills, and they only have been giving him one pill. (Photographic evidence obtained).</p> <p>On 03/18/25 at 1:25 PM, two Surveyors interviewed Staff I, LPN (Licensed Practical Nurse). The surveyor requested to see the medication blister pack for Levothyroxine medication. Staff I, LPN, gave a blister packet to the surveyors. There were 29 pills in the packet with 1 pill missing. Staff I stated that the other blister pack had been completed and was all gone and had been shredded. She acknowledged that the evening nurse Staff H, RN was working with her this morning and had brought the resident's pills out from his room and threw them away. They were not taken by the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 03/18/25 at 7:45 PM with Staff H, RN she was asked about Resident #242's thyroid medication. She stated she went into the resident's room around 5:30 AM, woke him up and said good morning I have your medication. She said she watched the patient put it in his mouth but then she stated he said he needed 2 pills. She told him he only takes one. When she went back into the resident's room a couple hours later, (she was helping the floor nurse that was on duty), the resident handed her the pills. She kept saying to the surveyor I only gave him 1 pill, that is all he takes. I looked at the computer with the other nurse and she said the same thing. The surveyor had a difficult time understanding her and requested another phone call in the morning with a Spanish speaking nurse from AHCA.</p> <p>During a telephone interview on 03/19/25 at 9:46 AM with Staff H, RN and another AHCA Surveyor Nurse who speaks Spanish, she spoke with Staff H, RN. She stated to the AHCA Surveyor that at</p> <p>5:00 AM, the resident was scheduled 2 levothyroxine and 1 Dulcolax; I prepped the meds for the resident and in the process I dropped the pitcher of water and I went out to get more water for him and as I got back he had an empty medication cup; so I assume he had taken all his meds ; later when it was brought to my attention the meds were still in the medication cup there was only 1 levothyroxine and the 1 Dulcolax; I should of verified he had indeed taken the meds while I was in the room with him; I don't know what happened with the second levothyroxine so I did not give him the second one I gave him a new dose of the same two pills left in the medication cup (1 levothyroxine and 1 Dulcolax) and I discarded the old medications found.</p> <p>On 03/19/25 at 10:50 AM the Surveyor went into Resident #242's room and asked him to reiterate what happened yesterday with the pills left on the table. He stated that normally the nurse comes around 5:00 AM and will wake me up but in this case, she tapped me and stated here are the pills and put them on the table and left. I saw 1 thyroid pill and a Dulcolax which I don't take since my bowels are moving fine though I did accept one yesterday. The surveyor asked if water was ever spilled, he said no.</p> <p>On 03/19/25 at 10:54 AM the Surveyor asked the nurse on the cart Staff J, LPN to show the Surveyor the levothyroxine blister pack. She pulled out one that had the resident's name on it. There were 10 pills still in the blister pack. It was filled 03/05/25 and documents 30 of 60 pills. Refill 03/30/25. The surveyor asked if there was another blister pack, and she pulled out a second blister pack that had 1 pill gone of 30 pills. This was the blister pack that was shown to Surveyors yesterday. The MAR shows the resident received 14 days of Levothyroxine (03/06/25-03/19/25) which then shows that of the 14 days there should be 28 pills gone in the blister pack that included the 1 from the second blister pack. Instead, there are 21 pills that were left out of the blister pack. There are 10 pills that were not given. (Photographic evidence obtained).</p> <p>52179</p> <p>3) Review of the facility policy Administering Medication, included Medications are to be administered within one hour of the prescribed time unless otherwise specified (for example, before or after meal orders).</p> <p>Review of the record revealed Resident #66 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the current orders revealed Resident #66 was receiving methocarbamol oral tablets for muscle spasms three times per day at 8-hour intervals at 6 AM, 2 PM and 10 PM. This medication is administered at intervals to allow for consistent muscle relaxation.</p> <p>During a medication administration observation on 3/19/2025 at 4:06 PM, Staff C, RN was observed dispensing and administering the medication to Resident #66. The scheduled administration time was 2 PM.</p> <p>Retrospective review of the Medication Administration Audit Report from 3/09/2025 to 3/20/2025 revealed that the medication was not administered during the correct time frame or abide by scheduled time interval of 8 hours on 7 of 34 occasions as follows:</p> <p>On 03/10/25 the 2 PM dose of methocarbamol was signed off as administered at 7:09 PM. The dose due at 10 PM on 03/10/25 was administered at 9:02 PM.</p> <p>On 03/11/25 the 2 PM dose of methocarbamol was signed off as administered at 5:10 PM. The dose due at 10 PM on 03/11/25 was administered at 10:50 PM.</p> <p>On 03/12/25 the 2 PM dose of methocarbamol was signed off as administered at 5:42 PM. The dose due at 10 PM on 03/12/25 was administered at 9:09 PM.</p> <p>On 03/13/25 the 2 PM dose of methocarbamol was signed off as administered at 4:29 PM. The dose due at 10 PM on 03/13/25 was administered at 9:49 PM.</p> <p>On 03/15/25 the 2 PM dose of methocarbamol was signed off as administered at 7:03 PM. The dose due at 10 PM on 03/15/25 was administered at 11:24 PM.</p> <p>On 03/17/25 the 2 PM dose of methocarbamol was signed off as administered at 6:21 PM. The dose due at 10 PM on 03/17/25 was administered at 9:12 PM.</p> <p>On 03/19/25 the 2 PM dose of methocarbamol was signed off as administered at 4:06 PM. The dose due at 10 PM on 03/19/25 was administered at 9:20 PM.</p> <p>On 03/20/25 at approximately 10 AM, the Regional Nurse Consultant was made aware of the above concerns.</p> <p>36734</p> <p>4. Record review revealed Resident #83 was admitted to the facility on [DATE]. An interview was conducted with Resident #83 on 03/17/25 at 10:00 AM. The resident stated she had diarrhea for a while now, and she was tested for C-Diff (Clostridioides Difficile), a highly contagious bacterium that causes diarrhea and colitis (swelling of the colon). Resident #83 stated she had not heard of any results.</p> <p>A review of the resident's physician orders revealed an order dated 03/12/25 for a stool sample for C-Diff. Further record review did not reveal a stool sample for C-Diff was collected or sent as ordered for Resident #83.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON) on 03/20/25 at 2:00 PM. The DON confirmed the above.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on record review and interview, the facility failed to ensure a physician ordered urology appointment in a timely manner for 1 of 1 sampled resident, Resident #60, who had a suprapubic (located in the lower abdomen) urinary catheter.</p> <p>The findings included:</p> <p>Review of the record revealed Resident #60 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had an indwelling urinary catheter. Review of the current physician's orders revealed Resident #60 had a suprapubic urinary catheter. Further review of these orders documented a urinary consult appointment was ordered on 03/04/25. Review of the record lacked any evidence of an upcoming or completed appointment.</p> <p>Observations on 03/17/25 at 9:57 AM, 03/17/25 at 2:23 PM, and on 03/18/25 at 9:05 AM revealed very cloudy urine in the drainage tube of the urinary catheter for Resident #60.</p> <p>During an interview on 03/20/25 at 11:20 AM, when asked the process for obtaining consults, Staff M, Registered Nurse (RN), explained that usually Staff L, Medical Transportation Coordinator/Central Supply, took care of making the appointments. The RN stated that sometimes they would also make appointments. During the interview, Staff M stated she was unaware of any urology appointment for Resident #60. The Director of Nursing (DON) was nearby and phoned Staff L, who told the DON she had not yet made the appointment for Resident #60.</p> <p>During an interview on 03/20/25 at 11:28 AM, when asked if she had made or attempted to make an appointment for Resident #60, Staff L, Medical Transportation Coordinator/Central Supply person stated she had not. When asked the process for making appointments, Staff L stated the orders come to her from either the nurse practitioner or nurse, with the resident's face sheet and reason for the appointment. Staff L stated she had not received the reason for Resident #60's appointment, had not reached out to staff to obtain a reason for the appointment, and had not attempted to make the appointment.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on record review and interview, the facility failed to maintain a nutritional status for a resident receiving dialysis therapy related to ordered nutritional supplement for 1 of 1 resident reviewed for Dialysis (Resident #25).</p> <p>The findings included:</p> <p>Resident #25 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and was dependent for activities of daily living. The assessment further documented the resident received dialysis treatment.</p> <p>A review of Resident #25's care plan revealed a care plan dated 02/22/23 for a nutritional risk for disease management of End Stage Renal Disease on hemodialysis and history of significant weight change. Interventions included to provide and serve supplements as ordered (dated 01/26/25) and Registered Dietician (RD) to evaluate and make diet change recommendations as needed (dated 02/22/23).</p> <p>A review of Resident #25's orders revealed an order dated 01/16/25 for Nepro (nutritional supplement) 8 fluid ounces daily at bedtime for increased protein needs.</p> <p>A review of a dietary progress note dated 03/11/25 documented Resident #25 was consuming Nepro daily, providing an additional 420 calories and 19 grams of protein. The dietary progress note further documented the resident was at risk for malnutrition and was underweight for age, and a need to encourage additional calories in the resident's diet by inquiring about the resident's favorite food.</p> <p>A review of Resident #25's Medication Administration Record (MAR) for 03/25 revealed documentation of the resident consuming 100-237 milliliters of Nepro daily, with 1 refusal.</p> <p>An interview was conducted with Resident #25 on 03/20/25 at 9:30 AM. The resident stated he does not consume the ordered Nepro at night because it upsets his stomach. The resident stated sometimes he does not like the food provided by the facility. The resident further stated no one had inquired about his food preferences.</p> <p>An interview was conducted with the Registered Dietician (RD) on 03/20/25 at 11:00 AM. The RD stated she was not aware Resident #25 was not consuming the ordered nutritional supplements. The RD further stated she had not followed up with the resident's food preferences.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, interview, and record review, the facility failed to ensure care and service for oxygen therapy for 3 of 5 sampled residents, as evidenced by the failure to properly store the nebulizer mask for Resident #37, failure to ensure physician order for oxygen use for Resident #192, and failure to follow physician orders for the amount of oxygen used for Resident #117.</p> <p>The findings included:</p> <p>1) Review of the record revealed Resident #37 was admitted to the facility 12/10/22 with an active diagnosis of respiratory disorder. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, on a 0 to 15 scale, indicating moderate cognitive impairment. This MDS also revealed the resident was dependent upon staff for mobility. Review of the current orders revealed the resident had received a medication four times daily via nebulizer (device to administer medication by spraying a fine mist) since 01/22/25.</p> <p>An observation on 03/17/25 at 8:57 AM revealed the nebulizer machine on the arm rest of the resident's recliner, with the mask lying partially on top of the machine and partially on top of personal items that were on the recliner. The mask was not stored in any type of protective covering. The date on the mask was 03/15/25. Photographic evidence obtained.</p> <p>During a subsequent observation on 03/19/25 at 8:08 AM the same nebulizer mask dated 03/15/25 was now stored in a clear plastic bag.</p> <p>During an interview on 03/20/25 at 12:09 PM, when asked how a nebulizer mask should be stored between uses, Staff M, Registered Nurse (RN), stated it should be stored in a bag. When asked what she should do if she found a nebulizer mask out of the bag, the RN stated she should get a new nebulizer set (a new mask and tubing).</p> <p>During an interview on 03/20/25 at 12:10 PM, when asked who was responsible for ensuring changing of oxygen equipment and proper storage, the Director of Nursing (DON) stated the night shift nurses are responsible for the routine changing of oxygen equipment on a weekly basis, but that all nurses were responsible for proper storage. The DON stated they also have a respiratory therapist in the building every Tuesday and Thursday who helps out and will sometimes do the weekly oxygen equipment changing. The DON stated she saw a bag in Resident #37's room on Tuesday (03/18/25) that was dated 03/08/25, and since the respiratory therapist was in the building, she asked her to change it out. The DON agreed the respiratory therapist should have changed out the entire nebulizer set.</p> <p>2) Review of the record revealed Resident #192 was admitted to the facility on [DATE]. Review of progress notes and oxygen saturation levels indicated the resident had used oxygen since 03/11/25. Review of the orders revealed the order for oxygen use was entered on 03/19/25, after the surveyors had entered on 03/17/25.</p> <p>An observation on 03/17/25 at 12:37 PM revealed Resident #192 in bed with oxygen being used. The tubing was dated 03/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 at 12:21 PM, when asked if a resident utilizing oxygen should have a physician's order for such, the DON stated the expectation is that oxygen is used as per the physician's order.</p> <p>33103</p> <p>3) Review of Resident #117's medical records revealed that Resident #117 was admitted to the facility on [DATE] with diagnoses to include COPD (Chronic Obstructive Pulmonary Disease), Dementia, Visual Loss, Hypertension, Type II Diabetes, and Cardiomyopathy.</p> <p>A review of the physician orders reveal that the resident is on continous Oxygen 2 lpm (liters per minute) start date of 01/10/25. A review of the resident's progress notes revealed the nurse is documenting that the resident is on 3 lpm.</p> <p>Review of the Resident's care plan dated 08/22/24 documents the resident has Emphysema/COPD with interventions that included to monitor for difficulty breathing (Dyspnea) on exertion, and Oxygen setting via NC (nasal cannula) 3 lpm continuously (initiated 09/24/24).</p> <p>Observations were made of the resident on the following days:</p> <p>03/17/25 at 12:58 PM Resident on oxygen, O2 concentrator on 4.5 LPM. Order documents 2 LPM.</p> <p>03/18/25 at 7:55 AM Resident out of bed sleeping with his head on bed table, has O2 on at 4.5 LPM.</p> <p>03/19/25 at 8:20 AM Resident is observed out of bed having breakfast, he has his O2 at 4.5 LPM. The surveyor asked him if he ever touches his machine and moves the dial on the machine. He stated, no I do not touch it.</p> <p>03/19/25 at 2:40 PM went to resident's room and the oxygen was at 2 lpm.</p> <p>During an interview on 03/19/25 at 11:12 AM with Staff E, RN (Registered Nurse) she was asked if she has any resident who are on oxygen. She said yes, only Mr.----) and pointed at his room. Asked what her process is when someone is on oxygen. She says she checks the resident oxygen sats in morning, checks concentrator. The surveyor asked what the physician order is for O2, she said 2 lpm. The surveyor asked to tell her what the O2 concentrator is set at. She said 5 lpm. She didn't seem alarmed. When the surveyor asked is that what it is supposed to be at, she says well he moves it. The surveyor stated there is nothing in the care plan that documents that.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167</p> <p>Based on observation, interview, and record review, the facility failed to ensure pain medication was administered as ordered for one of three residents reviewed, Resident #109.</p> <p>The findings included:</p> <p>A clinical record review indicated Resident #109 was admitted to the facility on [DATE] with a diagnosis that included depression. The quarterly comprehensive assessment conducted on 12/17/24 included a brief interview with a mental status score of 11, suggesting that the resident was moderately cognitively impaired.</p> <p>Further review of the comprehensive care plan, revised on 01/05/25, revealed that Resident #109 was diagnosed with an arterial stasis ulcer on the left lower leg. The care plan included interventions such as administering prescribed medications for pain management.</p> <p>On 02/28/25, the physician ordered 50 mg tramadol to be administered as two tablets orally every eight hours as needed for moderate to severe pain, rated between 5 and 10.</p> <p>On 03/17/25, at 8:59 AM, Resident #109 expressed concerns regarding the pain medication (tramadol) prescribed as needed. He reported that there was an instance where a nurse declined to provide him with the medication, causing delays, and mentioned receiving only one tablet instead of the prescribed two. He revealed his pain level as an eight daily and noted that it could escalate to a ten when seated in a wheelchair. His left leg was observed to be wrapped in kerlix, and his left foot appeared swollen. The resident conveyed that his pain management was inadequate.</p> <p>Additionally, a review of the medication monitoring control record on 03/20/25, at 8:45 AM indicated that on 03/19/25, at 2 PM, Resident #109 had received only one tablet of tramadol 50 mg instead of the prescribed two tablets.</p> <p>On 03/20/25, at 9:22 AM, the regional nurse consultant was interviewed and confirmed the findings after reviewing the medication monitoring control record.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on record review and interview, the facility failed to ensure dialysis communication forms were completed, and Hemodialysis Dietitian Recommendations were carried out in a timely manner for 1 of 1 resident reviewed for hemodialysis (Resident #25).</p> <p>The findings included:</p> <p>Resident #25 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and was dependent for activities of daily living. The assessment further documented the resident received dialysis treatment.</p> <p>A review of Resident #25's care plan revealed a care plan for the resident needs dialysis related to renal failure, with dialysis days Mondays, Wednesdays, and Fridays.</p> <p>A review of Resident #25's orders revealed an order dated 11/06/24 to complete dialysis communication form in (Narcotic book), hand it to the dialysis nurse. Collect it from the dialysis nurses, complete vital signs and put completed form in Narcotic binder for filing every Monday, Wednesday, and Friday.</p> <p>An order dated 01/26/25 was for in-house dialysis Monday, Wednesday and Friday at 10:00 AM.</p> <p>Furthermore, there was an order for Cinacalcet Hcl 60 milligrams one time a day every Monday, Wednesday and Friday for renal with dialysis dated 01/01/25, and TUMS (Calcium Carbonate) 500 milligrams 3 times a day for high phosphate dated 02/01/25.</p> <p>An interview was conducted with Staff Z, a Registered Nurse, on 03/20/25 at 12:00 PM. Staff Z stated dialysis communication forms were not kept in the narcotic book, but a dialysis communication binder stored at the nursing station.</p> <p>A review of Resident #25's dialysis communication forms revealed missing forms for on 03/03/25, 03/07/25, 03/10/25, 03/17/25, and 03/19/25.</p> <p>Furthermore, a Renal Dietitian Recommendation Form dated 02/10/25 documented to discontinue Tums and hold Cinacalcet due to lab values on 02/05/25.</p> <p>A review of Resident #25's Medication Administration Record (MAR) revealed Tums was discontinued 02/25/25 (15 days after the renal dietitian recommendation), and the Cinacalcet was never held.</p> <p>An interview was conducted with the Registered Dietitian (RD) on 03/20/25 at 11:00 AM. The RD acknowledged the above.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on interview and record review, the facility failed to ensure a resident with PTSD (Post-Traumatic Stress Disorder) was assessed, and the care plan was individualized for 1 of 1 resident reviewed for PTSD (Resident #91).</p> <p>The findings included:</p> <p>Resident #91 was admitted to the facility on [DATE] with diagnoses that included PTSD. Record review revealed comprehensive assessment dated [DATE] that documented the resident was cognitively intact and was independent for activities of daily living.</p> <p>A review of Resident #91's care plan revealed a care plan dated 03/18/24 for behaviors related to Post Traumatic Stress Disorder and Obsessive Compulsive Disorder. Further review of the care plan did not reveal any specific trauma, behaviors, or triggers for behaviors.</p> <p>An interview was conducted with Resident #91 on 03/17/25 at 11:00 AM. The resident confirmed a diagnosis of PTSD, and stated it was the result of an abusive childhood and things that happened as an adult. Resident #91 stated crowds of people trigger him, and If anything pops off, I'm going to finish it.</p> <p>An interview was conducted with the Social Service Director (SSD) on 03/20/25 at 8:15 AM. The SSD acknowledged Resident #91's care plan was generic and not tailored to the resident's personal experience and reactions/triggers to situations.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on observation, interview, and record review, the facility failed to ensure there was sufficient staff to upload physician progress notes in a timely manner for 1 of 1 resident reviewed for diarrhea (Resident #83), and failed to ensure a urology consult was obtained in a timely manner for 1 of 1 sampled resident (Resident #60).</p> <p>The findings included:</p> <p>1. Resident #83 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact, and dependent for activities of daily living.</p> <p>Record review revealed no physician progress notes for 2025.</p> <p>An interview was conducted with medical records on 03/20/25 at 3:50 PM. Medical records stated physician notes were sent by the month for residents to be uploaded into resident's electronic medical records(EMR). Medical records stated it takes approximately 3 days to upload the physician notes into all the resident's EMR. Medical records acknowledged she had not uploaded any physician progress notes this year. Medical records further stated the facility's census had increased, and she had been busy helping with credentialing staff related to a high staff turnover.</p> <p>A simultaneous interview was conducted with the director of Nursing (DON). The DON stated they may need to train someone to assist with uploading physician progress notes into resident's EMR, as the medical records stated she could use some help.</p> <p>An observation of the medical records office revealed a large stack of physician progress notes to be uploaded in resident's EMR.</p> <p>25404</p> <p>2. Review of the record revealed Resident #60 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had an indwelling urinary catheter. Review of the current physician's orders revealed Resident #60 had a suprapubic urinary catheter. Further review of these orders documented a urinary consult appointment was ordered on 03/04/25. Review of the record lacked any evidence of an upcoming or completed appointment.</p> <p>Observations on 03/17/25 at 9:57 AM, 03/17/25 at 2:23 PM, and on 03/18/25 at 9:05 AM revealed very cloudy urine in the drainage tube of the urinary catheter for Resident #60.</p> <p>During an interview on 03/20/25 at 11:20 AM, when asked the process for obtaining consults, Staff K, Registered Nurse (RN), explained that usually Staff L, Medical Transportation Coordinator/Central Supply, took care of making the appointments. The RN stated that sometimes they would also make appointments. During the interview, Staff K stated she was unaware of any urology appointment for Resident #60. The Director of Nursing (DON) was nearby and phoned Staff L, who told the DON she had not yet made the appointment for Resident #60.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 at 11:28 AM, when asked if she had made or attempted to make an appointment for Resident #60, Staff L, Medical Transportation Coordinator/Central Supply person stated she had not. When asked the process for making appointments, Staff L stated the orders come to her from either the nurse practitioner or nurse, with the resident's face sheet and reason for the appointment. Staff L stated she had not received the reason for Resident #60's appointment. Staff L provided a list of physician ordered consults, that had been printed out on 03/12/24, which contained the order for Resident #60. When asked what she does when she doesn't have the face sheet or reason for the appointment, Staff L stated she would reach out to the nurse but hadn't had time to do so for this resident. Staff L volunteered that she was not only the person that made appointments, but also had to take residents to their appointments, and take care of Central Supply. Staff L stated she just hadn't had time to make all the appointments.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>39167</p> <p>Based on interview and record review, the facility failed to ensure narcotic removal was documented in the medication administration records (MARs) for 3 of 9 residents reviewed during the medication storage review process. This involved Residents #39, # 69 and #71.</p> <p>The findings included:</p> <p>On 03/20/25 at 12:27 PM the medication storage and labeling review process started. The medication binder on cart 1 was selected for review. During the review process, it was revealed that Resident # 39 had a physician order of Tramadol 50 mg 1 tablet by mouth every 12 hours as needed for pain. The medication control record was compared against the March 2025 MARs. There were discrepancies between the records. The medication control record revealed that the Tramadol was removed on 03/11/25 at 9:52 PM and 11 PM, however the MARs lack documentation for the removal at 9:52 PM. It was also documented the Tramadol was removed on 03/12/25 at 11 AM, 9:17 PM, and 11:28 PM. The MARs lacked documentation for the removal at 11 AM and 11:28 PM.</p> <p>Clinical record review evidenced Resident #69 had order of Tramadol 50 mg 1 tablet by mouth every 6 hours as needed for pain. The medication control record was compared against the March 2025 MARs. There were discrepancies between the records. The medication control record revealed that the Tramadol was removed on 03/17/25 at 4:56 AM, 12:40 PM, and 7:40 PM, however the MARs lacked documentation evidence for the removal at 12:40 PM, and 7:40 PM.</p> <p>An additional record review revealed Resident #71 had physician order of Lorazepam 0.5 mg 1 tablet by mouth as needed for anxiety. The medication control record was compared against the March 2025 MARs. There were discrepancies between the records. The medication control record revealed that the Lorazepam was removed on 03/17/25 at 10:18 AM and 6:50 PM. However, the MARs lacked documented evidence for the removal at 6:50 PM. It was also documented on 03/18/25 that the Lorazepam was removed at 5:13 PM and 6:30 PM, however the MARs lacked documented evidence of the removal at 6:30 PM.</p> <p>On 03/20/25 at 2:14 PM an Interview was conducted with the DON, she was made aware of the identified concerns related to discrepancies in the March 2025 MARs for narcotic removal for Resident's #39, #69, and #71.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103</p> <p>Based on Record review and interview the facility failed to ensure adequate monitoring of side effects and behaviors for psychotropic medications for 1 of 5 residents reviewed for unnecessary medications, Resident #103.</p> <p>Resident #103 was admitted to the facility on [DATE] with diagnoses to include Generalized Anxiety, Major Depressive Disorder, Bipolar Disorder, Schizoaffective Disorder and Diabetes Mellitus. Review of the Physician Orders revealed that the resident is currently taking Venlafaxine HCl ER Oral Tablet Extended Release 24 Hour Give 150 mg by mouth one time a day for Depression and Give 37.5 mg by mouth one time a day for Depression, Quetiapine Fumarate Oral Tablet 200 MG Give 200 mg by mouth at bedtime for schizophrenia, Divalproex Sodium Oral Tablet Delayed Release 500 MG Give 500 mg by mouth two times a day for bipolar disorder and Divalproex Sodium Oral Tablet Delayed Release 250 MG Give 250 mg by mouth one time a day for bipolar disorder.</p> <p>During an interview on 03/20/25 at 12:07 PM with Staff D, LPN (Licensed Practical Nurse) she was asked how they monitor a resident who has behaviors. She stated she doesn't know this well but knows he has a history of depression, schizoaffective disorder and that he is on an antidepressant and an antipsychotic. When she pulled him up on the computer, she was unable to find any behavioral monitoring and did not know what or how she would document it. She stated that he is very quiet and has never seen him have any behaviors.</p> <p>During an interview on 03/20/25 at 12:25 PM with the Regional Nurse Consultant she was asked about behavioral monitoring, how it is documented and who they do it on. She was asked to pull this resident up on the computer and acknowledged that he should have behavioral monitoring documented. She reviewed Discontinued orders and stated he had behavioral monitoring prior to last discharge. He was sent to hospital from 02/02/25-02/08/25 and 02/21/25 and 02/25/25. He was never put back on behavioral monitoring when he came back on 02/25/25.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>25404</p> <p>Based on observation, interview and record review, the medication error rate was 14.81 percent. Four medication errors were identified while observing a total of 27 opportunities, affecting 1 of 7 residents observed (Resident #193).</p> <p>The findings included:</p> <p>A medication pass observation was made for Resident #193 on 03/19/25 beginning at 8:39 AM with Staff J, Licensed Practical Nurse (LPN). The LPN obtained medications from the medication cart to include artificial tears eye drops, two docusate sodium (a stool softener) 100 mg (milligram) gel tablets, and one hydralazine (lowers blood pressure) 25 mg tablet. Upon entering the room, the LPN administered one eye drop in each of the resident's eyes. The LPN then gave Resident #193 the 6 pills, including the two docusate sodium and the one hydralazine. The LPN stated the resident's blood pressure was 156/93.</p> <p>Review of the corresponding Medication Administration Record (MAR) for March 2025, which included the current physician orders, revealed Resident #193 was to receive two eye drops in each eye, only one tablet of the docusate sodium, and the hydralazine only if the systolic (top number of the blood pressure) was greater than 160. Further review of this MAR revealed the resident was to receive two Senna 8.6 mg tablets at this time, as the docusate sodium was ordered as needed.</p> <p>During a side-by-side review of the record and interview on 03/19/25 at 2:47 PM, Staff J, LPN, stated the resident had asked for the stool softener, but agreed she gave two tablets instead of the ordered one tablet. When asked how many drops of the artificial tears she administered into the resident's eyes, the LPN stated she placed one drop in both eyes. The LPN reviewed the order and agreed the order was for two drops. When asked about blood pressure parameters for the hydralazine, the LPN stated there were none. Upon hovering over the order in the electronic record, the parameters popped up in a box on the computer screen, and the LPN agreed she should not have administered the medication. When asked about the Senna 8.6 mg tablets ordered for that morning, that still were not documented as provided, the LPN stated she did not have any Senna on her medication cart. The LPN stated she was going to go to central supply to get some but had not gotten around to it.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 1 of 5 residents during the medication pass observation (Resident #193,) and for 1 of 1 random sampled resident whose medications were observed at his bedside (Resident #242)</p> <p>The findings included:</p> <p>1) A medication pass observation was made for Resident #193 on 03/19/25 beginning at 8:39 AM with Staff J, Licensed Practical Nurse (LPN). The LPN obtained a box of artificial tears and placed it on top of the medication cart. The LPN then decided to go into the resident's room to obtain his blood pressure. The LPN left the eye drops on top of the cart, unattended. A random resident was observed at that time, leaving her room, and self-propelling down the hallway in front of the medication cart.</p> <p>During an interview on 03/19/25 at 2:47 PM, the LPN agreed she had left the eye drops on top of the medication cart earlier that morning, and agreed with the concern related to unsecured medications.</p> <p>33103</p> <p>2) Review of Resident #242 medical records revealed that Resident #242 was admitted to the facility on [DATE] with a diagnosis to include Adrenocortical Insufficiency. A review of the Physician's Order documented Levothyroxine Sodium 112 MCG Tablet 2 Tablets (224MCG) by mouth in the morning for Hypothyroid start date 03/05/25 and Docusate Sodium Capsule 100</p> <p>MG to give 1 capsule by mouth two times a day for Constipation Start Date-03/07/2025.</p> <p>During an observation and an interview on 03/18/25 at 08:15 AM with Resident #242, he stated that the nurse came in at 5:00 AM, woke him up to take his Thyroid medication which is supposed to be taken prior to a meal. He stated that she put the pill cup on his bed table and left, the pill cup had 1 Docusate and 1 Levothyroxine pill. He said he did not take it because he is supposed to get two Levothyroxine pills, and they only have been giving him one pill. The surveyor observed the pill cup with 1 Levothyroxine and 1 Docusate Sodium Capsule sitting in a pill cup on the bed tray next to bed. Photographic evidence obtained.</p>		

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NAME OF PROVIDER OR SUPPLIER Aspire at Saint Lucie		STREET ADDRESS, CITY, STATE, ZIP CODE 611 S 13th St Fort Pierce, FL 34950	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on record review and interview, the facility failed to have a complete resident record for 5 of 28 sampled residents (Residents #83, #64, #37, #60, and #79).</p> <p>The findings included:</p> <p>1. Resident #83 was admitted to the facility on [DATE]. Record review revealed the last documented physician progress note was in November 2024.</p> <p>An interview was conducted with medical records person in the presence of the Director of Nursing (DON) on 03/20/25 at 3:50 PM. Medical records stated physician notes were sent by the month for residents to be uploaded into resident's electronic medical records(EMR). Medical records stated it takes approximately 3 days to upload the physician notes into all the resident's EMR. Medical records acknowledged she had not uploaded any physician progress notes this year.</p> <p>Resident #83's medical records was incomplete.</p> <p>25404</p> <p>2. Review of the records during the survey from 03/17/25 through 03/20/25 for Residents #37, #60, #64, and #79 all lacked any recent documented physician visits. The records for Resident #37 and #60 lacked any documented physician visits. The most current physician visit progress note in the record of Resident #64 was from 08/14/24. The most current physician visit progress note in the record of Resident #79 was dated 09/17/24.</p> <p>The medical records person was asked to locate and provide any documented physician visit progress notes for the four above residents. The following documented physician visits were found somewhere in the medical records office, but had not been scanned into the resident's record as per their verbalized process:</p> <p>a) September 2024, October 2024, November 2024, and January 2025 physician visits were found for Resident #37 but not part of the current medical record.</p> <p>b) December 2024 and January 2025 physician visits were found for Resident #60 but not part of the current medical record.</p> <p>c) December 2024 and January 2025 physician visits were found for Resident #64 but not part of the current medical record.</p> <p>d) September 2024 and October 2024 physician visits were found for Resident #79 but not part of the current medical record.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 in the afternoon, the Medical Records person first explained that the physician sends his notes to the facility monthly and she was able to scan them into the records within the next month. Upon receipt of physician visit progress notes from September 2024 through January 2025, the Medical Records person agreed she had not scanned the notes into the resident records and the medical records were not current. The Director of Nursing (DON) was present during this interview and stated the physician for these four residents was in the building at least weekly and sees all of the residents on a monthly basis. The DON agreed the clinical records were not being kept current.</p> <p>3. Review of the record revealed Resident #60 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident received nutrition and fluids via a feeding tube. An observation on 03/17/25 at 2:13 PM revealed the resident was receiving 125 ml of water every 2 hours, as per the tube feeding pump settings.</p> <p>Review of the physician order dated 03/17/25 revealed a dietitian consult for increased water flushes related to abnormal laboratory values. The resident's blood urea nitrogen (BUN) level was elevated, an indication of kidney function, which could also indicate a need for more fluids. Review of the record lacked any dietary note regarding the needed consult or provision of the consult.</p> <p>During an interview on 03/20/25 at 2:22 PM, when asked about the ordered dietitian consult dated 03/17/25, the Registered Dietitian (RD) stated she spoke with the nurse practitioner, and they decided not to increase the fluids anymore because of the resident's sodium level. When asked if she had documented the consult anywhere, the RD stated she had not.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734</p> <p>Based on record review, interview, and observation, the facility failed to implement transmission based precautions related to suspected C-DIFF (a contagious intestinal infection) for 1 of 1 resident reviewed for diarrhea (Resident #83); Failed to follow infection control standards during medication administration observation for 3 of 6 sampled residents (Residents #193, #10, and #65); and failed to maintain laundry in a manner to prevent spread of infection.</p> <p>The findings included:</p> <p>1. Resident #83 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact, and dependent for activities of daily living.</p> <p>Resident #83 was care planned for antibiotic therapy related to empiric treatment on 03/14/25.</p> <p>Record review revealed a change in condition progress note dated 03/12/25 that documented Resident #83 had diarrhea. The physician was notified and orders received for blood work, a stool culture, and to increase fluids.</p> <p>A review of Resident #83's orders revealed orders dated 03/14/25 for Flagyl (antibiotic) 500 milligrams 3 times a day for empiric treatment for 7 days, and Azithromycin (antibiotic) 250 milligrams give 2 tablets in the evening for empiric treatment for 1 day and give 1 tablet in the evenings for empiric treatment for 4 days.</p> <p>An interview was conducted with Staff Y, a Registered Nurse, on 03/20/25 at 1:00 PM. Staff Y stated the Nurse Practitioner (NP) had seen Resident #83 and had told her it might be C-Diff (an contagious infection of the intestines). Staff Y further stated Resident #83's room mate also had diarrhea.</p> <p>Resident #83 was not on contact or special isolation to prevent the spread of suspected infection.</p> <p>25404</p> <p>2. A medication pass observation was made for Resident #193 on 03/19/25 beginning at 8:39 AM with Staff J, Licensed Practical Nurse (LPN). The LPN gathered the resident's medications to include a vial of artificial tears that was stored in a box. The LPN took the box of eye drops into the resident's room, failed to use any type of tray or barrier, and placed the eye drop box directly on the resident's chair. After administration of the eye drops, the LPN returned the box of eye drops to the medication cart.</p> <p>During an interview on 03/19/25 at 2:47 PM, Staff J, LPN agreed she took the box of eye drops into the room and that she should not have done so as the inside of her medication cart was considered clean, and the box was now potentially contaminated.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. A medication pass observation was made for Resident #10 on 03/19/25 beginning at 9:31 AM, with Staff M, Registered Nurse (RN). The RN gathered the ordered Timolol eye drops, that were stored in a plastic bag, and took the eye drops in the bag into the resident's room. The RN placed the plastic bag directly on the resident's over-the-bed table, without any type of tray or barrier.</p> <p>Staff M returned to the medication cart and placed the now contaminated plastic bag into the clean medication cart.</p> <p>During an interview on 03/19/25 at 5:15 PM, when asked about the eye drop box or bag taken into a resident room, Staff M, RN, stated she had not thought about taking the eye drop box or bag into a resident room as a problem.</p> <p>4. Review of the policy Transdermal Medications - Applications revised on 08/22/17 documented staff should wear gloves during the administration of any transdermal patch.</p> <p>A medication pass observation was made for Resident #65 on 03/19/25 at 9:37 AM with Staff M, RN. The RN obtained medications from the medication cart and popped the pills from the pharmacy bubble pack card into a medication cup. When the RN popped an Amiodarone tablet from the pharmacy card, the pill went directly into her hand. The RN simply turned her hand and placed the pill into the cup with four other pills. The RN also obtained a Lidocaine patch from the medication cart for Resident #65.</p> <p>The RN went into the room and administered the pills to Resident #65. She then administered the patch to Resident #65 without donning gloves.</p> <p>During an interview on 03/19/25 at 5:15 PM, when asked if it was appropriate to pop a pill into her hand to then put it into the medication cup for a resident, Staff M, RN stated no and did not disagree with the observation. When asked if gloves are worn during the administration of a patch, the RN stated sometimes she wears them and other times she does not.</p> <p>52127</p> <p>5. Review of Policy # 026, effective date 03/16/18 with a version date of 02/01/25 revealed in part that employees should put on appropriate Personal Protective Equipment (tear-resistant reusable gloves, gown/apron, and or face shield/goggles) prior to collecting, transporting, or sorting linens. Further review of the policy revealed that all soiled linen must be covered during transportation.</p> <p>Review of Management of the Laundry Policy dated 01/2016 on page 28 lists the steps in the laundry process including that the collection of soiled laundry should be checked at regular intervals to keep the soiled linen from over-flowing, which may cause odor and infection control problems.</p> <p>On 03/19/25 at 3:20 PM, laundry staff were observed pushing two large bins with bare hands in the hallway with linens flowing over the sides of the bins with the lids resting on top of the linens as the bins were too full to allow the lid to close.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an Interview with the District Manager of Housekeeping and Laundry on 03/19/25 at 3:25 PM, she was asked about the use of Personal Protective Equipment (PPE) during laundry services to which she replied that gloves and gowns are used when transferring/sorting dirty laundry. When asked if staff use gloves when pushing the bin of dirty linens/clothing inside the building she replied, no, because the lid is on, and the bin is covered. When the District Manager was asked what about the bins that were lined up outside of the laundry room that were overflowing with laundry, and the lid was not able to be closed and she responded, Yes, then the staff would wear gloves.</p> <p>During a tour of the laundry area on 03/19/25 at 3:30 PM, accompanied by the District Manager of Housekeeping and Laundry revealed a dried substance on the inside surface of the middle dryer while linens were in the dryer, the hand washing sink and eyewash station in the soiled room of the laundry area was stained and a rusty/corroded pipe was located directly next to it, the area behind the three washing machines had debris including plastic, wood, and metal pieces on and around the water pipes and washing machines.</p> <p>Photographic evidence obtained of all findings during the tour of the Laundry.</p>		