STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, record review, and interview, the facility failed to ensure one resident (#81) out of three residents reviewed for resident rights had their choices honored. Findings included: An observation on 08/06/24 at 10:26 a.m. revealed Resident #81 was in his room laying in bed with a hospital gown on. During an interview on 08/06/24 at 10:26 a.m., Resident #81 stated, no one was assisting him out of bed when he asked to get up. Resident #81 stated he asked for assistance to get out of bed daily, but no one would assist him. Resident #81 stated staff seemed too busy and I'm getting tired of being put off with no help. Resident #81 stated he even requested to talk with the Director of Nursing (DON) and had not had that request honored . An observation on 08/06/24 at 1:37 p.m., Resident # 81 remained in his bed with the same hospital gown. During an interview on 08/06/24 at 3:37 p.m., Resident # 81 stated he informed his nurse earlier that he would like assistance getting out of bed and into his wheelchair today. Resident # 81 stated the nurse informed him that she would be back, and no one had come back so he continued to lay in bed. An observation on 08/06/24 at 3:37 p.m., revealed Resident #81 remained in bed. Review of the Admission Record showed Resident #81 was admitted to the facility on [DATE] with diagnoses that included but not limited to Venous insufficiency (chronic) (peripheral), Unspecified atrial fibrillation, Chronic obstructive pulmonary disease, weakness, unsteady on feet and muscle weakness (generalized). Review of the quarterly Minimum Data Set (MDS) dated [DATE], Section C-Cognitive Patterns showed Resident #81 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care plan showed Resident #81 had a Focus- [Resident #81] is at risk for decreased ability to perform ADLS in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting related to chronic disease process, COPD, Lymphedema, recent hospitalization . Goal- Will maintain highest capable level of ADL ability throughout the next review period as evidenced by his/her ability to perform ADL'S. Interventions: -1/4 side rails for bed mobility -Assist of 2 or more with bed mobility. -Assist of 2 with transfers. - Enablers for positioning and bed mobility -Monitor laboratory test results and report abnormal results to MD/ARNP - Observe for decline in ADL function. Refer to rehab therapy if decline in ADL'S is noted. - Provide cueing for safety and sequencing to maximize current level of function - PT/OT/SP treatment as ordered by MD/ARNP An observation on 08/07/24 at 10:28 a.m., revealed Resident # 81 was in bed. An observation on 08/07/24 at 2:03 p.m., revealed Resident # 81 remained in bed. During an interview on 08/07/24 at 2:18 p.m., Staff D, Unit Manager (UM), Licensed Practical Nurse (LPN) stated she talked with Resident #81 yesterday about getting up out of bed. Staff D stated she went to the therapy department and made sure he was able to get up. Staff D stated therapy informed her Resident #81 was able to get out of bed with a Hoyer lift. Staff D stated the plan was to get him out of bed today. She said Resident #81 was waiting for his wounds to heal before getting up out of bed and he only wanted out of bed an hour at a time, so it would need to be coordinated. Review of the Weekly Non-Pressure Wound Evaluation dated 07/23/24 showed the venous wound on Resident #81's right lower extremities (RLE) was healed. An addition review of a second Weekly Non-Pressure Wound Evaluation dated 07/23/24 showed the venous wound on Resident #81's left lower extremities (LLE) was healed. Review of the Order Summary Report revealed no current wound treatment. During an interview on 08/07/24 at 2:24 p.m., Resident #81 stated that he was not assisted out of bed yet today however the nurse came back into his room a few minutes ago and said staff were going to assist him out of bed today. During an interview on 08/07/24 at 2:44 p.m., Staff E, Regional Director of Operations (RDO) stated I got the back story. Resident # 81 had not been getting out bed lately because the big guy with non-normal human strength [the Physical Therapy Assistant (PTA)] could assist Resident # 81 out of bed by himself but had been out for surgery. The RDO stated the nursing staff was having trouble coordinating the Hoyer lift to get Resident #81 out of bed for the 20 to 30 minutes that he tolerated, so Resident #81 had not been getting out of bed lately. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Task tab titled Transfers on 08/07/24 at 3:13 p.m., revealed Resident #81 had only been assisted out of bed on 07/31/24 with a two persons physical assist with no Resident refusals during the 14-day look back period from 07/25/24 to 08/07/24. An observation on 08/08/24 at 10:40 a.m., revealed a Resident Rights sign posted on the hallway near the Director of Nursing (DON) Office. The sign posted stated Quality of Life .(b) Self-determination and participation The resident has the right to . (1) choose activities, schedules and healthcare consistent with his or her interests, assessments or plan of care; (3) Make choices about aspects of his or her life in the facility that are significant to the resident. Photographic evidence obtained.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48223 Based on interview and record review, the facility failed to honor a resident's decision to formulate an advance directive and did not ensure a current copy of the Advance Directive was in the resident's medical record for one resident (#55) of five sampled residents. During an interview on 8/6/2024 at 4:55 p.m., Resident #55 stated, I have spoken to several nurses when I returned from the hospital as I want to be a Full Code and change my Health Care Surrogate (HCS). I know this conversation occurred prior to 7/2/2024. I met with the Director of Social Services (DSS), discussed the [HCS] and request of being a full code. The DSS came back and told me everything was taken care of. Resident #55 continued to state never receiving the requested copies from the DSS and kept checking with the nurses regarding the changes and wanting to be a Full Code. Resident #55 stated, On [7/2/2024] the physician stated I was capable of making my own decisions. Still, I was not changed to a Full Code. I've seen the DSS at the nurses' cart, while the cart was at my door. Although, the DSS would state she didn't have time right now. Review of a progress note from the Resident's Advanced Practice Registered Nurse (APRN), 6/30/2024 at 21:18 revealed CODE STATUS: Full Code. Review of the Order Summary dated 8/7/2024 reveals Resident #55 was a DNR. Review of Resident #55's plan of care revealed resident was a DNR. An interview was conducted with Staff O, Licensed Practical Nurse (LPN) on 8/7/2024 at 1:40 p.m. Staff O stated caring on a regular basis for Resident #55. Staff O confirmed Resident #55 had been asking to be a Full Code since return from the hospital earlier this summer. I told the DSS on a couple occasions that Resident #55 wanted to be Full Code. I don't know why it has taken so long to complete. An interview was conducted with the Director Social Service (DSS) on 8/7/2024 at 2:04 p.m. The DSS stated Resident #55 requested to see her regarding wanting to be a DNR, this was completed. The DSS continued to state the resident did request to change her HCS and this was completed. The DSS stated not having any knowledge Resident #55 wanted to change her code status. An interview was conducted with the Director of Nursing (DON) on 8/7/2024 at 2:15 p.m. The DON said the process for a code change for a resident who was alert and oriented should be followed. The nurse would contact the physician and receive the order change and ensure all documents were in order. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Advanced Directives with a revision date of 11/14/2018, revealed: Policy: The center will abide by state and federal laws regarding Advanced Directives. The center will honor all properly executed advanced directives that have been provided by the resident and/or representative. Process: . 2. Social Service Director and/or Business Development Coordinator/designee will assist the resident/resident representative to complete the Advanced Directives Discussion Document. If an advanced directive exists, the Social Services and/or Business Development Coordinator/designee will obtain a copy and place it in the resident's medical record. 5. Advanced directives will be reviewed: *quarterly *Hospice Admission . Request for a Do Not Resuscitated Policy and Procedure was requested and not provided by the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on observation, interview, and record review, the facility failed to ensure a clean and home like environment in two (#311 and #405 B) of sixty-one rooms observed. Findings included: 1. A review of the facility's work order #7384 for room [ROOM NUMBER], created on 7/27/24 at 12:42 p.m. showed ac leaking. A review of the facility's work order #7374 for room [ROOM NUMBER] B, created on 7/25/24 at 1:29 p.m., showed air conditioner running water on the floor. On 8/6/24 at 10:08 a.m., wet linen was observed piled under the Packaged Terminal Air Conditioner (PTAC) in room [ROOM NUMBER]. The resident in the room said the PTAC had been leaking for about a month. The room was muggy with a musty odor. (Photographic Evidence Obtained.) On 8/7/24 at 9:45 a.m., the same observation was made in room [ROOM NUMBER] (Photographic Evidence Obtained). On 8/8/24 at 9:52 a.m., the same observation was made in room [ROOM NUMBER] (Photographic Evidence Obtained).) 2. On 8/6/24 at 10:46 a.m., a blanket with a yellow ring and appeared dry was observed under the PTAC unit in room [ROOM NUMBER] (Photographic Evidence Obtained). On 8/7/24 at 2:34 p.m., the same observation was made in room [ROOM NUMBER] B. (Photographic Evidence Obtained). On 8/8/24 at 10:54 a.m., the same observation was made in room [ROOM NUMBER] B. On 8/7/24 at 9:54 a.m., during an interview Staff K, Certified Nursing Assistant (CNA) said maintenance related issues were reported through the facility's electronic building maintenance system. On 8/8/24 at 9:50 a.m., an interview and observation of room [ROOM NUMBER] was conducted with the Nursing Home Administrator (NHA). The NHA said he was not aware of the issue, and he would get the maintenance staff to address the issue. The NHA said all the facility's staff know how to report issues in the facility's electronic building maintenance system. He said maintenance needed to remove the unit and clean the drain. The NHA said the issue would be addressed today. On 8/8/24 at 10:26 a.m., during an interview, Staff L, Licensed Practical Nurse (LPN) said maintenance issues were reported in the facility's electronic building maintenance system. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/24 at 4:46 p.m., during an observation and interview in room [ROOM NUMBER] B, the NHA immediately called the maintenance director. The NHA said the maintenance director would address the issue. The NHA removed wet linen from under the PTAC and piled the linen in front of the unit. On 8/8/24 at 5:59 p.m., the NHA said staff should be checking resident rooms daily. A review of the facility's policy and procedure, subject Maintenance, effective date 11/30/2014 showed: Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify/areas items in need of repair. Procedure: all items needed maintenance assistance will be reported to maintenance using the maintenance repair request form. Environmental services personnel will check for completed forms throughout the day. The requests will be prioritized and completed according to need.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview, the facility failed to ensure the accuracy of the Preadmission Screening and Resident Review's (PASRRs) and obtain a Level II screening when appropriate for three (#44, #11, and #46) of six residents sampled for PASRR's. Findings included: 1. A review of Resident #44's Admission Record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed the resident had the following diagnoses prior to the readmission: - Paranoid schizophrenia, onset 4/1/22. - Psychotic disorder with delusions due to known physiological condition, onset 4/1/22. - Recurrent moderate Major Depressive Disorder, onset 10/1/22. - Mild Dementia in other diseases classified elsewhere with other behavioral disturbance, onset 10/1/22. - Unspecified hallucinations, onset 4/2/21. - Other sexual dysfunction not due to a substance or known physiological condition, onset 10/27/23. - Other schizoaffective disorders, onset 5/11/21. - Delusional disorders, onset 6/10/20. The diagnosis of Cognitive Communication Deficit (CCD) was added to Resident #44's diagnosis information on 7/14/24. An interview was attempted with Resident #44 on 8/6/24 at 3:21 p.m., the resident way lying in bed and when spoken to, the resident turned her head away from this writer and asked the kids if the hillbillies were cute. The room contained both roommates of the resident, (both of whom were lying in bed), the resident, and this writer, there were no kids or hillbillies in the room. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #44's PASRR Level I Screen, dated 7/26/24, which was completed at the facility and submitted by the Director of Nursing (DON), showed the resident had mental illnesses the (MI) or suspected MI's of anxiety disorder, depressive disorder, psychotic disorder, schizoaffective disorder, schizophrenia, delusional disorder, other sexual dysfunction not due to a substance or known physiological condition, and hallucinations. The PASRR revealed the resident did not have any disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage, no interpersonal functioning limitation, no issue with concentration, persistence, and/or pace, and no issue with adaptation to change. The screening revealed the resident had a secondary diagnosis of dementia with a primary diagnosis of a serious MI or ID. The PASRR revealed Resident #44 had no diagnosis or suspicion of a Serious Mental Illness or Intellectual Disability and a Level II PASRR was not required. Review of a recent Psychiatry Note, dated 7/30/24, for Resident #44 revealed the reason for encounter was Today, I saw the patient as it was reported to me that patient is unstable requiring psychiatric assessment. The note revealed prior to the last visit the resident was doing well, and patient was unstable and hallucinating when Seroquel was decreased. The physician noted As per collected information, patient has hallucinations and delusions chronically. She sees people who are not on the room. She cries and screams due to hallucinations. The assessment revealed the resident had Impaired insight and judgement, recall/short-term memory, remote memory, attention span/concentration, language, and fund of knowledge. 2. During an observation on 08/06/2024 at 10:20 a.m., Resident #11 was observed lying in bed dressed in a hospital gown, sleeping. During an observation on 08/07/2024 at 11:45 a.m., Resident #11 was observed sitting up in her bed with staff setting up her lunch tray. She was observed with her bedside table within reach and eating lunch. A review of Resident #11's Admission Record showed she was admitted to the facility on [DATE] with diagnoses of senile degeneration of brain, unspecified dementia, other persistent mood disorder, insomnia, and paranoid schizophrenia. A review of the Level I PASRR, dated 07/24/2024, showed in Section I-Part A MI (Mental Illness) or suspected MI had anxiety disorder, depressive disorder, and schizophrenia were all marked. Part B. ID (Intellectual disability) or suspected ID was blank. Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 5 were marked no. Question 6, Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an Serious Mental Illness or intellectual Disability, was marked no. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no. Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation on 08/06/2024 at 9:50 a.m., Resident #46 was observed dressed for the day sitting in a wheelchair in the common room of the 100 hall. During an observation on 08/07/2024 at 10:10 a.m., Resident #46 was observed dressed for the day sitting in a wheelchair in the common room of the 100 hall. Review of Resident #46's Admission Record showed Resident #46 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, psychotic disorder with delusions due to known physiological condition, and major depressive disorder. Review of the Level I PASRR, dated 07/24/2024, showed in Section I-Part A MI (Mental Illness) or suspected MI (Mental Illness) Depressive Disorder, and other with Dementia, Insomnia and mood disorder typed in were marked. Part B. ID (Intellectual disability) or suspected ID (Intellectual disability) was blank. Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 5 were marked no. Question 6, Does the individual have a secondary diagnosis of dementia, related neurocognitive disorder (including Alzheimer's disease) and the primary diagnosis is an Serious Mental Illness or intellectual Disability, was marked no. Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked no. Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked. During an interview on 08/08/2024 at 12:45 p.m., the Social Services Director, reviewed the PASRR level 1 for Resident #11, #44 and #46, and stated question 6 of section II was marked incorrectly and should have been marked yes for having a secondary diagnosis of dementia for Resident #11 and #46 and question 7 for Resident #44 of section II was marked incorrectly and should have been marked yes. She reviewed the [company name] submission website and confirmed that a level 2 PASRR had not been submitted for Resident #11, #44 and #46. She stated she did not typically do the level 1 PASRR's, the DON (Director of Nursing) was the one who completed them. She [SSD] reviewed the PASRR's that came in from the hospital and was responsible for gathering the information for residents who needed a level 2 completed. She stated she was taught to look at the resident's psych notes to confirm the resident's diagnosis. Review of the facility's Preadmission Screening and Resident Review (PASRR) Policy, dated 11/08/2021, states The center will assure that all Serious Mental Ill (SMI) and Intellectually Disabled (ID) residents receive appropriate pre-admission screenings according to Federal/State guidelines. The purpose is to ensure that the residents with SMI or are ID receive the care and services they need in the most appropriate setting. Procedure, 4. If it is learned after admission that a PASRR Level II screening is indicated, it will be the responsibility of Social Services to coordinate and or inform the appropriate agency to conduct the screening and obtain the results. 50434

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 48223 Based on interview and record review, the facility failed to develop and implement an effective discharge plan for one (#449) of three residents reviewed. During an interview on 8/8/2024 at 12:16 p.m. with Resident #449, she stated her discharge was not arranged. She said she was admitted to the facility from the hospital after a motor vehicle accident. She stated the physician stated the benefit would come from therapy. She stated, Everything was going well, then the insurance company thought I should be discharged . I had to appeal. Each time I had to be the one to follow up on if the appeal was granted etc. The Social Service Director (SSD) hardly assisted at all. The [SSD] asked when I was admitted , if I would be going home, with who and if I would need home health care at home. On 3/13/2024 the facility told me I would be discharging [the next day]. No other information was provided to me. I arranged to borrow a walker from a friend and the facility permitted me to borrow a wheelchair. At discharge the facility told me to go to the emergency room for the wound on my leg. The wound orders had changed right before discharge. I repeatedly called the facility and left messages with the [SSD] and the Nursing Home Administrator (NHA), their names were given to me at discharge. No one responded to my calls until 3/21/2024. I was already back in the hospital, the [SSD] emailed with my daughter. A review of the Social Service Note dated 3/4/2024 at 12:36 p.m., signed by the SSD revealed Resident #449 was given a Notice of Medicare Non-Coverage (NOMNC) for last covered day for 03/06/2024. The resident did not agree with her discharge at that time. The resident made an appeal. The resident's discharge plan was home with spouse. A review of the Social Service Note dated 3/11/2024 at 15:46 p.m., signed by the SSD revealed resident's discharge plan was to return home with her spouse when able to go upstairs to enter the home. Review of the Discharge Summary dated 3/14/2024 at 12:28 p.m. completed by nursing revealed: Reviewed discharge instructions page by page with Resident. Resident voiced understanding. Instructions to follow up with wound care and her follow up ortho appointment at the end of this month. Resident does not have a Primary Care Physician (PCP) in the community here in FL but Resident states family will pursue. Discharge instructions placed in folder with current med list. Resident is discharging with facility wheelchair and will return wheelchair to facility once hers has been delivered by insurance. Resident shared how thankful for stay here, how great therapy was and how wonderful nursing has been. Resident seems to have great friends and family support in the community. A review of the Social Service Note dated 3/21/2024 at 13:20 p.m. signed by the SSD revealed, This writer followed up with resident regarding Durable Medical Equipment (DME) and Home Health Care (HHC) after discharge. This writer followed up with [name of DME company]. This writer will contact [name of HHC company] to follow up regarding HHC. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/2024 at 2:06 p.m., the SSD stated remembering Resident #449 had several appeals due to the insurance company wanting to stop payment. The SSD stated the resident requested to be discharged . The SSD did not know when this conversation occurred. The SSD stated not having any documentation on additional documentation regarding discharge or when setting up the HHC. The SSD wanted additional time to find the information. No information was brought back to the surveyor by the end of the survey. Review of the facility's policy and procedures titled Interdisciplinary Discharge Planning dated 11/30/2014 revealed that Policy: discharge planning begins on the day of admission. The process involves the resident and family, care management/social services, and those members of the clinical team involved in the residence care. Procedures: 1. We discharge goal and estimated length of stay will be established upon admission and reviewed/revised at the residence 1st and subsequent team conference(s). 2. Discharge plans are adjusted, as appropriate, at subsequent team conferences. a. Care Management/Social Services monitors progress towards discharge goals. b. Care Management/Social Services responsible for coordinating necessary outside services 1) Outside services will be contacted for services 2) Home visits scheduled and completed 3. Residents discharged to home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs by the Care Manager/designee. The Care Manager/designee will complete a Discharge Summary for each resident . 4. Prior to discharge home, the resident and their family will receive Resident's Discharge Summary & Guide. The Care Manager/Social Worker will complete the form with input from each discipline. When completed, this form provides a comprehensive picture of the resident's current status and recommendations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on observation, interview, and record review, the facility failed to ensure three (#147, #47 and #68) of four residents reviewed had dressings changed appropriately and per physician orders. The facility failed to ensure one (#37) of one resident had a splint applied and documented as ordered. Findings included: 1. During an interview on 08/06/24 at 10:46 a.m., Resident #147 stated he had a wound on his hand and arm. Resident #147 stated the dressing was dirty because the facility had not changed it. Resident #147 stated the facility changed it when he was first admitted to the facility but then did not. An observation on 08/06/24 at 10:46 a.m., revealed Resident #147 had dressings on his right hand/wrist area and another on the upper right arm that was visibly soiled and not dated. The dressing on his right-hand/wrist area had a brown dirty looking substance on the dressing and was not dated. Resident #147 gave (State Agency) SA Surveyor verbal permission to take a picture of the right hand/wrist and arm dressings. Photographic evidence obtained. A review of the Admission Record showed Resident #147 was admitted to the facility on [DATE] with diagnoses that included but not limited to Other specified sepsis, metabolic encephalopathy, bacteremia, thrombocytopenia and pemphigus vulgaris. A review of the Brief Interview for Mental Status (BIMS) evaluation dated 08/06/24 showed Resident #147 had a BIMS score of 15 which indicated intact cognition. Photographic evidence obtained. A review of the Order Summary Report showed the following physician orders related to dressing changes: - A physician order dated 08/02/24 showed, cleanse 3 small open areas on Left lower back with NS, apply Triamcinolone/bacitracin mixture to all open areas and leave open to air- every night shift for wound healing. - A physician order dated 08/02/24 showed, Paint left posterior pinky toe area with betadine daily leave open to air- every day shift for wound healing, - A physician order dated 08/02/24 showed, Cleanse right shoulder with NS, apply Triamcinolone/bacitracin and leave open to air- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse right elbow with NS, apply Triamcinolone/bacitracin mixture to area, cover with xeroform and wrap with kerlix daily and as needed if soiled or dislodged- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse left inner thigh with ns, pat dry , apply collagen and leave open to air- every day shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A physician order dated 08/02/24 showed, Cleanse left groin area with ns, pat dry apply collagen to wound and leave open to air- every day shift for wound healing. -Cleanse right shoulder with NS, apply Triamcinolone/bacitracin and leave open to air- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse right arm with ns, pat dry apply mixture of Triamcinolone /bacitracin to all open areas on arm cover with xeroform and wrap with kerlix- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse left scrotum area with ns, apply collagen and leave open to air daily- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse right hand and wrist with ns, apply xeroform and wrap with kerlix daily and prn if soiled or dislodged- every day shift for wound healing. - A physician order dated 08/02/24 showed, Cleanse right hip with ns, pat dry, mix bacitracin with Triamcinolone a ND apply cover with abd- every day shift for wound healing related to Pemphigus Vulgaris. Review of the August 2024 Treatment Administration Record (TAR) showed Resident #147 did not receive the following dressing changes on 08/05/24. - Cleanse left groin area with ns, pat dry apply collagen to wound and leave open to air- every day shift for wound healing - Cleanse left inner thigh with ns, pat dry, apply collagen and leave open to air- every day shift - Cleanse left scrotum area with ns, apply collagen and leave open to air daily- every day shift for wound healing - Cleanse right arm with ns, pat dry apply mixture of Triamcinolone /bacitracin to all open areas on arm cover with xeroform and wrap with kerlix- every day shift for wound healing. - Cleanse right elbow with NS, apply Triamcinolone/bacitracin mixture to area, cover with xeroform and wrap with kerlix daily and as needed if soiled or dislodged- every day shift for wound healing. - Cleanse right elbow with NS, apply Triamcinolone/bacitracin mixture to area, cover with xeroform and wrap with kerlix daily and as needed if soiled or dislodged- every day shift for wound healing. - Cleanse right hand and wrist with ns, apply xeroform and wrap with kerlix daily and prn if soiled or dislodged- every day shift for wound healing - Cleanse right hip with ns, pat dry, mix bacitracin with Triamcinolone a ND apply cover with abd- every day shift for wound healing related to Pemphigus Vulgaris. - Cleanse right ankle with NS, apply collagen cover with xeroform to the area and cover with border dressing- every day shift for wound healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse right shoulder with NS, apply Triamcinolone/bacitracin and leave open to air- every day shift for wound healing. - Paint left posterior pinky toe area with betadine daily leave open to air- every day shift for wound healing. 2. An observation on 08/06/24 on 10:58 a.m. revealed Resident #47 was sitting in a wheelchair beside his bed. Resident #47 had a soiled dressing on his right lower leg not dated. Resident #47 had blankets under his foot. During an interview on 08/06/24 on 10:58 a.m., Resident #47 stated he had been dealing with the swelling in his right lower leg for over a month. Resident #47 stated he put the blankets were under his right foot because sometimes his leg would drain a small pool of fluids out of it. A review of the Admission Record showed Resident #47 was originally admitted to the facility on [DATE] with diagnoses that included but not limited to chronic embolism and thrombosis of unspecified deep veins of proximal lower extremity, bilateral, low back pain, unspecified osteoarthritis, type 2 diabetes and hereditary and idiopathy neuropathy. A review of the quarterly Minimum Data Set (MDS) dated [DATE], Section C-Cognitive Patterns showed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. A review of the Order Summary Report showed the following physician orders related to dressing changes: - A physician order dated 08/03/24 showed, Cleanse right lower leg with NS pat dry apply medical grade honey, add silver calcium alginate and wrap with kerlix. - every day shift. A review of the August 2024 Treatment Administration Record (TAR) showed Resident #47 did not receive the following dressing change on 08/05/24: -Cleanse right lower leg with NS pat dry apply medical grade honey, add silver calcium alginate and wrap with kerlix. - every day shift. During an interview on 08/07/24 at 4:49 p.m., Staff F, Regional Nurse Consultant (RNC) stated she expected staff to date all dressings and to document the treatment in the TAR. Review of the facility's policy Dressing Change revised date 12/06/17 stated, Policy: A clean dressing will be applied by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered. Procedure: .Document in medical record. 37999 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/6/24 at 10:22 a.m., Resident #68 was observed sitting in a wheelchair in the hallway directly outside of doorway to the resident's room. The observation revealed the resident's right lower extremity was extremely edematous and had a bumpy rough surface. On top of the resident's right foot was a white patch of dry-looking skin. Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM) asked if the resident had a shoe to put on and the resident replied that a shoe would have to be specially made. The staff member asked if the resident had a sock to be put on and the resident responded they told her to keep it off due to cutting circulation off. During an interview on 8/6/24 at 10:40 a.m., Resident #68 revealed her right leg had an infection in it. The resident's right leg was observed without a dressing and in an area directly above the anterior ankle was a scant amount of a bright red wet-looking substance appearing to be coming from a crease in between the numerous bumpy areas. The area was mentioned to and acknowledged by Staff J, who was on other side of hallway administering medications. The staff member stated she would get to it. An observation was made on 8/6/24 at 3:10 p.m. of Resident #68 sitting outside of her room in a wheelchair, yelling down hallway to Staff J as the staff member was walking toward the nursing station. The resident yelled that the staff member had to dress the right leg. The observation revealed a dressing had not been applied to the resident's leg. A review of Resident #68's Admission Record showed the resident had been originally admitted on [DATE] and readmitted on [DATE]. The record included the diagnoses but was not limited to not elsewhere classified lymphedema, morbid (severe) obesity due to excess calories, need for assistance with personal care, and skin transplant status. A review of the [name of wound care vendor] Nurse Practitioner (NP) note, dated 7/30/24, showed the right lower extremity had a partial thickness venous wound, which measured 17-centimeter (cm) x 6 cm x 0.1 cm and covered a area of 102 cm2. The wound had been acquired on 2/5/24, had reopened, and had a moderate amount of serosanguineous exudate. The treatment instructed staff to cleanse with normal saline, cover with silver alginate and rolled gauze daily. A review of Resident #68's July 2024 Treatment Administration Record (TAR) revealed the following physician order: - Clean anterior RLE with normal saline, pat dry, apply skin prep and abdominal (abd) pad, and wrap with (rolled gauze) every shift for weeping. The order started on 7/29/24, discontinued on 8/1/24, and the TAR documentation revealed the order had been administered during the night shift on 7/29 and both day and night shifts on 7/30 and 7/31/24. Review of Resident #68's August TAR revealed the following physician order: - Clean anterior RLE with normal saline, pat dry, apply skin prep and abd pad, and wrap with (rolled gauze) every night shift for weeping. The order was started on 8/1/24 at 7:00 p.m. and was discontinued on 8/8/24 at 11:57 a.m. The TAR documentation showed staff had administered this dressing during the night shift except for 8/3/24 and was Held on 8/7/24. Review of Resident #68's July and August TAR's did not show the Wound NP's treatment order, dated 7/30/24, had been implemented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NP skin and wound note, date of service 8/6/24 at 9:46 a.m., revealed Resident #68 was seen due to follow up for a right lower extremity (RLE) venous ulcer. The exam showed the resident had bilateral lower extremity (BLE) edema with a thickened texture. The assessment was the wound measured 17 cm x 6 cm x 0.1 cm with a surface area of 102 square cm's and a moderate amount of serosanguineous exudate. The treatment recommendations were to cleanse with normal saline, apply collagen to base of wound, secure with rolled gauze, and change daily. The note was signed on 8/6/24 at 9:51 a.m. by the NP. On 8/8/24 at 9:50 a.m., Resident #68 was observed sitting on her bed with lower her extremities dangling from the side of bed. The RLE was wrapped with rolled gauze and dated 8/7/24. The resident stated they don't usually wrap it. An interview was conducted with Staff H, LPN on 8/8/24 at 11:42 a.m., the staff member reported the wound care team came in on Tuesday, the Unit Manager received the wound care orders from the provider and put them into the computer. The staff member stated if the wound was new, staff would call the primary care provider. An interview was conducted with Staff D, LPN/North wing UM on 8/8/24 at 11:43 a.m., the staff member reported the UM's do rounds with the wound Advanced Practitioner Registered Nurse (APRN). The staff member reported the APRN type up their report and the order would come from it. Staff D stated the primary care provider deferred orders to the wound care providers. The staff member reviewed the NP Wound assessment dated [DATE] and confirmed the order was for silver alginate and cover with rolled gauze. Reviewing the TAR she confirmed the order was for skin prep to be applied. Staff D reviewed the wound care NP note on 8/6/24 and confirmed the order for Resident #68's RLE had not been changed, still read for skin prep and rolled gauze to be applied. The staff member reviewed the discontinued orders and confirmed the order for silver alginate and collagen had not been implemented. During an interview on 8/8/24 at 12:00 p.m. Staff H reported working 3 - 12 hour shifts during the week and Resident #68 did not refuse treatments and did not remove dressings. Review of Resident #68's August TAR showed the Wound Care NP order regarding the application of collagen and wrapping with rolled gauze had not been implemented until 8/8/24 and the resident did not have an order for an as needed (prn) dressing change from 7/30 until 8/8/24. An interview was conducted with the Director of Nursing (DON) on 8/8/24 at 12:04 p.m., the DON stated Staff D had started in the position on Tuesday (8/6/24). The DON stated the wound report gets emailed to herself and the Assistant DON, the UM's round with the Wound APRN and any changes would be verbally communicated to the UM. The UM should have made the changes and the orders should have been implemented. The DON stated typically there should be a prn order in case the dressing got dirty or wet. The observation of Resident #68 was discussed and the DON stated the nurse should have dressed the wound and if there was not a prn order the nurse should have obtained one from the physician. Review of the policy - Dressing Change, revised on 12/6/17, revealed A clean dressing will applied by a nurse to a wound as ordered to promote healing. The policy described the procedure for applying a dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy - Physician Orders, revised on 3/3/21, revealed The center will ensure that Physician orders are appropriately and timely documented in the medical record. The procedure for routine orders showed: - A nurse may accept a telephone order from the Physician, Physician Assistant, or Nurse Practitioner (as permitted by state law). - The order will be repeated back to the physician, PA, or ARNP for his/ her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMAR/eTAR). - For pharmacy orders the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing, or completing the order electronically. - The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders require that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record. 4. On 8/6/24 at 11:31 a.m., a wrist splint was observed on the bedside dresser of Resident #37 while the resident laid in bed. The resident was non-verbal but did show staff put it on by nodding her head, the resident shook head in response to liking to wear it. On 8/7/24 at 9:53 a.m., the wrist splint of Resident #37 was shown to be lying on the bedside dresser next to the resident's bed. On 8/8/24 at 4:00 p.m. an observation was made of Resident #37's wrist splint lying near the front of the bedside dresser next to the resident's bed. On 8/9/24 at 8:49 a.m. an observation was made of Resident #37's wrist splint lying near the front of the bedside dresser next to the resident's bed. Review of Resident #37's Admission Record showed the resident was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to left hand contracture, functional quadriplegia, and aphasia. Review of Resident #37's physician orders revealed the resident to wear left (L) hand splint on and off daily or as tolerated by patient every day and night shift, on in a.m./off in p.m., this order was dated 8/3/24. Review of Resident #37's June 2024 Treatment Administration Record (TAR) showed a order for Patient (Pt) to wear left (L) hand splint on and off daily or as tolerated by patient every day and night shift, on in am/off in pm. The order started on 5/7/23 and was discontinued on 8/3/24. The nursing documentation showed the resident's splint was off 21 times, on eight times, and Y one time out of 30 opportunities during the day shift. The night shift documented the resident's splint was on three times and off twenty-seven times during the night shift. The TAR did not reveal the amount of time the resident tolerated the splint being on during the eight times it had been applied. The TAR did have an area for staff to document on and off during the day and night shifts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #37's July 2024 TAR showed an order for Patient (Pt) to wear L hand splint on and off daily or as tolerated by patient every day and night shift, on in am/off in pm. The order started on 5/7/23 and was discontinued on 8/3/24. The documentation showed the splint was off during the day shift 21 times out of 31 opportunities, y was documented twice during the day shift, and on 8 times during the day shift. The night shift documentation revealed the resident's splint was off twenty-nine times, on once, and no revealing documentation on 7/11/24. The TAR did not reveal the amount of time the resident tolerated the splint being on. The TAR did have an area for staff to document on and off during the day and night shifts. Review of Resident #37's August 2024 TAR showed an order, dated 5/7/23 for Pt to wear L hand splint on and off daily or as tolerated by patient every day and night shift, ON in am/off in pm. The record had an area for staff to document whether on or off during each shift. The TAR revealed the splint was off during the three available day shifts and twice on the night shift prior to the discontinuation of the order at 9:38 p.m. on 8/3/24. An order, Pt to wear L hand splint on and off daily as tolerated by patient every day and night shift, ON in am/off in pm was started at 7:00 a.m. on 8/4/24. The order did not allow for documentation of on and/or off during either day or night shifts. The TAR revealed a checkmark had been documented on the day and night shifts of 8/4 - 8/8/24. Per the TAR chart code legend a checkmark revealed the item had been administered. Review of Resident #37's progress notes, including eMAR notes, from 6/9/to 8/9/24 did not reveal documentation of how long the resident tolerated wearing the splint, how the resident tolerated wearing the splint or any behavior associated with the wearing of the splint. Review of the Certified Nursing Assistant (CNA) Tasks for Applying splints device(s) per order, apply splint to left hand as pt will allow. showed Resident #37's splint was on on 7/16, 7/18, 7/27, 7/28, 7/30, 7/31, 8/3, and 8/8/24. The tasks did not reveal the resident refused application of the splint from 7/16 to 8/8/24. The task documentation did not show how long the resident tolerated wearing the splint. Review of Resident #37's care plan showed the Registered Nurse (RN) and CNA were responsible for apply splint as tolerated as ordered related to the resident having contractures of left hand and was at risk for impaired skin integrity, pain and injuries related to cerebrovascular accident (CVA) (and) quadriplegia/paraplegia. The RN was to refer to restorative nursing and therapy as needed. The resident's goal was to remain free from complications of impaired Range of Motion (ROM) through next review date. The care plan showed the resident had a potential for pain/discomfort related to diagnosis of functional quadriplegia, left hand contracture, gout, very limited mobility, history of chronic pain syndrome, and abdominal cramps. The interventions instructed nursing to assess/monitor for non-verbal indicators of pain (pacing, agitation, anxiety, facial grimacing, tearfulness/crying, sad/distant facial expression, gasping/groaning, yelling out) and left hand splinting related to contractures as tolerated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff G, Restorative Aide, on 8/9/24 at 8:40 a.m., the staff member reported responsibilities of the restorative department was assisting with showers, ROM, exercises, Walk to Dine program, and when resident's did not have a payor source for therapy we pick them up, and put splints/braces on. Staff G said she used to put Resident #37's splint on but did not anymore because it caused the resident a lot of pain. The staff member reported the last time putting the resident's splint on was last week, did not have any documentation of the application, and the resident was not on the restorative program and had not been since approximately the beginning of the year. Staff G stated it would be therapy's responsibility to put the splint/brace on. The staff member stated she had been asked by the previous Unit Manager to put splint on so it was about 2 weeks ago, from what the staff member could see the splint caused pain, the resident would yell out and only time that occurred was due to pain. An interview was conducted with Staff I, CNA, on 8/9/4 at 8:50 a.m., the staff member reported not putting Resident #37's splint on, restorative put it on. During the interview with Staff I, on 8/9/24 at 8:50 a.m., Staff G reported being mistaken, therapy did not put Resident #37's splint on, nursing did. The staff member clarified nursing was not the aides but the nurses. An interview was conducted with the Director of Nursing (DON) on 8/9/24 at 9:35 a.m., the DON reported Resident #37 was not on restorative so it was on the TAR for nursing to put it on, the order was to wear as tolerated but it did cause the resident pain. The DON confirmed there were more off's then on's on the June and July TAR's and wasn't any documentation either in the progress notes or TAR of how long the resident tolerated the brace/splint. The DON stated she understood the findings. An interview was conducted with the DON on 8/9/24 at 11:21 a.m., the DON stated per Resident #37's therapy notes, the splint had been tolerated up to 3 hours and the resident had been discharged from therapy on 6/28/24. The DON stated the facility had a communication error related to who was responsible for putting on the splint, therapy and the nursing electronic documentation systems were not integrated so they needed to work on communication. Review of the Occupational Therapy Discharge Summary date 6/28/24, showed at the time of OT discharge Resident #37 tolerated wearing the orthotic device 3.5 hours and 5 minutes of passive ROM to left hand prior to donning the orthotic device. Review of the policy - Prevention Contractures, revised on 8/22/17, revealed To prevent contracture of extremities where those residents who no longer have full use of their extremities. All contracture prevention devices should be removed at least daily for hygiene and observation of skin conditions. Each resident must be evaluated for need of contracture prevention procedures on admission, readmission, and as needed. Residents with inactive extermination should have range of motion exercises done to those extremities as part of their daily care. Some residents may have braces or splints to prevent or help release contractures- be sure to follow the physician's order regarding the schedule of when to put these on and when to remove them.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49227 Based on record review and interview the facility failed to follow the pharmacist recommendations to monitor for behaviors for two residents (#76 and #89) of two Medication Regimen Reviews (MRR) reviewed. Findings included: 1. Review of Resident #76's admission record showed an admitted [DATE], with diagnoses to include bipolar disorder. Review of Resident #76's order summary report, active orders as of 8/7/24 showed the following: Trazadone 50 mg daily for depression Review of Resident #76's August 2024 Medication Administration Report (MAR) showed Trazodone 50 mg was administered daily at 9:00 a.m. Review of Resident #76's care plan showed risk for complications related to the use of psychotropic drugs, initiated on 6/3/24. Interventions included monitor for continued need of medication as related to behavior and mood. Monitor for side effects and consult the pharmacist as needed, initiated on 6/3/24. Review of Resident #76's Pharmacist's Report to Nursing, dated 6/7/24 showed this resident was currently receiving psychotropic medication with required behavior monitoring Trazodone 50 mg for depression. Nursing recommendations: Please add behavior monitoring for .antidepressants . to ensure that behaviors being treated are being helped and adverse effects are also being tracked. On 8/7/24 at 5:01 p.m. the facility had not initiated the pharmacist recommendations for Resident #76. 2. Review of Resident #89's admission record showed an admitted on 5/23/24, with diagnoses to include major depressive, mood, and psychotic disorders. Review of Resident #89's order summary report, showed active orders as of 8/7/24 included Divalproex 1250 mg two times daily for mood disorder, Trazodone 100 mg daily for depression, and Citalopram 20 mg daily for depression. Review of Resident #89's July 2024 Medication Administration Report (MAR) showed Trazodone 50 mg two tabs were administered daily at 9:00 a.m. Citalopram 20 mg administration began on 8/16/24 at 9:00 a.m. Depakote 1250 mg (dose increased on 7/12/24), administration started on 7/12/24 at 9:00 a.m. Review of Resident #89's care plan showed risk for complications related to the use of psychotropic drugs: antidepressant .for mood disorder, initiated on 8/6/24. Resident #89's care plan interventions include . monitor for continued need of medication as related to behavior and mood. Monitor for side affects and consult the pharmacist as needed, initiated on 8/6/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 5:01 p.m. the facility had not initiated the pharmacist recommendations for Resident #89. On 8/7/24 at 5:16 p.m. during an interview the Director of Nursing (DON) said Resident #76's and Resident #89's pharmacist recommendations did not get done, they were missed. Review of the facility's policy titled, Consultant Pharmacist Services Provider Recommendations, dated May 2022. Policy: Regular and reliable consultant pharmacist services are provided to residents. Procedures: C. The consultant pharmacists agrees to render the required service in accordance with local state and federal laws, regulations, and guidelines and professional standards of practice. E. The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility This includes but is not limited to: -3. Assistance in the identification an evaluation of medication-related issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	08/09/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41015 Based on record review and interview, the facility failed to ensure one Dietary Manager out of one Dietary Manager met at least one of the minimum qualifications for the position. Findings included: During an interview on 08/06/24 at 9:00 a.m., Staff B, Dietary Manager (DM) identified as the facility's Dietary Manager. Review of the dietary staff credentials, provided by the facility, showed a Servsafe Certification for Staff A, Corporate Area Support Manager (CASM) with an expiration date 11/12/26. During an interview on 08/06/24 at 1:41 p.m., the Administrator stated Staff A, CASM was not full time and goes between two facilities. The Administrator stated Staff A, CASM was not on the employee list because he was a Traveler and worked for a contracting company. A review of the Nursing Home Key Staffing Form identified Staff B, Dietary Manager as the Dietary Manager for the facility. A review of the Active Employee Report provided by the facility, showed Staff A, CASM was not an employee listed for the facility. During an interview on 08/06/24 at 1:55 p.m., Staff B, Dietary Manager (DM) stated that she was not a Certified Dietary Manager (CDM). Staff B stated she started as the Dietary Manager in the facility around November 2023. Staff B stated that Staff A, CASM goes between his facility and this facility to help. Staff B stated that she was not Servsafe certified but planned to get that certification soon. During an interview on 08/08/24 at 11:00 a.m., Staff A, CASM stated he came to the facility every now and then and was not present in the facility daily. Staff A, CASM stated that he was more like the Problem Solver for the facility. During an interview on 08/08/24 at 4:08 p.m., Staff C, Human Service Director (HSD) stated when she first started working at the facility on 06/06/22 Staff B was a Cook. Staff C was unable to verify what date Staff B became the designated Dietary Manager for the facility.